Congregate Living & Social Services Licensing Board
Tuesday, March 26, 2024, 6:00 PM
Council Chambers, 2nd fl of City Hall, 3 Washington St.

AGENDA

I. **Call to Order:** Roll Call
II. **Vote for Vice Chair**
III. **Minutes of Previous Meeting:** February 27, 2024
IV. **Unfinished Business:**

Updates:
Southwestern Community Services
Keene Serenity Center

V. **Applications:**

Continued CLSS-2024-02: Applicant, Patricia Forman, House Supervisor for Emerald House, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located 32 Emerald St., and is in the Downtown Growth District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Continued CLSS-2024-07: Applicant, Gregg Burdett, Executive Director for Covenant Living of Keene, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located 95 Wyman Rd., and is in the Rural District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Continued CLSS-2024-03: Applicant, Ryan Gagne, Executive Director for Live Free Recovery, is requesting a Congregate Living & Social Services License for a Residential Drug/Alcohol Treatment Facility, located at 881 Marlboro Rd., and is in the Rural District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Continued CLSS-2024-04: Applicant, Ryan Gagne, Executive Director for Live Free Recovery, is requesting a Congregate Living & Social Services License for a Residential Drug/Alcohol Treatment Facility, located at 106 Roxbury St., and is in the Downtown Edge District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-01: Applicant, Melissa Castor, Executive Director for Alpine Healthcare, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located at 298 Main St., and is in the High Density District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-05: Applicant, Hilary Seifer, Executive Director for American House Keene, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located at 197 Water St., and is in the Business Growth & Reuse District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-06: Applicant, Jay Haston, Executive Director for Cedarcrest Center, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located at 91 Maple Ave., and is in the Low Density District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-08: Applicant, Amanda McSweeney, Executive Director for Keene Center Genesis Healthcare, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located at 677 Court St., and is in the High Density District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-09: Applicant, Michael Johnson, Executive Director for Langdon Place of Keene, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located at 136 Arch St., and is in the Rural District and as defined in Chapter 46, Article X of the Keene City Ordinances.

CLSS-2024-15: Applicant, Matthew McCall, Vice President of Community Services for Unity House, is requesting a Congregate Living & Social Services License for a Small Group Home, located at 39 Summer St., which is in the Downtown Transition District and as defined in Chapter 46, Article X of the Keene City Ordinances.

VI. **New Business:**
VII. **Non-Public Session**: (if required)
VIII. **Adjournment**

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City of Keene
New Hampshire

CONGREGATE LIVING AND SOCIAL SERVICES LICENSING BOARD MEETING MINUTES

Tuesday, February 27, 2024 **6:00 PM** **Council Chamber, City Hall**

Members Present:
Andrew Oram, Chair
Alison Welsh
Jennifer Seher

Staff Present:
Jesse Rounds, Community Development Director
Corinne Marcou, Board Clerk

Members Not Present:
Medard Kopczynski
Tom Savastano

1) Call to Order: Roll Call

Chair Oram called the meeting to order at 6:01 PM.

2) Voting for Chair & Vice Chair

Ms. Welsh nominated Mr. Oram as Chair for 2024. Ms. Seher seconded the nomination, which carried unanimously.

The Board tabled nominating a Vice Chair until the March 26 meeting.

3) Minutes of Previous Meeting: November 28, 2023

A motion by Ms. Welsh to adopt the November 28, 2023 meeting minutes was duly seconded by Ms. Seher and the motion carried unanimously.

4) Unfinished Business:

A) Updates:

i) *Southwestern Community Services*

Jesse Rounds, Community Development Director, recalled that when Southwestern Community Services' (SCS) application was last before the Board, the Fire Chief reported that their two shelters, one on Roxbury Street and the other on Water St., were over the approved occupancy in the Fire Code. SCS had a variance pending with the State of NH Fire Marshall's office to allow

the overage in beds. In the interim, the City provided local approval for the overage until the variance ruling. Mr. Rounds recommended tabling this application until the NH Fire Marshall's ruling. If the Fire Marshall does not grant the variance, SCS would need to appear before this Board again to take action. Because the SCS application had not yet been opened to the public, this matter could be tabled.

Ms. Seher motioned to table the SCS application until the variance relative to the NH Fire Code is granted or not, with the understanding that SCS will appear before the CLSS Board for a public session in the coming months. Ms. Welsh seconded the motion, which was carried unanimously.

ii) ***Keene Serenity Center***

Mr. Rounds recalled that the Board granted the Keene Serenity Center a conditional license, dependent upon receiving their Conditional Use Permit (CUP) from the Planning Board (PB) and passing the Fire Department (FD) and Housing inspections. Upon inspection to close out the license, the Housing Inspector found unpermitted work and the Fire Department found several issues as well. It is likely that the CUP would need an extension while other permits are pending.

Ms. Welsh recalled her frequent request to receive the FD and Housing inspections before these CLSS meetings, so the Board members have time to review them. Megan Manke, Fire Prevention Lieutenant, noted that this case was unique because the Serenity Center has active permit applications. In the future, Lt. Manke will continue sending Ms. Marcou the inspection reports as they are available. Ms. Marcou recalled that she was working to create an advanced schedule for these inspections—a month and a half before each hearing—so that she could send the inspection reports to the Board in advance of the meetings. The Fire Department must provide 45 days to an applicant to correct any violations; in an ideal scenario, the violations would be corrected before the applications are before this Board.

No action from the Board was needed at this time for the Serenity Center.

iii) ***57 Winchester Street***

A letter was received from the owners of the lodging house at 57 Winchester Street. The letter was sent to all the neighbors informing them of the change in ownership. Lt. Manke said the only thing remaining for this property was to have their fire alarm tested.

Ms. Welsh motioned to remove the conditions of approval for LB 23-19 so it is now fully approved. Ms. Seher seconded the motion, which carried unanimously.

5) <u>Applications:</u>

A) <u>Continued LB 23-07</u>: Applicant, Gregg Burdett, Executive Director for Covenant Living of Keene, is requesting a Congregate Living & Social

Services License for a Residential Care Facility, located 95 Wyman Rd., and is in the Rural District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Chair Oram opened the hearing and requested Staff comments. Mr. Rounds reported that Staff originally requested this application from Covenant Living of Keene in June 2023. The owners repeatedly did not provide the necessary information. The Executive Director, Gregg Burdett, ultimately provided the information required. Covenant Living's license would be due for renewal in March 2024, so it was up to the Board whether to proceed with the renewal at this meeting, or delay until March to issue a new 2024–2025 license Ms. Marcou recalled that in June 2023, Covenant Living submitted a 600-page application packet, which needed to be reorganized and structured to meet the needs of this Board.

Ms. Seher thought it was odd to wait until March if the Board had questions they could pose at this meeting. The rest of the Board agreed, so they proceeded with the 2023 review.

Chair Oram welcomed Andy Mackey, Facilities Director of Covenant Living of Keene. Mr. Mackey said this application was for the assisted living/nursing care section of the property at 100 Wyman Road (95 Wyman Road is apartments that are exempt from CLSS review). Discussion ensued between Mr. Mackey and the Board.

Ms. Seher expressed concerns about the neighborhood relations plan. She did not see how Covenant Living was reaching out to the surrounding community, but only that Covenant is open to the community wanting to connect with them. It was high-level and did not mention any local entities or connections. Mr. Mackey was unclear on what the Board sought given that this location's only two neighbors are 1/8-mile and 1/4-mile away from the facility. Ms. Seher said she was struck by a portion of the application on being a "good corporate citizen" given that there were no mentions of anything specific to this region. She also thought it was not obvious who members of the community should contact with questions or concerns.

Mr. Mackey sought clarity on what the Board was seeking. Covenant Living bought a pre-established facility (formerly Hillside Village). Ms. Seher was looking for the local connection. While Ms. Seher saw some examples in the emergency preparedness plan, she still did not find anything specific to the Monadnock region, including how the State of NH works with the region. She also did not see anything about aging services. Mr. Mackey said that anyone who needs to connect with Covenant Living can come to the front door or call the main desk (phone number on website; corporate contacts are listed in emergency preparedness plan). Ms. Seher was unable to locate a phone number in the application with NH's 603 area code, nor did she find a staff member listed, to whom the public can communicate problems. Mr. Mackey explained that Covenant Living has a very active marking program, and that Googling Covenant Living would provide a local phone number; Ms. Seher's experience said that was not her experience.

Ms. Seher asked if Covenant Living was reaching out to other local entities on topics like emergency preparedness. Mr. Mackey said yes, Covenant Living has memorandums of understanding with other companies, like Genesis. Ms. Seher asked for the application to list the names and contacts of those within Covenant Living's emergency preparedness network.

Mr. Mackey sought a consistent format or checklist of what to include in the CLSS application package, which he thought was broad. He said it would have been easier if the application specifically questioned who Covenant Living reaches out to in emergencies, for example. Mr. Mackey said they used to have an arrangement with Diluzio Ambulance, which he thought had shifted to Cheshire EMS. Ms. Seher suggested reviewing other entities' applications, like Emerald House, for examples of how to document the local process for emergencies.

Ms. Welsh said she understood Mr. Mackey's frustrations. She noted that this Board tended to get caught-up on the neighborhood relations plan, in particular, to ensure all these agencies are good community members (e.g., with little Police activity and disturbances) and are welcomed in their neighborhoods. She understood that the context was slightly different for Covenant Living because they have few close neighbors. Other good neighborhood relations activities could include open houses, for example, inviting people to tour the facility and making it a more accessible community space. Ms. Welsh agreed that there should be a template to make these applications less confusing. Mr. Mackey explained that he had only worked with Covenant Living for five months and added that there are a lot of hours involved in an application like this.

Chair Oram agreed, recalling that in fall 2023, the Board discussed reviewing how they consider different types of facilities. In listening to the different points-of-view during this meeting, the Chair thought it was clear that the Board has a responsibility to ensure that what it seeks is as clear as possible for the varying applicants. Chair Oram heard a disconnect, much of which was the Board's responsibility, but some was Mr. Mackey's because groups like Genesis provided sufficient applications; however, that information was much more than what the Board really wanted. Chair Oram asked Ms. Seher if her questions had been fully answered. Ms. Seher said she still had another question. It seemed to Chair Oram that a larger discussion was needed, so he recommended continuing this application so Mr. Mackey could work with City Staff to complete the application. Mr. Mackey reiterated that there were a lot of hours involved in this application as well as a $165 permit fee. Chair Oram clarified that the permit cost is not within this Board's purview.

Mr. Rounds noted that City Staff provide all applicants with examples and an outline of what is required in the application. If there was concern about the time involved, Mr. Rounds encouraged Mr. Mackey to work with Ms. Marcou to complete the application. Mr. Rounds understood the frustrations and concerns that sometimes arise while trying to create and streamline a new process, like this license. Staff would continue trying to make this easier for applicants in the future.

Chair Oram reiterated that there was a miscommunication at hand that needed clearing up. Ms. Seher noted that she was not trying to criticize Mr. Mackey, and for some things she should have contacted City Staff for clarity. Her other question was about Covenant Living's staff training; while there were a lot of details on nursing, there were less about social work and fielding complaints that could arise for a long-term care facility. Mr. Mackey said there is a staff pastor who counsels residents and staff. He added that the bulk of this facility is 81 beds of independent apartment living. There is also an established grievance policy overseen by the State of NH, and the Federal government oversees the skilled nursing. Ms. Seher did not see these details in the application.

Ms. Welsh made the following motion, which was duly seconded by Ms. Seher. On a vote of 3–0, the Congregate Living and Social Services Licensing Board continued application LB 23-07 until the March 26, 2024 meeting at 6:00 PM.

B) <u>CLSS-2024-02:</u> Applicant, Patricia Forman, House Supervisor for Emerald House, is requesting a Congregate Living & Social Services License for a Residential Care Facility, located 32 Emerald St., and is in the Downtown Growth District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Chair Oram opened the hearing. Mr. Rounds noted that Emerald House's staff could not attend due to illness.

Chair Oram made the following motion, which was duly seconded by Ms. Seher. On a vote of 3–0, the Congregate Living and Social Services Licensing Board continued application CLSS-2024-02 until the March 26, 2024 regular meeting at 6:00 PM.

C) <u>CLSS-2024-03:</u> Applicant, Ryan Gagne, Executive Director for Live Free Recovery, is requesting a Congregate Living & Social Services License for a Residential Drug/Alcohol Treatment Facility, located at 881 Marlboro Rd., and is in the Rural District and as defined in Chapter 46, Article X of the Keene City Ordinances.

Chair Oram opened the hearing and requested Staff comments. Mr. Rounds reported that this was a license renewal and nothing in the application had changed since the prior approval. Lt. Manke reported that following the December 2023 inspection, only one very minor item was still pending; she was clear that it was up to the Fire Department to complete, and this delay was not because of the applicant.

Chair Oram welcomed Jennifer Houston, Clinical Director of Live Free Recovery, who said that all programming was the same as last year. She had taken the Board's feedback from the last meeting, though there were still some things pending. Chair Oram asked what still remained from that to-do list. Ms. Houston replied that she created a formal document on staff training, she

enhanced engagement with neighbors (minus the jail, which is not interested). Ms. Welsh noticed that some requested details on staff training were not provided in the renewal application. Ms. Houston expressed confusion as she did not know she was supposed to submit these things in advance of this hearing. Ms. Welsh's concern with staff training was due to it being a detox level of care, so she wanted to ensure staff are qualified and receive annual training. Ms. Houston asked what she should submit; she said she was not told to submit anything new since nothing at the facility had changed. Ms. Houston was happy to meet the request once there was clarification.

Ms. Marcou asked whether Ms. Houston could provide the remaining items in advance of the March 26, 2024 meeting. Ms. Houston said yes, but she had not been asked to resubmit for the renewal. Ms. Marcou suggested continuing this hearing until the unfinished business of the March 26 meeting if the Board thought it might have further questions about the submission, or the application could be approved conditionally.

Ms. Houston said she wanted to understand what the Board wanted so she could meet the expectations. Chair Oram suggested that Ms. Houston should work with Ms. Marcou. Based on the level of care and clientele, Ms. Welsh wanted it to be clear that the Live Free Recovery staff are fully trained, including a list of what training the staff had received and their qualifications beyond those. Ms. Houston said that was somewhat subjective and asked for further clarification. Ms. Welsh quoted from the application: "*All licensed staff are required to follow the New Hampshire Board of Licensed Professionals guidelines for obtaining CE and maintaining their license. Staff are required to bring in their updated license when renewal occurs.*" She wanted to ensure that all are trained, licensed, and capable of handling this facility. Training should be identified clearly for each person. Ms. Welsh sought the licenses required and what employees need to do to maintain licensure, in addition to the trainings Live Free Recovery provides annually. Ms. Houston was clear that she does not work for the State of NH, and she has no jurisdiction to tell staff the status of their licensures. Ms. Welsh wanted to know what trainings Live Free Recovery provides that all staff are required to attend, in addition to the items the Board requested during approval last year.

Ms. Marcou explained the difference between continuing an application and approving conditionally. If the intent was to review the extra material to be submitted by Ms. Houston, then Ms. Marcou recommended continuing this hearing so it can all be reviewed collectively.

Mr. Rounds asked if there was a requirement for the applicant to describe the trainings they provide. Ms. Welsh thought so, as other applicants had provided those details. Mr. Rounds was still unsure whether submitting that material was required. Ms. Houston did not recall a required list of trainings. Ms. Marcou clarified that the application only lists that a staff training and procedures plan is required, but does not go on to demand a list of trainings. Mr. Rounds said City Staff would help Ms. Houston with that.

Chair Oram thought this was the nature of any new process. Given the Board's obligation to ensure it is clear about its requests, he thought it was fairest—and least burdensome to the applicant—to continue this application.

Ms. Welsh made the following motion, which was duly seconded by Ms. Seher. On a vote of 3–0, the Congregate Living and Social Services Licensing Board continued application CLSS-2024-03 until the March 26, 2024 regular meeting at 6:00 PM.

D) <u>CLSS-2024-04:</u> Applicant, Ryan Gagne, Executive Director for Live Free Recovery, is requesting a Congregate Living & Social Services License for a Residential Drug/Alcohol Treatment Facility, located at 106 Roxbury St., and is in the Downtown Edge District and as defined in Chapter 46, Article X of the Keene City Ordinances.

If the Board had questions similar to those they presented above for application CLSS-2024-03, Mr. Rounds suggested opening this hearing and continuing it as well. Chair Oram opened the hearing and again welcomed Ms. Houston, Clinical Director of Live Free Recovery. There were no further comments from Lt. Manke.

With this application as well, Ms. Welsh was seeking more details on required staff trainings, and a more elaborate neighborhood relations plan. She understood why the neighborhood relations plan was more challenging for the 881 Marlboro Road location, but thought it was more possible for this location. Ms. Houston said she was doing her best with outreach to the nearby apartments, where the residents are not always consistent.

Ms. Welsh made the following motion, which was duly seconded by Ms. Seher. On a vote of 3–0, the Congregate Living and Social Services Licensing Board continued application CLSS-2024-04 until the March 26, 2024 regular meeting at 6:00 PM.

6) <u>New Business:</u>

A) 2024 Meeting Calendar

A motion by Ms. Seher to accept the 2024 meeting calendar was duly seconded by Ms. Welsh and the motion carried unanimously.

There was no other new business.

7) <u>Non-Public Session (if required)</u>

Chair Oram asked in what situations a non-public session would be required. Mr. Rounds confirmed that there was almost no chance of this Board needing a non-public session.

8) <u>Adjournment</u>

There being no further business, Chair Oram adjourned the meeting at 6:59 PM.

Respectfully submitted by,
Katryna Kibler, Minute Taker
March 5, 2024

Reviewed and edited by,
Corinne Marcou, Board Clerk

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:	
Case No.	LB 24-01
Date Filled	12/27/23
Rec'd By	CM
Page	1 of 3
Tax Map#	584-065-000
Zoning District:	DT-G

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

○ Drug Treatment Center	○ Group Home, Small	○ Homeless Shelter
○ Fraternity/Sorority	○ Group Resource Center	○ Lodging House
○ Group Home, Large	○ Residential Drug/Alcohol Treatment Facility	◉ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 32 Emerald St

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Monadnock Affordable Housing Corp.	**NAME/COMPANY:** Monadnock Family Services
MAILING ADDRESS: 831 Court St. Keene, NH 03431	**MAILING ADDRESS:** 64 Main St Keene
PHONE: (603) 352-6161	**PHONE:** (603) 352-6649
EMAIL: jmeehan@keenehousing.org	**EMAIL:** pforman@mfs.org
SIGNATURE: [signature] **DATE:** 12/17/23	**SIGNATURE:** Patricia Forman **DATE:** 12/27/23
PRINTED NAME: Joshua R. Meehan **TITLE:** Executive Director	**PRINTED NAME:** Patricia Forman **TITLE:**

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY:	**NAME/COMPANY:** Monadnock Family Services
MAILING ADDRESS:	**MAILING ADDRESS:** 64 Main St Keene
PHONE:	**PHONE:** (603) 352-6649
EMAIL:	**EMAIL:** pforman@mfs.org
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Patricia Forman **TITLE:**

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Residents of Emerald House are clients of Monadnock Family Services and qualify as adults with severe and persistent mental illness. Emerald House staff offers ADL's coaching and prompting, as well as making and keeping appointments, providing transportation, 1:1 general support in the community, ordering and administering medications, meal planning and preparation and crisis intervention.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Emerald House is a ten bed, 24 hour staffed facility. The ten beds are consistently filled. During the day, from the hours of 7 AM to 7 PM, there may be 2-5 staff members working, while 1-2 other MFS providers may be in the house or on the grounds working with clients. Residents may host two visitors during the hours of 10 AM to 5 PM. The facility has 4,616 sq. ft. of living space and sits alone on a 0.24 acre lot.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

The average stay at Emerald House is 3 years.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled _____
Rec'd By _____
Page _____ of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

○ Drug Treatment Center	○ Group Home, Small	○ Homeless Shelter
○ Fraternity/Sorority	○ Group Resource Center	○ Lodging House
○ Group Home, Large	○ Residential Drug/Alcohol Treatment Facility	◉ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 95 Wyman Road, Keene, New Hampshire 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Covenant Living of Keene	NAME/COMPANY: Covenant Living of Keene
MAILING ADDRESS: 95 Wyman Rd., Keene, NH 03431	MAILING ADDRESS: 95 Wyman Road, Keene, NH 03431
PHONE: (603) 353-0608	PHONE: (603) 353-0608
EMAIL: GBurdett@CovLiving.org	EMAIL: GBurdett@CovLiving.org
SIGNATURE: DATE: 1/15/24	SIGNATURE: DATE: 1/15/24
PRINTED NAME: Gregg Burdett TITLE: Executive Directo	PRINTED NAME: Gregg Burdett TITLE: Executive Director

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	NAME/COMPANY:
MAILING ADDRESS:	MAILING ADDRESS:
PHONE:	PHONE:
EMAIL:	EMAIL:
SIGNATURE: DATE:	SIGNATURE: DATE:
PRINTED NAME: TITLE:	PRINTED NAME: TITLE:

SUBMITTAL CHECKLIST

A complete application must include the following items and submitted by one of the options below:

- **Email:** communitydevelopment@keenenh.gov, with *"CLSS License Application"* in the subject line

- **Mail / Hand Deliver:**
  Community Development (4th Floor)
  Keene City Hall,
  3 Washington St, Keene, NH 03431

The submittal requirements for a Congregate Living & Social Services License application are outlined further in **Chapter 46, Article X** of the City of Keene Code of Ordinances.

Note: Additional information may be requested to complete the review of the application.

✓ **PROPERTY OWNER:** *Name, phone number and address*	✓ **POINT OF 24 HOUR CONTACT:** *Name, phone number, and address of person acting as the operator, if not owner* **Same as owner**
✓ **REQUIRED DOCUMENTATION:** *Provide all required state or federal licenses, permits and certifications*	✓ **WRITTEN NARRATIVE:** *Provide necessary information to the submittal requirements*
✓ **PROPERTY INFORMATION:** *Description of the property location including street address and tax map parcel number*	✓ **APPLICABLE FEES:** $165.00 application *(checks made payable to City of Keene)*
○ **COMPLETED INSPECTION:** **or** *Inspection date:* _____	✓ **SCHEDULED INSPECTION:** *Inspection date:* 1/10/24
✓ **OPERATIONS AND MANAGEMENT PLAN:** Plan based on the industry standard *"Best Management Practices"* to include:	✓ **LOCATION MAP:**

◊ Security Plan
◊ Life Safety Plan
◊ Staff Training and Procedures Plan
◊ Health and Safety Plan
◊ Emergency Response Plan
◊ Neighborhood Relations Plan
◊ Building and Site Maintenance Procedures

In addition, Homeless Shelters will provide:

◊ Rules of Conduct, Registration System and Screening Procedures
◊ Access Policies and Procedures

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Covenant Living of Keene is a senior living continuing care retirement community affiliated with Covenant Living Communities and Services, a multi-institutional continuing care system of retirement communities, assisted living facilities and/or skilled nursing facilities affiliated with The Evangelical Covenant Church.
Covenant Living of Keene consists of 140 units of independent living, 43 units of assisted living, 18 memory support units and 20 skilled nursing beds. There is no required minimum age, but in general, residents of the facility are age 62 and older.
Covenant Living of Keene offers a broad range of health care services to its residents, including assisted living services, care for the memory impaired, skilled nursing and respite care. Residents who require either assisted living services or memory support for dementia receive assistance with such routine activities of daily living as bathing, grooming, dressing, eating, ambulating, and taking medications. The skilled nursing facility is a 24-hour facility. Residents have access to services such as routine health screenings, nursing care, and specialized services such as speech, physical and occupational therapy. Resident are also able to stay in the skilled nursing center while recovering from a sort-term illness of injury.
Covenant Living of Keene also offers dining facilities and recreational activities such as art classes, exercise facilities, woodworking, and entertainment, cultural arts and educational opportunities.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Covenant Living of Keene is approximately 350,000 square feet of of structures located on 66 acres of real estate, currently housing 180 independent living residents and 54 residents in its healthcare facilities. There are 131 employees, including security, offering 24 hours per day/7 days per week care to the residents, with approximately 50 visitors per day.

Housing is designed for seniors to meet their physical, psychological, recreational, social, and spiritual needs. All residential units contain special design features and an emergency call and voice communication system. In addition, each unit has sprinklers for fire protection and a smoke-detection system. Covenant Living of Keene is therefore able to admit non-ambulatory residents to the community and permit residents who are ambulatory at the time they enter the community to remain in their units and "age in place" if their circumstances change.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

The average length of stay for residents of the independent living units is nine years. The average length of stay for resident of the assisted living units is four years.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. CLSS - 2024-03
Date Filled 2/16/24
Rec'd By GM
Page 1 of 4
Tax Map# 240-033-000-001
Zoning District: Rural

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

- ○ Drug Treatment Center
- ○ Fraternity/Sorority
- ○ Group Home, Large
- ○ Group Home, Small
- ○ Group Resource Center
- ◉ Residential Drug/Alcohol Treatment Facility
- ○ Homeless Shelter
- ○ Lodging House
- ○ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 881 Marlboro Rd Keene, NH 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: 2nd Chance Solar, LLC	**NAME/COMPANY:** Live Free Recovery Services, LLC
MAILING ADDRESS: 21 Madbury Rd Durham, NH 03824	**MAILING ADDRESS:** 106 Roxbury st. Keene, NH 03431
PHONE: -	**PHONE:** (877) 932-6757
EMAIL:	**EMAIL:** rgagne@livefreerecoverynh.com
SIGNATURE: **DATE:**	**SIGNATURE:** Ryan Gagne **DATE:** 2/16/24
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Ryan Gagne **TITLE:** Owner/CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY:	**NAME/COMPANY:** Live Free Recovery Services, LLC
MAILING ADDRESS:	**MAILING ADDRESS:** 106 Roxbury ST Keene, NH 03431
PHONE:	**PHONE:** (877) 932-6757
EMAIL:	**EMAIL:** info@livefreerecoverynh.com
SIGNATURE: **DATE:**	**SIGNATURE:** Jennifer Houston, LICSW, MLADC **DATE:** 2/16/24
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Jennifer Houston **TITLE:** Clinical Director

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Clinically appropriate withdrawal management services will be provided for men and women 18 years of age and older. There are licensed nurses and clinical staff, residential services staff, and support staff. This facility is staffed with awake staff members 24/7.
There will be residential services including group therapy, case management, psychiatric services, and peer support.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

There will be maximum of 22 clients at the building. There will be staff at the building 24 hours a day. There is an outdoor smoking area that the clients use throughout the day.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

The average length of stay is between 4 to 7 days.

Congregate Living & Social Services Licensing Inspection Checklist

Name of Organization: Live Free Recovery

Address of Property: 881 Marlboro Rd

1)	Exterior	N/A
Notes:	No concerns noted.	
2)	Hallways/Stairwells	N/A
Notes:	No concerns noted.	
3)	Storage/Closets	N/A
Notes:	No concerns noted.	
4)	Bathrooms	N/A
Notes:	Multiple bathroom ceilings are peeling paint and have moisture damage. No appearance of proper mechanical ventilation.	
5)	Basement/Attic/Utility Room	N/A
Notes:	Utility room ceiling has hole in it.	
6)	Kitchen/Food Prep Area	N/A
Notes:	No concerns noted.	
7)	Bedrooms/ Classrooms	N/A
Notes:	No concerns noted.	
8)	Common Areas	N/A
Notes:	No concerns noted.	
9)	Offices	N/A
Notes:	No concerns noted.	
10)	Electrical Systems	N/A
Notes:	No concerns noted.	
11)	Heating System	N/A
Notes:	No concerns noted.	
12)		
Notes:	Work without a permit. Added a floating wall to the conference room to create office space. Concerns from fire department. Concerns over outlet coverage.	

Date of Inspection: December 19, 2023	Inspector: Ryan Lawliss

City of Keene

FIRE DEPARTMENT

Office of the Fire Marshal

Office: 31 Vernon Street Keene, NH 03431

Telephone: (603) 357-9861 • **Fax:** 603-283-5668

KFDlifesafety@keenenh.gov

NOTICE OF VIOLATION AND ORDER TO CORRECT

Date of Inspection:	12/19/2023
Date of Notice:	01/16/2024
Occupancy:	Live Free Recovery Services 881 Marlboro Road Keene, NH 03431
Owner:	2ND CHANCE SOLAR LLC 21 MADBURY RD. DURHAM, NH 03824

This Notice details the findings of the inspection conducted on 12/19/2023. Present at this inspection was Lt. Meghan Manke. The buildings were inspected for compliance with the minimum standard for existing buildings as required by the State Fire Code and State Building Code. The building was inspected for fire and life safety concerns. Other problems with the building may need to be addressed that are outside the scope of this inspection. This Notice reflects the violations that were observed at the time of the inspection. Other violations may exist that were not observed at the time of the inspection. In summary, the building is classified as Rooming/Lodging . Below is a breakdown of the observed Fire Code Violations. Pursuant to RSA 154:2, II(a), RSA 47:17, XVI, and City Code Section 42-1, you are hereby ordered to correct the below violations within 45 days of receipt of this Notice.

VIOLATIONS OF STATE FIRE CODE

NFPA 1: 11.1.3.2. Multiplug Adapters. Multiplug adapters shall not be used as a substitute for permanent wiring.

Multiplug in nurses office

NFPA 101: 13.3.1 Protection of Vertical Openings Any vertical opening shall be enclosed or protected in accordance with Section 8.6

-Opening in ceiling in sprinkler room
-Opening in ceiling/top of wall in sprinkler room (data cables)

NFPA 13:8.6.6.1 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.

Reduce height of storage in supply closet

NFPA 72: 18.5.11. Visible Signaling. Public mode visible signaling shall meet the requirements of Section 18.5 using visible notification appliances. 18.5.1.2 *
The coverage area for visible occupant notification shall be as required by other governing laws, codes, or standards. Where the other governing laws, codes, or standards require visible occupant notification for all or part of an area or space, coverage shall only be required in occupiable areas as defined in 3.3.178.

No strobe present in new, unpermitted office space. Per CD, will work with them to ensure new space is compliant and appropriate permits are pulled.

CORRECTION OF VIOLATIONS OF STATE CODES

Due to the severity of these violations, you are hereby ordered to correct these violations within 45 days of receipt of this Notice; a reinspection will be conducted on 45 days from this Notice. City Code Sec. 42-1(a).

If a violation is unable to be correct within the timeframe provided, within 45 days of receipt of this Notice, you must provide an action plan to correct those violations. A corrective action plan may be sent to: KFDlifesafety@keenenh.gov.

APPEALS

If you disagree with Notice, you may appeal to the Keene Fire Chief, or his designee, **within 10 days of the date of your receipt of this Notice**. City Code Sec. 42-32; RSA 31:39-c, I. Your appeal must be sent to: KFDlifesafety@keenenh.gov.

If, following the Keene Fire Chief's or his designee's review, you disagree with the decision of the Keene Fire Chief or his designee, you may appeal the Keene Fire Chief's decision to the City of Keene's Board of Appeals **within 15 days of your receipt of the Fire Chief's decision**. RSA 674:34, I; City Code Sec. 2-741 - 2-743.

A request for a variance from or exception to the State Fire Code may be made to the State Fire Marshal. RSA 153:4-a, I; N.H. Admin. R. Saf-C 6005.04. Such a request may be made via: https://www.nh.gov/safety/divisions/firesafety/documents/variance-request-form.pdf. A copy of any request for a variance or exception made to the State Fire Marshal shall be mailed to the City of Keene Fire Department, 31 Vernon Street, Keene, NH 03431.

FURTHER INFORMATION

If you have any additional questions or concerns, do not hesitate to contact me at the contact information below.

MEGHAN MANKE
mmanke@keenenh.gov
FIRE PREVENTION OFFICER

CERTIFICATION OF DELIVERY

I, MEGHAN MANKE, certify that I delivered this Notice to the Owner listed above on via:

- ☐ Certified Mail
- ☐ In-Hand Delivery

Signature:

ATTACHMENTS

This Notice includes the following attachments:

Good afternoon

I am writing to introduce myself to you and to let you know Live Free Recovery Service is operating at identified locations in Keene.The new owners are doing a thorough screening of all tenants and will maintain the building in conformity with the neighborhood. We encourage you to contact me with any questions or concerns you may have with regards to the building and any thing that happens there that is causing a disturbance in the neighborhood.

I can be reached at any time at 877-932-6757 or by email at info@livefreerecoverynh.com

Sincerely,

Live Free Recovery Services

We must abide by HIPPA as well as CFR42
42 CFR, Part 2 Summary Overview 42 CFR Part 2 (commonly referred to as "Part 2") are the federal regulations governing the confidentiality of drug and alcohol abuse treatment and prevention records. The regulations set forth requirements applicable to certain federally assisted substance abuse treatment programs limiting the use and disclosure of substance abuse patient records and identifying information. These regulations were enacted in 1987 by the Secretary of the US Department of Health and Human Services (HHS) as authorized by both the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1972. These Acts and the Part 2 regulations provide comprehensive privacy protections in an effort to encourage people to seek treatment for substance abuse problems. Part 2 sets forth the limited circumstances in which substance abuse patient information may be used or disclosed, and no uses or disclosures other than those detailed in the regulations are permitted. Generally, written patient consent is required to disclose the patient's records. A written consent must contain certain elements and be narrowly tailored to limit disclosure to the specific parameters in the consent. There are exceptions to the consent requirement, which permit programs to disclose or use substance abuse patient information: • In the course of internal program communications; • In a communication with a Qualified Service Organization (an outside organization that provides services to the program, such as dosage preparation or lab analysis); • In medical emergencies; • In response to a crime against program personnel or on program premises (or threats to commit such a crime); • For research activities; • For audit and evaluation activities; • To report suspected child abuse or neglect; • In circumstances involving certain minors or incompetent patients; and • In response to a valid court order. All of these exceptions have very specific requirements and are limited in scope. What Programs Are Covered by Federal Confidentiality Laws? 42 CFR Part 2 applies to any program that: 1) Involves substance abuse education, treatment, or prevention; and 2) Is regulated or assisted by the federal government (42

U.S.C. § 290dd-2; 42 C.F.R. § 2.11- 2.12). What Information Is Protected? 42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. How Can Protected Information Be Shared? Information can be shared if written consent is obtained through a Release of Information Form (ROI). A written consent form requires ten elements (42 C.F.R. § 2.31(a); 45 C.F.R. § 164.508(c)): 1) The names or general designations of the programs making the disclosure; 2) The name of the individual or organization that will receive the disclosure; 3) The name of the patient who is the subject of the disclosure; 4) The specific purpose or need for the disclosure; 5) A description of how much and what kind of information will be disclosed; 6) The patient's right to revoke the consent in writing and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice; 7) The program's ability to condition treatment, payment, enrollment, or eligibility of benefits on the patient agreeing to sign the consent, by stating: a. The program may not condition these services on the patient signing the consent; or b. The consequences for the patient refusing to sign the consent. 8) The date, event, or condition upon which the consent expires if not previously revoked; 9) The signature of the patient (and/or other authorized person); and 10) The date on which the consent is assigned. The consent form must also include the language: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

STAFF TRAINING MATERIALS

Jennifer Houston, MLADC, LICSW

LIVE FREE RECOVERY SERVICES, LLC 17 Kit Street Keene, NH 03431

Live Free Recovery Services, a 3-year-old family business whose passion is about opening doors for clients that others have shut, welcomes you.

We specialize in Providing extraordinary treatment services to achieve extraordinary outcomes. our sweet spot. If you want to belong to a team that does that well every day, this company's a great fit for you.

You'll love coming to work every day if you get, want, and have the capacity to do:

- ***Show compassion in a one on one setting***
- ***Challenge clients in positive and supportive way***
- ***Understand and value the importance of up-to-date thorough documentation***
- ***Run engaging and interactive groups with the clients***
- ***Be part of a team that works collectively***

Client Belongings:

Bed Bug Protocol

- ALL OUTSIDE BELONGINGS MUST BE ZAPPED FOR A MINIMUM OF ONE HOUR
- Confirm with first shift it has been completed
- Includes bags and suitcases
- When placing whole bags and suitcases in zapper, make sure that they are open and unzipped.
- Zapper must be at 125 degrees Fahrenheit for the ENTIRE HOUR.

Smoke Breaks

- Hourly smoke breaks (As time permits)
- Nicotine bucket ALWAYS be in staff hands.
- Staff hands out cigarettes and vapes
- Smoke breaks are ALWAYS supervised by staff.

Phone Calls

- Client phone calls done in the RSS office ONLY
- Phone calls are ten minutes long
- Staff dials the phone for the client
- Phone calls are ALWAYS monitored and supervised by staff

Outside AA Meeting Etiquette

<u>For Clients</u> (Go over in van every time we take to a meeting as a reminder)

- Sit together
- Respectful of coffee, creamer, and snacks
- Bring an offering (Cookies, etc.).
- Mindful of language used.
- Always representing Live Free

<u>For Staff</u>

- It is important to remember even if we are in recovery ourselves, we are taking clients to a meeting as a part of our job, not our own recovery.
- Staff should not be on their phones, sharing in group discussion, or meeting up with friends or significant others
- Take note of how clients show up at meetings for shift notes
- ALWAYS REPRESENTING LIVE FREE

In-House Commitments

- Schedule in house commitments from 7:00 pm – 8:00 pm.
- Get prior approval for all commitments from a supervisor.
- Identify and summarize the commitment in evening shift notes. Can we add something about “identify commitment speakers, who they are, where they came from (Home sober living)
- In-House Groups
- If there is no commitment scheduled, run a group with the clients during the commitment time slot

- Too much downtime in the evenings invites chaos into the house – Keep to the schedule
- Groups can be AA- based - (Big book, 12&12, Daily Reflections etc.)
- Identify and summarize the group in evening shift notes.

Q15s (15 minute checks)

NAME	300	315	330	345	400	415	430	445	500	515	530	545	600	615	630	645	700	715	730	745	800	815	830	845	900	915	930	945	1000	1015	1030	1045	1100

- Use this sheet as a guide to keep track of all clients during the second shift.
- Do rounds of the house every 15 minutes to put eyes on every client
- Take note of where clients are congregating. These notes will help you with your shift notes later.
- Common areas? Tv? Games?
- Which clients are congregating together?
- Bedrooms? Isolating?
- Reading/Writing/crafting/napping?

Second Shift Schedule

Afternoon meds: 3:30-4:00
Phone Calls: 4:00-6:00
Commitment/Group: 7:00-8:00
Night Meds: 8:00-9:30
Pull Remotes at 10:00 and have a last smoke break
Clients in bedrooms by 10:30
10:30 – 11:00 STAFF WRITES SHIFT NOTES.

Shift notes are an essential task completed by housing to inform the clinical team on client's behavior.

PROPER DOCUMENTATION/HOW TO REPORT

- **No Opinions,** strictly **fact-based** observations
- "SEEMS", "APPEARS", or ANYTHING OF THAT NATURE ARE NOT OKAY FOR SHIFT NOTES
- No slang, or swear words unless directly quoting a client for issue-related purposes.
- **Not only for reporting negative behavior** - If a client is doing great, the team wants to hear about it!
- Should include chores, participation in commitments/meetings, phone call interactions, peer interactions, how are they spending their time?
- Keep it client specific
- **EXAMPLE**
    - "Rose N has been upset with her peers, **AS EVIDENCED BY** her telling the entire room to 'go to hell' and spending the rest of the evening in her bedroom".

- **Commitments** - Please include a brief summary of the commitment. Who came to the house/What kind of commitment was it? Did the clients engage and participate?

Shift notes are **NOT OPTIONAL** and are a mandatory task for second and third shift Mon-Fri and first, second, and third shift Sat and Sun.

Shift Notes

Notes should be client specific (Follow the template)
No OPINIONS, document FACT-BASED observations
Stay away from using words like SEEMS or APPEARS.
Do not use slang or swear words unless DIRECTLY QUOTING A CLIENT for issue-related purposes.
Refer to the example shift note below as a guide.

EXAMPLE SHIFT NOTE

Shift Report

Date: 04/02/2023
Shift: 3pm to 11pm
Staff on Duty: Jen

Census: 10
Admissions this shift: 1 Darlene
Discharges this shift: 0

Brief overall summary of the shift:
Clients in positive space tonight, clients were visible in all common areas laughing and talking.
The new admission Darlene arrived at 5pm, search of person and urine were done at that time.
At 7pm a commitment came from Primary Purpose AA group (Judy and Michelle) all clients were in attendance

All clients attended incoming commitment, **Please indicate who came in for the commitment, I.E. "Judy from Haven of Hope"** completed chores, took medications, ate dinner, were in bed/awake at appropriate time. Clients in positive spirits, were helpful and respectful of peers and staff etc.

Did clients make a call? Who did they call? What did you observe, i.e. planning to AMA, talking about discharge, making positive statements, etc.

CLIENT NOTES:
Client 1 (Anna) Anna spent most of the shift in the downstairs living room. She used her phone time to call her mother. They had a positive call. She went to bed without any issues
Client 2 (Gertrude) Gertrude was crocheting in the downstairs living room the entire shift. Gertrude did not have a phone call this evening. She did ask a member of the incoming commitment to be her sponsor
Client 3 (Phyllis) Phillis spent most of the evening isolating in her room. Other than making a phone call to her husband Bob Vance. This call was negative and argumentative, Phyllis repeatedly asked him to come take her home. Phyllis was prompted x3 to come to the commitment before she joined
Client 4 (Penelope) Penelope spent most of the evening bullying her roommate. Penelope continues to bully this roommate about missing food and hoarding Penelope's preferred snack. This was overheard by this writer and included statements such as "you fat pig, those Oreos were mine"
Client 5 (Sylvia) Sylvia was present at the commitment and went to bed without issue. Did not have a phone call.
Client 6 (Bethany) Bethany was present at commitment went to bed without issue. Did not have a phone call.
Client 7 (Yvonne) Yvonne was upset after having tense conversations with her roommate. Yvonne asked this writer to discuss the possibility of her moving rooms. Yvonne made a call to her sponsor and was in positive space throughout the call.
Client 8 (Ursula) Ursula slept the entire shift, an email was sent to med provider with vital signs and symptoms.
Client 9 (Darlene) Darlene was visibly impaired on admission, this was observed as difficulty remaining alert, nodding off at the table, slurred speech, unstable on her feet. Darlene was shown to her room and was able to stay there for the remainder of the shift
Client 10 (Petunia) Petunia was present at commitment went to bed without issue. Did not have a phone call.

Completed Tasks:
Ie. House laundry completed, med count, q15 minute checks

Tasks that need to be completed for the next shift:
Finish searching Darlene's belongings and log property, they are currently in the bug zapper

Behavioral Issues/Client Concerns:
Ie. Yvonne and Penelope had a heated discussion this writer witnessed regarding food. This writer specifically heard Penelope use negative language and name calling. Yvonne did not engage and left the room.

Medical:
Darlene will need to be assessed.
Ursula was ill and in bed all shift, vitals and symptoms sent

Supplies needed:
One bottle of detergent left, three rolls of toilet paper left, cleaning supplies, sharpie, pens, trash bags etc.

Person Searches

- Complete in a closed off area
- Instruct client to remove each article of clothing except for their bottom undergarments
- Search clothing thoroughly in front of the client
- All pockets
- Run fingers along all seams, searching for irregularities
- Search every nook and cranny of the bra (If applicable – there are many hiding spots in this garment)
- Turn socks inside out
- Search foot ware thoroughly
- Instruct the client to shake out their hair in front of you. (If hair is tied up or in a bun, have them remove the elastic as well before shaking out their hair)
- Instruct the client to put their thumbs in the waistband of their bottom undergarment and rotate them around all the way to the back to show staff nothing is hidden inside.
- This is usually the time to collect cell phones, pocketknives, lighters, vapes, and cigarettes. Bring a gallon Ziplock with you.
- Dispose of any narcotics and/or paraphernalia with a second staff person. Make sure it is documented properly.
- It is important to remember that Live Free reserves the right to conduct a person's search at any time, NOT JUST AT INTAKE. If you SUSPECT – Do the search. It could save a life.
-

Room Searches

- Live Free reserves the right to search any bedroom at any time. It is important to conduct random room searches and immediate searches on suspicion.
- Search everything in the room you can think of possibly being a hiding place
- Ceiling tiles
- Mattresses/pillows/bed area in general
- Drawers/closets/all bags
- Nightstands
- Random room searches will usually help you discover if clients are hoarding food or hiding nicotine products.
- UA's
- Observed UA's need to be completed on admission, immediately on suspicion of use, and at a minimum of twice weekly while they are in treatment with Live Free.
- All UA's are to be sent to Dominion Labs for analysis. (Including quick cups).
- Complete 1 on 1 with client in a bathroom.
- Be constantly aware of client's body language
- Dipping a quick cup in the toilet bowl water will alter the results of the cup. (And is a good indication of foul play)
- Use a "hat" on suspicion and instruct the client to keep their hands in the air while producing.
- Constant acute observation during this entire process is absolutely necessary.
- Shuffling, constant hand movements, dropping the cup, nervous body language are all indicators of foul play during a UA.

Boundaries

Even though we may know clients from our past using days, gone to treatment with, or just identify with, it is important to remember that they are **clients** and we are **staff**.

Unless you have been given permission by a supervisor for extenuating circumstances you are not to provide your personal cell phone number (Or be communicating by cell phone) with any of our clients or past clients. If a current client is struggling and reaches out, please redirect them to their clinical staff and inform a supervisor. If a past client is struggling and reaches out, please redirect them to the admissions line. **(877) 932-6757**

We should not be accepting "Friend Requests" on social media from IOP clients and/or other PHP/IOP Alumni.

We should not be spending any time with clients that is not in a clinical setting at the center.

I understand that the recovery community is small, and you will encounter each other in 12-step recovery meetings and events. If they approach and say hi, please keep your interactions cordial and brief.

Observed Medication Pass

Moving forward when giving medications, ANY medications, mouth checks need to be done on the clients.

I understand that this extends medication time, however the safety of the clients is of the highest importance. If we are not doing mouth checks consistently, it is much easier for the clients to divert their medication.

Please have the clients do the following when administering medications:

If wearing long sleeves, roll their sleeves up to/past the elbow. Their hands need to remain in sight at all times.

It is very easy to drop pills down a long sleeve shirt or sweatshirt

The client should not be handling the medication, they should be dumping it in their mouth directly from a medication cup and not placing the medication in their hands.

It is very easy to drop pills onto their lap, the floor, a sweatshirt pocket etc. if they are handling the pills

If the client is taking a dissolving medication (Suboxone, Subutex) they need to remain in sight of staff until the medication is completely dissolved. This should take a minimum of 3-5 minutes depending on the size of the strip or pill. The client should take all their other medications prior to taking this medication. The client can remain sitting in the office under staff supervision while it melts and the staff can see another client if staff feels comfortable closely monitoring both clients at once. **Keep in mind if there are two clients in the office at once, you cannot disclose personal information (names of medication, dosages of medications etc.)**

It is very easy to divert this medication by spitting it out once they leave the office

Prior to leaving the office, the client needs to show staff the inside of their mouth. Clients need to stick their tongue out as far as possible, lift it up and then down, and then side to side. Staff needs to be looking under the client's tongue as well as on the sides of the client's mouth and in the client's cheeks. If you feel the client has done these motions too fast, please have them repeat it slower. Clients will try to rush through this, and it is staff's responsibility to ensure they are thoroughly checking for cheeked medications.

Failure to follow this procedure when distributing medications moving forward may result in disciplinary action.

Medication Management and Withdrawal Symptom Recognition

- **Introduction and Facility Orientation: (30 minutes)**
- Welcome to the organization and introduction to the detox facility's mission and values.
- Facility tour, introduction to key personnel, and overview of the detox process.
- Explanation of the importance of supportive trainings for staff well-being and client care.

Module 1
Understanding Substance Use and Addiction

- Overview of common substances of abuse and their effects on the body.
- The neurobiology of addiction and its impact on behavior and brain function.
- Stages of addiction and the importance of empathetic understanding.

Module 2: Trauma-Informed Care

- Introduction to trauma-informed care principles and their relevance in detox.
- Recognizing signs of trauma in clients and understanding their triggers.
- Strategies for creating a safe and supportive environment for trauma survivors.

Module 3: Cultural Competency and Sensitivity

- Importance of cultural awareness and sensitivity in substance use treatment.
- Addressing diverse cultural, ethnic, and socio-economic backgrounds.
- Effective communication and respectful engagement with clients from different cultures.

Module 4: Self-Care and Stress Management

- Exploring the challenges and stressors of working in a detox facility.
- Introduction to self-care strategies: mindfulness, exercise, hobbies, etc.

- Encouraging staff to seek support, both internally and externally

Module 5: Communication Skills and De-escalation
- Effective verbal and nonverbal communication techniques.
- De-escalation strategies for diffusing tense situations.
- Role-playing exercises to practice communication and de-escalation.

Module 6: Medication Management and Withdrawal Symptom Recognition
- Proper administration and documentation of medications during detox.
- Recognizing common withdrawal symptoms for various substances.
- Identifying potential medical emergencies and appropriate actions.

Module 7: Ethical Considerations and Boundaries
- Ethical guidelines for interacting with clients, maintaining confidentiality, and respecting boundaries.
- Discussion of potential ethical dilemmas and how to address them.
- Balancing empathy and professionalism in client interactions.

Module 8: Team Collaboration and Interdisciplinary Approach
- Importance of interdisciplinary collaboration in substance use detox. Explain all roles and how they work together.
- Effective communication and teamwork among staff members.

Case-based discussions on collaborative problem-solving.
**Conclusion and Resources:
- Summarize key takeaways from the training.
- Provide a list of resources for further reading, support, and professional development.
- Express appreciation for staff's commitment to providing quality care in the detox facility.
**Training Evaluation and Feedback:
- Participants provide feedback on the training session.
- Collect insights for refining and improving future onboarding trainings.
**Closing Remarks:
- Acknowledge staff's dedication to their role in supporting clients through detoxification.
- Conclude the onboarding training by emphasizing the ongoing importance of supportive practices and continuous learning in the substance use detox environment.
- Express appreciation for staff's commitment to providing quality care in the detox facility.
**Training Evaluation and Feedback:
- Participants provide feedback on the training session.
- Collect insights for refining and improving future onboarding trainings.
**Closing Remarks:
- Acknowledge staff's dedication to their role in supporting clients through detoxification.
- Conclude the onboarding training by emphasizing the ongoing importance of supportive practices and continuous learning in the substance use detox environment.

Module 1:

In Live Free's Addiction Treatment Program providing an overview of common substances of abuse and their effects on the body is essential for staff members to understand the challenges clients may face during detoxification. Here's a general overview of common substances and their effects.

Alcohol:
- Central nervous system depressant.
- Effects: Impaired judgment, coordination, and motor skills. Slurred speech, memory impairment, nausea, and vomiting.

Opioids (Heroin, Prescription Painkillers):
- Central nervous system depressant.
- Effects: Euphoria, pain relief, drowsiness, slowed breathing, constipation. Risk of overdose and respiratory depression.

Benzodiazepines (Xanax, Valium):
- Central nervous system depressant.
- Effects: Anxiety reduction, sedation, muscle relaxation. Risk of physical dependence and withdrawal.

Stimulants (Cocaine, Methamphetamine):
- Central nervous system stimulant.
- Effects: Increased energy, alertness, heart rate, and blood pressure. Agitation, paranoia, risk of heart problems.

Cannabis (Marijuana):
- Mild hallucinogenic and depressant effects.
- Effects: Altered perception, relaxation, increased appetite. Impaired memory, coordination, and concentration.

Hallucinogens (LSD, Psilocybin Mushrooms):
- Alter perception and mood.
- Effects: Hallucinations, distorted sensory experiences, altered sense of time.

Inhalants (Glue, Aerosols):
- Depressant effects.
- Effects: Euphoria, dizziness, confusion. Risk of serious health complications, including brain damage.

Nicotine:
- Stimulant.
- Effects: Increased heart rate, alertness, and cognitive effects. Highly addictive.

Prescription Medications (Misuse):
- Effects vary depending on the medication.
- Opioids: Similar to heroin, can cause respiratory depression and overdose.
- Sedatives: Similar to benzodiazepines, can cause drowsiness and respiratory depression.
- Stimulants: Increased energy, alertness, and heart rate.

Effects of Detox:
- Withdrawal symptoms vary for each substance but may include anxiety, tremors, nausea, vomiting, diarrhea, muscle aches, irritability, and mood swings.
- Severe withdrawal can lead to medical complications, including seizures, delirium tremens (DT), and cardiac issues.

Understanding the effects of these substances helps detox staff recognize potential withdrawal symptoms and provide appropriate care during the detoxification process. It's important for staff to have a comprehensive understanding of these substances to ensure the safety and well-being of clients and to effectively support them in their recovery journey.

Here at Live Free, understanding the neurobiology of addiction and its impact on behavior and brain function is crucial for staff members to provide effective care and support to clients. Here's an overview of the neurobiology of addiction and its implications:

Neurobiology of Addiction:
- Addiction is a complex brain disease that involves changes in the brain's reward, motivation, and memory circuits.
- The brain's reward system involves the release of neurotransmitters like dopamine in response to pleasurable experiences, reinforcing certain behaviors.
- Repeated substance use can lead to alterations in brain circuitry, creating strong associations between substance use and reward.

Impact on Behavior:
- Addiction leads to compulsive drug-seeking and drug-taking behaviors, even in the face of negative consequences.
- Cravings, or intense urges to use substances, can be triggered by environmental cues or stressors.
- Behavioral patterns may revolve around obtaining and using the substance, often at the expense of other life priorities.

Brain Function Changes:
- Repeated substance use can lead to changes in brain structure and function, impacting decision-making, impulse control, and emotional regulation.
- Brain areas involved in judgment, self-control, and critical thinking can become impaired, leading to impulsive behavior.
- Tolerance develops, requiring higher doses to achieve the same effects, contributing to escalating substance use.

Neuroplasticity and Long-Term Changes:

- Chronic substance use can result in neuroplasticity, where the brain rewires itself to prioritize substance-related cues and rewards.
- Over time, this can lead to decreased responsiveness to natural rewards and increased sensitivity to drug-related cues.

Withdrawal and Cravings:
- When substance use is abruptly stopped or reduced, the brain experiences a state of imbalance, leading to withdrawal symptoms and intense cravings.
- These symptoms can drive continued substance use to alleviate discomfort.
Implications for Treatment:
- Understanding the neurobiology of addiction helps staff tailor interventions to address the underlying brain changes.
- Behavioral therapies, counseling, and support help clients learn coping strategies to manage cravings and develop healthier behaviors.
- Medications may be used to restore brain balance, alleviate withdrawal symptoms, and reduce cravings.

Live Free's Client-Centered Approach:
- Recognizing addiction as a brain disease reduces stigma and supports a compassionate, nonjudgmental approach.
- Clients' behaviors are viewed in the context of their brain changes, promoting empathy and understanding.

By grasping the neurobiology of addiction and its influence on behavior and brain function, detox staff can better comprehend the challenges clients face during detoxification and subsequent treatment. This knowledge guides the development of tailored interventions and strategies to support clients in their recovery journey.

In Live Free's Addiction Treatment Program understanding the stages of addiction and the importance of empathetic understanding is essential for providing effective care and support to clients. Here's an overview of the stages of addiction and why empathetic understanding is crucial:

Stages of Addiction:

Experimentation: Initial use of a substance out of curiosity or social influence.

Regular Use: Continued and repeated substance use, often for recreational purposes.

Risky Use/Problem Use: Substance use becomes more frequent and starts to have negative consequences, but the person may not recognize the severity.

Dependence/Addiction: Physiological and psychological dependence develops, leading to compulsive drug-seeking and use despite harmful effects.

Recovery: The process of overcoming addiction and establishing a substance-free lifestyle.

Importance of Empathetic Understanding:

Reducing Stigma: Empathetic understanding reduces stigma associated with addiction. Staff members who approach clients with empathy create a more welcoming and nonjudgmental environment, encouraging clients to seek help.

Building Rapport: Empathy helps build trust and rapport between clients and staff. Clients are more likely to engage in treatment when they feel understood and supported.

Effective Communication: Empathetic communication fosters open dialogue between clients and staff. Clients are more likely to share their experiences, challenges, and needs when they feel heard and respected.

Person-Centered Care: Empathetic understanding allows staff to see clients as individuals with unique struggles and strengths. This approach supports personalized treatment plans that address clients' specific needs.

Motivating Change: Empathy can motivate clients to make positive changes by emphasizing their strengths and potential for recovery. It helps clients recognize that they are not defined by their addiction.

Supporting Relapse Prevention: Empathetic understanding helps staff identify triggers and challenges that may lead to relapse. By addressing these factors empathetically, staff can assist clients in developing effective coping strategies.

Fostering Resilience: Empathy promotes a sense of belonging and support. Clients are more likely to develop resilience when they feel connected and understood by staff and peers.

Enhancing Treatment Outcomes: Empathetic understanding contributes to better treatment engagement and retention. Clients who feel supported and understood are more likely to remain committed to their recovery journey.

Empathy in Action is transformative
- Actively listen to clients' stories and experiences without judgment.
- Validate clients' feelings and struggles.
- Use nonverbal cues, such as eye contact and body language, to show attentiveness.
- Reflect back clients' emotions to demonstrate understanding.
- Tailor interventions and treatment plans to each client's unique circumstances.

Incorporating empathetic understanding into every aspect of Treatment here at Live Free helps create a compassionate and supportive environment that empowers clients to overcome addiction and achieve lasting recovery. Always remember these are not “bad people getting good”, but “sick people here to get well.”

Module 2: Trauma-Informed Care
Explanation of Live Free's trauma-informed care principles and their relevance in a substance abuse treatment detox program in SUD Treatment:

Trauma-Informed Care Principles:

Safety: Trauma-informed care prioritizes creating a physically and emotionally safe environment for clients. In a detox program, this means ensuring that clients feel secure and respected throughout the withdrawal and recovery process. Staff members use non-threatening language, respectful behavior, and establish clear boundaries to promote a sense of safety.

Trustworthiness and Transparency: Building trust is essential in trauma-informed care. Detox staff in NH should communicate openly with clients, provide clear information about procedures and expectations, and maintain consistency in their interactions. This transparency fosters trust and reduces anxiety, especially for clients who may have experienced betrayal or deception in the past.

Choice and Collaboration: Trauma survivors often feel a lack of control due to their experiences. Trauma-informed care empowers clients by involving them in decisions about their detox plan, treatment options, and daily routines. Collaborative decision-making allows clients to regain a sense of agency, leading to greater engagement and cooperation.

Empowerment and Voice: Trauma-informed care encourages clients to express their needs, preferences, and concerns. In a detox program, this principle means that clients' voices are valued, and their feedback is actively sought. Staff listen empathetically, validate clients' experiences, and ensure that they have opportunities to share their thoughts on their detox journey.

Cultural Sensitivity: Trauma-informed care recognizes and respects the cultural backgrounds and identities of clients. In a NH detox program, staff should be sensitive to cultural differences and tailor their approaches accordingly. Understanding cultural norms, beliefs, and practices helps create an inclusive and respectful environment.

Peer Support: Trauma-informed care values the importance of peer support. Clients who have experienced similar trauma can provide a unique source of understanding, empathy, and validation. Peer support groups or interactions can help reduce isolation, promote connection, and provide a safe space for sharing experiences.

Emotional Regulation: Trauma-informed care recognizes that trauma survivors may struggle with emotional regulation. Staff members in a detox program can teach clients healthy ways to manage and cope with overwhelming emotions. Techniques like mindfulness, deep breathing, and grounding exercises can be incorporated to help clients regulate their emotions during detox.

Flexibility and Personalization: Each trauma survivor's experience is unique, and trauma-informed care allows for flexibility in treatment approaches. Staff should tailor interventions to

meet individual needs, preferences, and readiness for change. This principle acknowledges that there's no one-size-fits-all approach and promotes client-centered care.

Resilience and Strengths-Based Approach: Trauma-informed care focuses on clients' strengths, resilience, and potential for growth. In a detox program, staff highlight clients' inner strengths and capabilities. This approach helps clients recognize their capacity to overcome challenges and empowers them to take an active role in their recovery.

Continuous Learning and Improvement: A trauma-informed approach involves ongoing learning and self-reflection for staff. Regular training and professional development on trauma-related topics ensure that staff remain informed about best practices. Staff members continually evaluate and improve their trauma-informed practices based on client feedback and emerging research.

Collaboration and Interdisciplinary Care: Trauma-informed care emphasizes collaboration among different disciplines involved in a client's care. In a detox program, this might involve coordination between medical staff, therapists, counselors, and peer support specialists. Collaborative decision-making ensures a holistic and comprehensive approach to treatment.

Post-Traumatic Growth: Trauma-informed care recognizes the potential for growth and positive transformation after experiencing trauma. In a detox program, staff can help clients reframe their experiences as opportunities for personal growth, resilience, and the development of new coping skills.

Cultural Humility: Cultural humility involves a deep respect for diverse cultural backgrounds. In a NH detox program, staff strive to understand each client's cultural context, beliefs, and values. This principle helps prevent cultural misunderstandings and promotes inclusivity and sensitivity.

Trauma-Informed Environment: Creating a physical environment that reflects trauma-informed principles is crucial. This might involve design elements that promote safety and comfort, as well as signage that communicates respect and dignity. An environment that supports sensory regulation and offers spaces for privacy can be particularly beneficial.

Self-Care for Staff: Trauma-informed care extends to staff well-being. Recognizing the potential for vicarious trauma, detox program staff should be encouraged to practice self-care, seek support, and engage in regular supervision and debriefing sessions.

By integrating these additional trauma-informed care principles into Live Free’s Treatment Modalities, staff can create a nurturing and empowering environment that supports clients in their journey of healing and recovery.

Relevance in Detox:

Reducing Retraumatization: Many clients entering detox have experienced trauma, and the detox process itself can be triggering. Trauma-informed care minimizes the risk of

retraumatization by providing a safe and supportive environment. Staff understand potential triggers and take steps to mitigate them.

Addressing Coping Mechanisms: Clients often turn to substances as a way to cope with trauma. Trauma-informed care acknowledges these coping mechanisms without judgment and helps clients develop healthier strategies for managing their emotions and stress during detox.

Respecting Boundaries: Trauma survivors may have difficulties with personal boundaries. Staff in a NH detox program are trained to respect clients' boundaries, seek consent for physical contact or procedures, and avoid re-traumatizing experiences.

Healing-Centered Approach: Trauma-informed care emphasizes healing and recovery. In detox, staff recognize that addressing trauma is a vital part of the healing process and integrate trauma-informed practices into treatment plans.

Building Resilience: By promoting empowerment, choice, and collaboration, trauma-informed care fosters resilience in clients. This resilience supports clients in navigating the challenges of detox and prepares them for ongoing recovery.

Long-Term Impact: Incorporating trauma-informed care principles during detox lays the foundation for a client's future engagement in treatment and recovery programs. Clients who experience trauma-informed care are more likely to feel supported, validated, and empowered, increasing the likelihood of successful long-term recovery.

Incorporating trauma-informed care principles in a substance abuse treatment detox program at Live Free not only enhances the quality of care provided to clients but also contributes to a culture of compassion, respect, and understanding within the facility. This approach recognizes the interconnectedness of trauma and substance use and supports clients in their journey towards healing and recovery.

Recognizing the signs of trauma in clients and understanding their triggers is a crucial aspect of providing trauma-informed care in a substance abuse treatment. Here's an explanation of this important component:

Recognizing Signs of Trauma:

- Hyperarousal: Clients who have experienced trauma may display signs of hypervigilance, irritability, and difficulty relaxing. They might startle easily, have trouble sleeping, or constantly scan their environment for potential threats.
- Hypervigilance: Clients may be excessively watchful and alert to their surroundings, as if anticipating danger. They might struggle to feel safe even in a controlled environment like a detox program.
- Avoidance: Trauma survivors often try to avoid reminders of their traumatic experiences. This could manifest as avoiding certain topics, places, or activities, which might be misinterpreted as resistance to treatment.

- Emotional Dysregulation: Clients might experience intense mood swings, anger outbursts, or difficulty managing emotions. These emotional responses can be triggered by memories of traumatic events.
- Physical Symptoms:Trauma can lead to physical symptoms such as headaches, gastrointestinal issues, or chronic pain. Medical staff should consider the possibility of trauma when assessing clients' physical health.

Understanding Triggers:

- Internal Triggers: These are emotions, thoughts, or bodily sensations that remind clients of their traumatic experiences. In a detox program, certain aspects of the detox process, such as withdrawal symptoms or medical procedures, could act as internal triggers.
- External Triggers: External cues in the environment can remind clients of their trauma. This might include certain smells, sounds, or visual stimuli. Detox staff should be aware of potential triggers within the detox environment.
- Anniversary Reactions: Trauma survivors might experience heightened distress around the anniversary of the traumatic event. Staff should be attentive to any increased emotional sensitivity during these times.
- Relationship Triggers: Interactions with certain people or authority figures can trigger memories of past trauma. Staff interactions should prioritize empathy, clear communication, and respect to minimize triggers.
- Sensory Triggers: Sensory experiences like touch, taste, or temperature can evoke traumatic memories. In a detox program, medical procedures or sensory overload should be approached with sensitivity.

Practical Considerations:

- Trauma-informed care involves creating an environment that minimizes potential triggers. This might include allowing clients to have some control over their environment or routines.
- Open communication with clients about their trauma history, triggers, and coping strategies is essential. However, staff should approach these conversations with caution and respect for the client's readiness to share.

Staff Training:

- Detox program staff should receive training on trauma-informed care principles, recognizing signs of trauma, and understanding triggers.
- Regular debriefing sessions and supervision for staff can provide a space to discuss challenging cases and emotions triggered by clients' trauma.
- By recognizing signs of trauma and understanding triggers, Live Free Recovery Treatment programs can create a safer and more supportive environment for clients, minimizing potential retraumatization and promoting the healing process.
- Live Free’s strategies to create a safe and supportive environment for trauma survivors in a Treatment Environment.

Staff Training and Education:

- Provide comprehensive training on trauma-informed care principles, trauma sensitivity, and recognizing signs of trauma.

- Educate staff about the potential impact of trauma on behavior, coping mechanisms, and treatment engagement.
- Include sessions on effective communication, active listening, and empathetic responses to trauma survivors.

Trauma-Informed Policies and Procedures:

- Develop trauma-informed policies that emphasize safety, choice, and empowerment.
- Create procedures for handling trauma triggers, emotional distress, and crisis situations in a trauma-sensitive manner.
- - Integrate trauma-informed language and practices into daily protocols.

Physical Environment:

- Design the detox facility with trauma sensitivity in mind, using calming colors, comfortable furniture, and soft lighting.
- Establish quiet, private spaces where clients can retreat if they feel overwhelmed or triggered.
- Display informational materials about trauma-informed care and resources for support.

Clear and Respectful Communication:

- Train staff to use nonjudgmental, clear, and compassionate language when interacting with clients.
- Emphasize the importance of active listening and validating clients' experiences without minimizing their feelings.
- Encourage open dialogue about trauma histories, triggers, and coping strategies.

Safety and Empowerment:

- Prioritize physical and emotional safety by implementing security measures and protocols.
- Collaborate with clients to establish a safety plan tailored to their needs and triggers.
- Empower clients to voice their preferences, make decisions, and actively participate in their treatment journey.

Individualized Treatment Plans:

- Conduct comprehensive assessments to identify trauma histories and individual needs.
- Develop personalized detox plans that take trauma histories into account and consider triggers and coping mechanisms.
- Regularly review and adjust treatment plans based on clients' progress and feedback.

Trauma-Informed Care Team:

- Assemble a multidisciplinary team of professionals trained in trauma-informed care, including medical staff, therapists, counselors, and peer support specialists.
- Foster a collaborative approach that integrates diverse expertise to address clients' physical, emotional, and psychological well-being.

Coping Skills and Emotional Regulation:

- Offer trauma-sensitive coping skills workshops, such as mindfulness, grounding techniques, and relaxation exercises.
- Provide clients with tools to manage emotions and triggers effectively during the detox process.

Peer Support and Community Building:

- Facilitate trauma-informed peer support groups where clients can share their experiences, challenges, and successes.
- Organize regular community-building activities to promote connection and reduce isolation.

Continuous Evaluation and Improvement:

- Establish mechanisms for ongoing program evaluation, including regular client feedback and staff discussions.
- Use feedback to identify areas for improvement and refine trauma-informed practices.

Self-Care for Staff:

- Offer regular staff training on managing vicarious trauma, stress, and burnout.
- Provide opportunities for staff to engage in self-care practices, attend support groups, and seek supervision.

Trauma-Informed Discharge Planning:

- Develop a discharge plan that supports clients' transition from detox to ongoing treatment or aftercare.
- Provide referrals to trauma-informed therapists, support groups, and community resources to continue the healing process.
- By implementing this comprehensive plan, in Treatment we can establish a safe, nurturing, and empowering environment for trauma survivors, promoting their healing and facilitating a successful detox and recovery journey here at Live Free.

Module 3: Cultural Competency and Sensitivity

The importance of cultural awareness and sensitivity that should be emphasized here at Live Free.

Cultural Competence Training:

Provide comprehensive training to staff on cultural competence, diversity, and inclusion.

Offer education about different cultures, traditions, beliefs, and practices relevant to the diverse population of clients.

Respect for Diversity:

Emphasize the value of treating all clients with respect, regardless of their cultural background.

Encourage staff to approach each client as an individual with unique needs and experiences.

Language Access:

Ensure that interpretation and translation services are available for clients who have limited English proficiency.

Make written materials, assessments, and treatment plans available in languages that clients can understand.

Cultural Assessment:

Conduct culturally sensitive assessments to understand clients' cultural backgrounds, values, and preferences.

Use this information to tailor treatment plans and interventions to align with clients' cultural needs.

Inclusive Environment:

Create an environment that respects and celebrates cultural diversity.

Display diverse artwork, symbols, and decorations that reflect different cultures and backgrounds.

Cultural Awareness of Triggers:

Recognize that certain cultural symbols, rituals, or experiences might act as triggers for trauma or substance use.

Be sensitive to potential cultural triggers and address them with care and understanding.

Flexibility in Treatment Approaches:

Be open to adapting treatment approaches to align with clients' cultural beliefs and practices.

Collaborate with clients to integrate cultural rituals or practices that support their healing journey.

Tailored Communication:

Adjust communication styles to suit clients' cultural preferences.

Be mindful of nonverbal cues, gestures, and personal space norms that may vary across cultures.

Ethical Considerations:

Be aware of cultural taboos, norms, and ethical considerations related to substance use and treatment.

Ensure that treatment plans respect clients' cultural values and do not contradict their beliefs.

Culturally Relevant Interventions:

Offer interventions that align with clients' cultural beliefs and values.

Incorporate culturally relevant coping strategies, mindfulness techniques, and expressive therapies.

Sensitivity to Trauma and Discrimination:

Understand the potential impact of cultural trauma, discrimination, and microaggressions on clients.

Provide a safe space where clients can discuss their experiences without judgment.

Collaboration with Cultural Experts:

Collaborate with cultural consultants, community leaders, or organizations to ensure culturally sensitive care.

Seek guidance from cultural experts to improve the program's responsiveness to diverse cultural needs.

Feedback and Continuous Improvement:

Encourage clients to provide feedback on their cultural experiences within the program.

Regularly review and refine cultural sensitivity practices based on client input and staff discussions.

By prioritizing cultural awareness and sensitivity here Live Free, you create an environment where all clients feel valued, respected, and understood, leading to more effective and equitable care.

Addressing diverse cultural, ethnic, and socio-economic backgrounds here at Live Free requires a comprehensive and sensitive approach. Here's how you can effectively address these factors:

Cultural Competence Training:

Provide cultural competence training to all staff members to enhance their awareness and understanding of various cultural backgrounds.

Offer education on cultural nuances, beliefs, traditions, and practices to ensure staff can provide respectful and inclusive care.

Multilingual and Multicultural Resources:

Make treatment materials, assessments, and information available in multiple languages to cater to clients with limited English proficiency.

Offer culturally relevant resources that reflect the diverse backgrounds of clients, helping them feel more comfortable and understood.

Culturally Tailored Assessment:

Develop assessment tools that consider cultural, ethnic, and socio-economic factors in understanding clients' substance use and treatment needs.

Gather information about clients' cultural beliefs, family dynamics, and support systems to inform treatment plans.

Individualized Treatment Plans:

Design treatment plans that respect and incorporate clients' cultural values, traditions, and preferences.

Collaborate with clients to develop strategies that align with their cultural and socio-economic backgrounds.

Inclusive Environment:

Create an environment that embraces diversity by displaying artwork, symbols, and decorations from various cultures.

Establish a safe and welcoming space where clients from different backgrounds feel valued and accepted.

Cultural Sensitivity in Communication:

Train staff to communicate effectively and respectfully across diverse cultural backgrounds.

Teach active listening and cross-cultural communication skills to enhance understanding and rapport.

Addressing Stigma and Discrimination:

Provide education and support to address the stigma associated with seeking treatment for substance use, especially in certain cultural contexts.

Create a nonjudgmental space where clients can discuss experiences of discrimination without fear of re-traumatization.

Socio-Economic Considerations:

Offer flexible payment options or financial assistance to ensure that socio-economic factors do not hinder access to treatment.

Collaborate with social service agencies to provide additional support for clients with specific socio-economic needs.

Family and Community Involvement:

Recognize the importance of family and community in various cultural backgrounds.

Involve family members or support systems in the treatment process with the clients' consent.

Diverse Therapeutic Approaches:

Offer a variety of therapeutic modalities that are sensitive to diverse cultural, ethnic, and socio-economic backgrounds.

Integrate culturally relevant practices such as mindfulness, art therapy, or traditional healing methods.

Peer Support:

Foster peer support groups where clients from similar cultural or socio-economic backgrounds can connect and share their experiences.

Encourage the sharing of cultural strengths and resilience within the peer support context.

Regular Feedback and Adaptation:

Regularly gather feedback from clients about their cultural and socio-economic experiences in the program.

Use this feedback to continuously adapt and improve the program's cultural responsiveness.

By addressing diverse cultural, ethnic, and socio-economic backgrounds here, you create a more inclusive and effective treatment environment that respects each client's unique identity and needs.

Effective communication and respectful engagement with clients from different cultures in Treatment are essential to provide culturally sensitive and equitable care. Here are strategies to achieve this:

Active Listening:

Practice active listening by giving your full attention and demonstrating genuine interest in what the client is saying.

Avoid interrupting and allow clients to express themselves fully before responding.

Use Clear and Simple Language:

Communicate in clear and straightforward language, avoiding jargon, slang, or complex terminology.

Check for understanding by asking clients to repeat or paraphrase what they've heard.

Nonverbal Communication:

Be aware of nonverbal cues like body language, gestures, and facial expressions.

Be respectful of cultural differences in nonverbal communication, as interpretations can vary.

Open-Ended Questions:

Use open-ended questions that encourage clients to share their thoughts, feelings, and experiences.

This allows clients to provide more context and insights into their cultural perspective.

Respect Cultural Norms:

Learn about cultural norms regarding eye contact, personal space, and physical touch.

Adapt your approach to align with the client's cultural comfort zone.

Seek Clarification:

If you're unsure about a cultural practice, belief, or term, respectfully ask the client for clarification.

This shows your willingness to learn and understand their perspective.

Reflective Responses:

Reflect back what the client has said to ensure accurate understanding and to validate their feelings.

This demonstrates empathy and shows that you are actively engaged in the conversation.

Avoid Assumptions:

Do not make assumptions about a client's cultural background or experiences based on stereotypes.

Instead, ask open-ended questions to learn more about their individual experiences.

Cultural Humility:

Approach interactions with cultural humility, acknowledging that you may not fully understand the client's background.

Be open to learning and adapting your communication style based on their needs.

Clarify Treatment Information:

Ensure that clients understand treatment plans, procedures, and goals.

Use visual aids, written materials, or diagrams to enhance comprehension.

Address Language Barriers:

If language barriers exist, provide interpretation services or bilingual staff to facilitate communication.

Make sure important information is accurately translated to avoid misunderstandings.

Empower Client Choice:

Encourage clients to express their preferences, concerns, and goals related to treatment.

Offer choices whenever possible to promote a sense of control and autonomy.

Avoid Confrontation:

Approach disagreements or challenges with sensitivity and a desire to understand.

Respectfully address differences while maintaining a non-confrontational tone.

Use Cultural Brokering:

If necessary, enlist the help of cultural brokers or interpreters who can bridge the gap between different cultures.

Regular Self-Reflection:

Continuously reflect on your own biases, assumptions, and communication style.

Seek feedback from colleagues and clients to improve your cultural competence.

By implementing these strategies, Live Free can create an environment where clients from diverse cultural backgrounds feel heard, respected, and understood, leading to more effective communication and better treatment outcomes.

Module 4 Self-Care and Stress Management

Challenges

Emotional Toll:

Working in a detox facility exposes staff to clients in distress, potentially triggering emotional responses and compassion fatigue.

High-Intensity Environment:

Detox facilities often operate around the clock, requiring staff to manage high-stress situations and maintain vigilance during crisis moments.

Challenging Behaviors:

Clients experiencing withdrawal may exhibit challenging behaviors such as aggression, irritability, or non-compliance.

Trauma Exposure:

Staff may interact with clients who have experienced trauma, hearing difficult stories that can impact their own well-being.

Physical Demands:

The nature of detox work may involve physical demands, such as assisting clients who are unsteady or in medical distress.

Relapse and Resistance:

Clients may relapse or resist treatment, leading to feelings of frustration or discouragement among staff.

Work-Life Balance:

Long shifts and high-demand schedules can strain work-life balance, leading to burnout over time.

Limited Resources:

Some facilities may face challenges related to resource availability, impacting the quality of care that can be provided.

Multidisciplinary Collaboration:

Coordinating care across various disciplines requires effective communication and collaboration, which can be challenging.

Legal and Ethical Concerns:

Navigating legal and ethical considerations when working with clients struggling with addiction can be complex.

Client Diversity:

Cultural, socio-economic, and demographic diversity among clients requires cultural competence and sensitivity.

Staff Resilience:

Supporting clients in their recovery while managing personal stressors requires staff to develop resilience and coping skills.

Managing Expectations:

Balancing clients' expectations with the reality of their recovery journey can be challenging.

Staff Turnover:

High-stress environments may contribute to staff turnover, affecting continuity of care.

Dual Diagnosis:

Addressing co-occurring mental health issues alongside substance use adds complexity to treatment.

Introduction to Self-Care Strategies: Mindfulness, Exercise, and Hobbies

Mindfulness:

Mindfulness involves being fully present in the moment, observing thoughts and feelings without judgment. It can help staff manage stress and enhance emotional well-being.

How to Practice Mindfulness:

Encourage staff to take short breaks during the day to focus on their breath and sensations.

Teach mindfulness techniques such as body scans, guided meditations, or mindful eating.

Suggest mindfulness apps that staff can use during breaks or at home.

Benefits:

Reduces stress and burnout by promoting relaxation and emotional regulation.

Enhances self-awareness and cultivates a nonjudgmental attitude.

Exercise:

Regular physical activity is essential for maintaining physical health and reducing stress. It also releases endorphins, improving mood and overall well-being.

Incorporating Exercise:

Provide opportunities for staff to engage in short stretching or movement breaks during shifts.

Offer fitness classes or gym memberships as part of staff benefits.

Organize team walks or outdoor activities to encourage socialization and exercise.

Benefits:

Boosts mood and energy levels, reducing stress and promoting a positive outlook.

Improves physical health, which in turn supports mental well-being.

Hobbies:

Engaging in hobbies and activities outside of work can be a valuable way for staff to unwind, recharge, and maintain a healthy work-life balance.

Encouraging Hobbies:

Encourage staff to identify and pursue hobbies they enjoy, whether it's reading, painting, gardening, or playing a musical instrument.

Provide a designated space where staff can engage in hobbies during breaks or downtime.

Benefits:

Fosters creativity and relaxation, allowing staff to disconnect from work-related stress.

Provides a sense of accomplishment and personal fulfillment.

Balancing Self-Care:

Highlight the importance of integrating these strategies into daily routines.

Encourage staff to experiment with different approaches to find what works best for them.

Emphasize that self-care is not selfish; it's a necessary practice to ensure effective and compassionate care for clients.

Here are more examples of self-care activities that any substance abuse treatment facility can consider to promote their well-being:

Journaling: Encourage staff to keep a journal to express their thoughts, feelings, and experiences. Writing can provide an emotional outlet and promote self-reflection.

Nature Walks: Spending time in nature, whether it's a short walk during breaks or a weekend hike, can offer a refreshing change of scenery and reduce stress.

Deep Breathing: Teach staff deep breathing exercises, which can be done discreetly during the workday to promote relaxation and mindfulness.

Artistic Expression: Engaging in creative activities like drawing, painting, or crafting can be therapeutic and provide an outlet for self-expression.

Reading: Suggest staff read books or articles that interest them, providing a mental escape and a way to unwind.

Cooking or Baking: Encourage staff to try new recipes and experiment in the kitchen, which can be a fun and rewarding way to relax.

Music: Listening to music or playing a musical instrument can be soothing and help shift focus away from stress.

Mindful Eating: Teach staff to eat mindfully, savoring each bite and paying attention to the sensory experience of eating.

Digital Detox: Encourage unplugging from screens for a set period each day to reduce screen-related stress.

Social Connections: Spending time with friends, family, or colleagues who provide positive support can boost mood and foster a sense of connection.

Volunteering: Engaging in acts of kindness and giving back to the community can provide a sense of purpose and fulfillment.

Laughter: Encourage staff to watch a funny movie, listen to a comedy podcast, or engage in activities that make them laugh.

Relaxation Techniques: Teach progressive muscle relaxation, guided imagery, or other relaxation techniques to manage stress.

Spa Day at Home: Suggest staff create a spa-like experience at home with a bubble bath, aromatherapy, and soothing music.

Gratitude Practice: Cultivate a gratitude journal or daily practice to focus on positive aspects of life.

Gardening: If possible, encourage staff to tend to plants, whether it's a small indoor garden or an outdoor space.

Pet Therapy: Spending time with pets or animals can provide comfort and reduce stress.

Yoga or Stretching: Incorporate gentle yoga or stretching exercises to promote physical and mental relaxation.

Learning: Engage in learning new skills or pursuing interests, such as taking an online course or attending workshops.

Mindful Technology Use: Teach staff to use mindfulness techniques while engaging with technology, like setting intention before using social media.

Remember, self-care is about finding activities that bring joy, relaxation, and a sense of well-being. Encourage staff to explore different options and customize their self-care routines based on their preferences and needs. The key is to prioritize regular self-care practices to maintain a healthy work-life balance and support their overall mental and emotional health.

Support and Resources:

- Provide resources on mindfulness, exercise routines, and hobby ideas.

- Offer workshops or training sessions on self-care techniques.

- Establish a supportive work environment where staff can openly discuss their self-care needs and challenges.

By introducing these self-care strategies of mindfulness, exercise, and hobbies to staff at Live Free Recovery, you can help create a workplace culture that prioritizes staff well-being, resilience, and effective care delivery to clients. Remember, when staff are equipped to take care of themselves, they are better prepared to provide high-quality care to those they serve. Encouraging staff to seek support, both internally and externally, is crucial for maintaining their well-being in a substance abuse treatment facility.

Here's an outline of ways to promote and facilitate staff seeking support:

Internal Support:

Regular Check-Ins:

Establish a system for regular one-on-one check-ins between supervisors and staff to discuss challenges, concerns, and well-being.

Peer Support:

Foster a culture of peer support by encouraging staff to connect and share experiences with colleagues.

Organize peer support groups where staff can discuss challenges, share coping strategies, and provide mutual encouragement.

Supervision and Debriefing:

Offer regular supervision sessions where staff can discuss difficult cases, emotional experiences, and any stressors they're facing.

Provide structured debriefing sessions after particularly challenging incidents to process emotions and share insights.

Staff Wellness Programs:

Create wellness programs that include workshops, seminars, and activities focused on stress management, self-care, and mental health.

Organize team-building exercises to strengthen connections and support within the staff

Employee Assistance Programs (EAP):

Provide information about EAP resources that offer confidential counseling, therapy, and support for staff members and their families.

External Support:

Professional Counseling:

Encourage staff to seek professional counseling or therapy outside of work to address personal challenges, stress, and emotional well-being.

Provide a list of local mental health professionals who specialize in supporting healthcare workers.

Support Groups:

Inform staff about local support groups or online forums where they can connect with others who share similar experiences.

Highlight support groups for healthcare professionals or those working in substance abuse treatment.

Community Resources:

Offer information about community resources such as mental health clinics, crisis hotlines, and local organizations that provide support.

Professional Development:

Support staff in attending conferences, workshops, and training sessions related to self-care, mental health, and stress management.

Flexible Scheduling:

Implement flexible scheduling options that allow staff to attend support group meetings, counseling appointments, or wellness activities.

Communication and Education:

Normalize Seeking Support:

Create an open and nonjudgmental environment where seeking support is encouraged and normalized.

Share stories of staff members who have sought support and benefited from it.

Awareness Campaigns:

Launch awareness campaigns that emphasize the importance of mental health and seeking support.

Distribute informational materials that highlight available resources and how to access them.

Training on Self-Care:

Provide training sessions on self-care, stress management, and recognizing signs of burnout to empower staff to take proactive steps.

Confidentiality and Privacy:

Confidential Channels:

Assure staff that seeking support will be kept confidential and will not impact their job security or performance evaluations.

Encourage Communication:

Remind staff that it's okay to reach out for support and that their well-being is a priority for the organization.

By implementing these strategies, you can create a supportive and caring environment within the substance abuse treatment facility that encourages staff to seek both internal and external support, ultimately contributing to their overall well-being and the quality of care they provide to clients.

Module 5 Communication Skills and De-escalation

Effective verbal and nonverbal communication techniques are crucial here at Live Free Recovery to establish trust, build rapport, and facilitate positive interactions with clients. Here are some techniques to consider:

Effective Verbal Communication:

- Active Listening: Give your full attention, maintain eye contact, and provide verbal cues (such as nodding) to show that you are engaged and interested in what the client is saying.
- Empathetic Responses: Respond with empathy and understanding, acknowledging the client's feelings and experiences. Use phrases like "I understand how you feel" or "That must be really challenging."
- Open-Ended Questions: Encourage clients to share more by asking open-ended questions that require more than a yes or no answer. For example, "Tell me about your experience" or "What thoughts have you had about your recovery?"
- Reflective Responses: Repeat or rephrase what the client has said to show that you've understood and to validate their feelings. This can help clients feel heard and understood.
- Clear and Simple Language: Use clear and straightforward language, avoiding jargon or technical terms that clients may not understand.
- Summarizing: Summarize the key points of the conversation to ensure mutual understanding and to demonstrate active engagement.
- Non-Judgmental Language: Avoid making judgments or assumptions about the client's experiences, choices, or behaviors. Create a safe space for them to share openly.

Effective Nonverbal Communication:

- Eye Contact: Maintain appropriate eye contact to convey attentiveness and interest. However, be mindful of cultural differences and individual preferences.
- Facial Expressions: Use facial expressions that match the tone of the conversation. A warm smile can help clients feel welcome and at ease.
- Gestures: Use gestures to emphasize points or show empathy, such as nodding to indicate understanding or using an open palm to convey openness.

- Body Language: Maintain an open and relaxed posture to create a sense of approachability. Avoid crossing arms or displaying defensive postures.
- Personal Space: Respect personal space boundaries, especially considering cultural norms. Maintain an appropriate distance that makes the client comfortable.
- Tone of Voice: Use a calm and empathetic tone of voice to convey understanding and support. Avoid sounding judgmental, impatient, or confrontational.
- Active Silence: Allow moments of silence to give clients time to process their thoughts or emotions. This can encourage them to share more deeply.
- Mirroring: Subtly mirror the client's body language and expressions to establish rapport and create a sense of connection.
- Respectful Touch: If appropriate and with consent, use respectful touch (e.g., a gentle pat on the shoulder) to convey support and care.
- Cultural Sensitivity: Be aware of cultural differences in nonverbal communication, such as varying norms for eye contact and physical touch.

By incorporating these effective verbal and nonverbal communication techniques, staff at Live Free can enhance their interactions with clients, create a supportive environment, and contribute to the overall success of the treatment process.

De-escalation strategies are essential for diffusing tense situations in a Treatment Center are key skills to acquire. Here are some of the best de-escalation strategies to consider:

- Stay Calm: Maintain a calm and composed demeanor, even in the face of hostility. Your calmness can help prevent the situation from escalating further.
- Active Listening: Listen attentively to the individual's concerns without interrupting. Show that you are genuinely interested in understanding their perspective.
- Empathize and Validate: Acknowledge the individual's feelings and frustrations. Use empathetic statements like "I understand this is difficult for you."
- Use Non-Threatening Body Language: Stand or sit at a comfortable distance, maintain an open posture, and avoid crossing your arms. This helps convey that you are non-threatening.
- Maintain Personal Space: Respect the individual's personal space to avoid triggering feelings of intimidation.

- Speak Softly and Slowly: Use a calm and soothing tone of voice. Speaking softly and slowly can help de-escalate a situation and reduce tension.
- Limit Commands and Directives: Minimize direct orders or commands, as these can escalate resistance. Instead, make requests and use polite language.
- Offer Choices: Give the individual options whenever possible. This empowers them to make decisions and reduces feelings of being controlled.
- Distraction and Diversion: Gently shift the focus of the conversation to a neutral or less triggering topic to divert attention away from the tension.
- Use Mirroring: Reflect the individual's emotions back to them in a nonjudgmental way. This can help them feel understood and validated.
- Avoid Arguing or Challenging: Refrain from engaging in arguments or debates, as these can escalate the situation. Focus on finding common ground.
- Offer Support and Reassurance: Let the individual know that you are there to help and support them. Reassure them that their well-being is a priority.
- Involve a Trusted Colleague: If the situation is escalating and you're having difficulty de-escalating on your own, involve a trusted colleague or supervisor for assistance.
- Offer a Break: If appropriate, suggest taking a break to allow both parties to cool off and regain composure.
- Safety Protocol: If the situation becomes physically threatening or unsafe, follow the facility's safety protocols and call for assistance.
- Aftercare Support: Once the situation is de-escalated, offer ongoing support and follow-up to address any underlying issues or concerns.
- Reflect and Debrief: After the incident, reflect on what worked and what could be improved. Hold debrief sessions with colleagues to share insights.

Training staff in these de-escalation techniques and providing regular practice scenarios can help them feel more confident and capable in managing tense situations effectively. It's crucial to prioritize the safety of all individuals involved while maintaining a compassionate and non-confrontational approach.

Role-playing exercises can be valuable tools for practicing communication and de-escalation skills in Treatment Settings. Here are some role-playing scenarios that staff can engage in to enhance their abilities:

- Agitated Client Intake: Role-play an intake scenario where a client is agitated and resistant. Practice active listening, empathetic responses, and de-escalation techniques to create a calming environment.
- Refusal of Medication: Act out a situation where a client refuses to take prescribed medication. Practice using non-confrontational language, offering choices, and addressing concerns.
- Confrontational Family Member:

        - Role-play a scenario involving a confrontational family member. Practice maintaining composure, setting boundaries, and effectively addressing their concerns.
    - Handling Triggers:
        - Create a scenario where a client becomes triggered by a specific topic. Practice using distraction techniques, offering coping strategies, and redirecting the conversation.
    - Emotional Disclosure:
        - Role-play a client who emotionally discloses sensitive information. Practice active listening, providing empathetic responses, and validating their feelings.
    - Disagreement Among Clients:
        - Act out a situation where two clients have a disagreement. Practice mediating the conversation, promoting respectful communication, and finding common ground.
    - Seeking Consent for Procedures:
        - Practice seeking consent from a client for a medical procedure or intervention. Emphasize clear communication, addressing concerns, and respecting autonomy.
    - Client with High Anxiety:
        - Role-play a scenario with a client experiencing high anxiety. Practice using calming language, grounding techniques, and guiding them through relaxation exercises.
    - Explaining Treatment Plans:
        - Act out a situation where you need to explain a complex treatment plan to a client. Practice using clear and simple language, visual aids, and ensuring their understanding.
    - Aggressive Behavior De-escalation:
        - Role-play a scenario involving a client exhibiting aggressive behavior. Practice maintaining personal safety, using non-confrontational language, and implementing safety protocols.
    - Cultural Sensitivity:

Create scenarios that involve clients from diverse cultural backgrounds. Practice cultural sensitivity, respectful communication, and adapting your approach to different cultural norms.

    - Expressing Boundaries:
        - Role-play situations where you need to express and maintain appropriate boundaries with clients. Practice assertiveness, clarity, and professionalism.

- Handling Noncompliance:
    - Act out scenarios where clients are noncompliant with treatment plans. Practice using motivational interviewing techniques, exploring reasons for noncompliance, and finding solutions.
- Emotional Distress:
    - Role-play a client in emotional distress. Practice providing immediate support, validating their emotions, and helping them access appropriate resources.
- Trauma Disclosure:
    - Create a scenario where a client discloses past trauma. Practice responding with sensitivity, validating their feelings, and referring them to trauma-informed care.

After each role-playing exercise, take time for debriefing and constructive feedback. Encourage staff to reflect on their communication and de-escalation techniques, discussing what worked well and identifying areas for improvement. Regular practice of these scenarios can enhance staff's confidence and competence in handling real-life situations effectively and compassionately.

Module 6 trainings Medication Management and Withdrawal Symptom Recognition

Proper administration and documentation of medications during detox at Live Free Recovery involves adhering to specific protocols to ensure the safe and effective management of medications for clients in detoxification. Here's a general overview of the process:

Medication Administration:

- Only authorized and trained staff members should administer medications.

- Administer medications according to the prescribed dosage, route (oral, intravenous, etc.), and frequency.

- Follow a "rights of medication administration" approach: right patient, right medication, right dose, right route, and right time.

- Double-check the client's identity using at least two unique identifiers (e.g., full name and date of birth) before administering medication.

- Avoid crushing or altering medication forms unless approved by a medical professional.

Documentation:

- Document medication administration immediately after it's given. Use the detox center's approved medication administration record (MAR) form.

- Include the client's full name, date of birth, medical record number, medication name, dosage, route, time of administration, and your initials.

- Note any additional details, such as specific instructions from a medical provider or any observed reactions.

- If a medication is refused by the client, document the refusal with the reason.

- Ensure accuracy, legibility, and completeness in documentation.

- All entries should be made in non-erasable ink and corrections should be initialed and dated.

Communication:

- Communicate any changes in medication orders promptly to the medical provider.

- Report any adverse reactions, side effects, or concerns related to medications to the medical team.

- Maintain open communication with other staff members involved in the client's care to ensure consistent and coordinated administration.

Controlled Substances:

- Follow strict protocols for the administration of controlled substances (e.g., opioids) to prevent diversion and ensure client safety.

- Document controlled substance administration with additional requirements, such as the amount administered and the client's pain level.

Storage and Security:

- Store medications securely, following state and federal regulations.

- Monitor and document medication storage temperature as required.

- Implement measures to prevent unauthorized access to medications.

Education:

- Ensure all staff members are properly trained in medication administration and documentation procedures.

- Provide ongoing education to staff regarding new medications, changes in protocols, and best practices.

Withdrawal identified:

Recognizing common withdrawal symptoms for various substances here at Live Free Recovery is crucial for ensuring the safety and well-being of clients undergoing detoxification. Here's a general overview of withdrawal symptoms associated with different substances:

Alcohol Withdrawal:

- Early symptoms: anxiety, tremors, sweating, nausea, vomiting, irritability.

- Severe symptoms: hallucinations, seizures, delirium tremens (DT).

- Delirium Tremens (DT): disorientation, severe agitation, high fever, hallucinations, rapid heartbeat.

Opioid Withdrawal:

- Early symptoms: anxiety, restlessness, muscle aches, yawning, runny nose, sweating.

- Gastrointestinal symptoms: nausea, vomiting, diarrhea, abdominal cramping.

- Psychological symptoms: irritability, insomnia, mood swings.

Benzodiazepine Withdrawal:

- Anxiety, restlessness, insomnia, irritability, muscle tension.

- Tremors, sweating, nausea, vomiting.

- Seizures (can occur with abrupt cessation of high-dose or long-term use).

Stimulant Withdrawal (e.g., Cocaine, Methamphetamine):

- Fatigue, excessive sleepiness, increased appetite.

- Psychological symptoms: depression, irritability, difficulty concentrating.

- Intense cravings for the substance.

Sedative-Hypnotic Withdrawal (e.g., Barbiturates, Sleep Medications):

- Anxiety, restlessness, difficulty sleeping.

- Tremors, sweating, nausea, vomiting.

- Seizures (can occur with abrupt cessation of high-dose or long-term use).

Nicotine Withdrawal:

- Irritability, anxiety, mood swings.

- Difficulty concentrating, increased appetite, weight gain.

- Intense cravings for nicotine.

Other Substances (various prescription medications, hallucinogens, etc.):

- Withdrawal symptoms vary widely depending on the substance.

- It's important to be familiar with potential withdrawal symptoms associated with specific substances.

Observations and Monitoring:

- Pay close attention to clients for any signs of distress, discomfort, or unusual behavior.

- Monitor vital signs, such as blood pressure, heart rate, and temperature.

- Document observed withdrawal symptoms accurately and promptly.

It's important to note that withdrawal symptoms can vary in intensity and duration based on factors such as the type and amount of substance used, the client's overall health, and their individual response to withdrawal. Detoxification from certain substances, especially alcohol and benzodiazepines, can be medically complex and may require close medical supervision.

Detox center staff should receive thorough training on recognizing withdrawal symptoms and responding appropriately. Additionally, any concerns or observed symptoms should be communicated to the medical team promptly for assessment and intervention. Always follow the detox center's protocols, state regulations, and the guidance of medical professionals when addressing withdrawal symptoms.

Medical emergencies:

Identifying potential medical emergencies and taking appropriate actions in a substance abuse treatment detox program in New Hampshire (NH) is essential for ensuring the safety and well-being of clients undergoing detoxification. Here's a general overview of how to identify potential medical emergencies and the steps to take:

Delirium Tremens (DT) in Alcohol Withdrawal:

- Symptoms: Disorientation, severe agitation, hallucinations, high fever, rapid heartbeat.

- Action: Contact medical professionals immediately. Provide a calm and safe environment. Monitor vital signs.

Seizures in Opioid or Sedative Withdrawal:

- Symptoms: Uncontrolled shaking or convulsions.

- Action: Ensure the client's safety by moving objects away. Protect the client's head. Time the duration of the seizure. After the seizure, keep the client in a side-lying position.

Severe Hypertension or Cardiac Symptoms:

- Symptoms: Extremely high blood pressure, chest pain, difficulty breathing.

- Action: Contact medical professionals immediately. Keep the client calm and comfortable. Monitor vital signs.

Severe Dehydration:

- Symptoms: Dry mouth, dark urine, dizziness, confusion.

- Action: Encourage the client to drink fluids. If symptoms worsen, seek medical assistance.

Severe Gastrointestinal Distress:

- Symptoms: Persistent vomiting, diarrhea, abdominal pain.

- Action: Monitor fluid intake. If symptoms are severe or prolonged, seek medical assistance.

Respiratory Distress or Overdose:

- Symptoms: Slow or labored breathing, loss of consciousness.

- Action: Administer naloxone if opioid overdose is suspected. Perform rescue breathing if breathing is very slow or stops. Seek immediate medical help.

Suicidal or Harmful Intent:

- Symptoms: Expressing thoughts of self-harm or harm to others, acting agitated or aggressive.

- Action: Ensure the safety of the client and others. Remove any potential means of harm. Involve mental health professionals or crisis intervention teams.

Allergic Reactions or Anaphylaxis:**

- Symptoms: Swelling, difficulty breathing, rash, hives.

- Action: Administer epinephrine if available and prescribed. Seek immediate medical attention.

Any Unexplained or Severe Symptoms:

- Action: Err on the side of caution and seek medical assistance if in doubt. It's better to have a medical professional evaluate the situation.

Document and Report:

- Document observed symptoms, actions taken, and outcomes accurately and promptly.

- Communicate the situation to the medical team and facility leadership.

Training and Preparedness:

- Staff should be trained in basic first aid, CPR, and how to respond to medical emergencies.

- Familiarize staff with the facility's emergency protocols and evacuation procedures.

Live Free staff should always prioritize client safety and well-being. It's crucial to have clear and well-communicated emergency response procedures in place, and all staff members should be familiar with them. If a potential medical emergency arises, do not hesitate to seek immediate medical assistance. Always follow the protocols and guidelines established by your detox program and the direction of medical professionals.

Module 7 Ethical Considerations and Boundaries

Interacting with clients, maintaining confidentiality, and respecting boundaries are critical ethical considerations in Treatment . Here are ethical guidelines to uphold in these areas:

Interacting with Clients:

Respect and Dignity:

- Treat all clients with respect, empathy, and dignity, regardless of their background or circumstances.

Non-Discrimination:

- Do not discriminate based on race, ethnicity, gender, sexual orientation, religion, or any other characteristic.

Client-Centered Approach:

- Tailor interactions to the individual client's needs, preferences, and goals.

Informed Consent:

- Obtain informed consent from clients before any assessment, treatment, or intervention, explaining the purpose, risks, and benefits.

Maintaining Confidentiality:

Confidentiality Agreement:

- Clearly communicate the confidentiality policy to clients, emphasizing the importance of protecting their privacy.

Limits of Confidentiality:

- Inform clients of the situations in which confidentiality may be breached, such as when there's a risk of harm to themselves or others.

Sharing Information:

- Share client information only with authorized personnel involved in their care, ensuring proper documentation and consent.

Secure Record-Keeping:

- Maintain secure and accurate records, protecting them from unauthorized access.

Communication Channels:

- Use secure and private communication channels when discussing client information with colleagues or other professionals.

Respecting Boundaries:

Professionalism:

- Maintain a professional demeanor and avoid any behavior that may be perceived as inappropriate or boundary-crossing.

Dual Relationships:

- Avoid engaging in dual relationships that could compromise objectivity and create conflicts of interest.

Personal Disclosures:

- Refrain from sharing personal information or experiences that may detract from the therapeutic relationship.

Social Media:

- Avoid connecting with clients on personal social media accounts to maintain a professional boundary.

Gifts and Favors:

- Do not accept or offer gifts, favors, or personal benefits from/to clients, as this can blur boundaries.

Additional Considerations:

Cultural Competence:

- Be culturally sensitive and aware of cultural differences to ensure respectful interactions.

Consent for Treatment:

- Obtain informed consent from clients before providing any form of treatment, including medications and interventions.

Reporting Requirements:

- Familiarize yourself with mandatory reporting requirements for issues such as child abuse, neglect, and harm to self or others.

Continuous Education:

- Stay updated on ethical guidelines, laws, and best practices in the field through ongoing training and professional development.

Supervision and Consultation:

- Seek supervision or consultation from experienced colleagues or supervisors when facing ethical dilemmas.

Adhering to these ethical guidelines ensures that clients receive the highest standard of care and respect at Live Free. It also contributes to maintaining a safe, supportive, and effective treatment environment.

Balancing empathy and professionalism in client interactions within Live Free Recovery is crucial for building rapport while maintaining appropriate boundaries. Here are actionable ways to achieve this balance:

Active Listening:

- Practice active listening to fully understand clients' concerns and emotions.

- Maintain eye contact, nod, and use verbal cues to show you are engaged.

Empathetic Responses:

- Acknowledge clients' emotions and experiences without judgment.

- Use empathetic statements like "I understand this is challenging for you."

Reflective Language:

- Reflect back what clients have shared to show you've understood.

- This validates their feelings and helps you clarify their perspective.

Validate Emotions:

- Validate clients' feelings and struggles to show empathy.

- Use phrases like "It's okay to feel that way" or "Your feelings are valid."

Set Clear Boundaries:

- Clearly communicate boundaries regarding personal disclosures or relationships.

- Explain the limits of confidentiality and the professional nature of the relationship.

Maintain Professional Language:

- Use appropriate and respectful language at all times.

- Avoid slang, jargon, or overly familiar terms.

Focus on Strengths:

- Highlight clients' strengths and positive qualities to boost their self-esteem.

- Use strengths-based language to empower them.

Avoid Overstepping:

- Avoid making assumptions or judgments about clients' experiences.

- Respect their autonomy and allow them to share at their own pace.

Offer Supportive Resources:

- Provide information about support groups, therapy options, and community resources.

- Show that you care about their well-being beyond the treatment program.

Use Open-Ended Questions:

- Encourage clients to share more about their experiences and feelings.

- Use questions like "Can you tell me more about that?" to facilitate dialogue.

Mindful Nonverbal Communication:

- Use appropriate facial expressions, gestures, and body language.

- Maintain a professional yet empathetic demeanor.

Address Emotional Triggers:

- If a client becomes upset, acknowledge their feelings and offer grounding techniques.

- Create a safe space for them to express themselves.

Adapt Communication Style:

- Adjust your communication style based on the client's needs and preferences.

- Some clients may respond better to a more formal approach, while others appreciate a warmer tone.

Regular Self-Care:

- Practice self-care to manage your emotional well-being and prevent burnout.

- A well-rested and emotionally regulated professional is better equipped to balance empathy and professionalism.

Reflect and Seek Feedback:

- Reflect on your interactions to assess the balance between empathy and professionalism.

- Seek feedback from supervisors or colleagues to continuously improve.

Remember, the goal is to create a therapeutic alliance that combines understanding and support with a professional and ethical approach. Striking this balance enhances the quality of care and contributes to positive client outcomes at Live Free.

Module 8 Collaboration and Interdisciplinary Approach

Importance of Interdisciplinary Collaboration in Substance Use Detox:

Interdisciplinary collaboration at Live Free Recovery is essential for providing comprehensive and effective care to clients. Substance use disorders are complex and often require a holistic approach that addresses medical, psychological, social, and emotional needs. Interdisciplinary collaboration ensures that various professionals with different expertise work together seamlessly to deliver well-rounded care. Here's why it's important:

Holistic Care: Clients in detox require care that goes beyond addressing physical symptoms. Collaboration among medical, mental health, and social support professionals ensures that clients receive holistic treatment addressing their physical, psychological, and social well-being.

Comprehensive Assessment: Different professionals bring unique perspectives to client assessments, leading to a more accurate and comprehensive understanding of clients' needs and challenges.

Tailored Treatment Plans: Collaboration allows for the development of individualized treatment plans that consider all aspects of a client's health and circumstances.

Enhanced Outcomes: When professionals work together, clients benefit from coordinated care that reduces the risk of conflicting interventions and enhances treatment outcomes.

Prevention of Gaps in Care: Collaboration reduces the likelihood of important aspects of care being overlooked or neglected.

Faster Decision-Making: Collaborative teams can make quicker, well-informed decisions by leveraging the expertise of multiple professionals.

Continuity of Care: Effective collaboration ensures a smooth transition of care as clients move through different phases of treatment.

Roles and How They Work Together:

In a substance abuse treatment detox program, several key roles collaborate to provide comprehensive care:

Medical Doctors or Psychiatrists:

- Assess clients' medical condition, withdrawal symptoms, and any co-occurring disorders.

- Prescribe medications for withdrawal management and address medical needs.

- Collaborate with other professionals to develop integrated treatment plans.

Nurses:

- Monitor clients' physical health, administer medications, and manage withdrawal symptoms.

- Provide education on health-related topics.

- Communicate with other team members to ensure a coordinated approach.

Therapists/Counselors:

- Conduct psychological assessments, provide counseling, and facilitate group therapy.

- Address clients' emotional and psychological needs, including trauma and coping strategies.

- Collaborate with other team members to align treatment goals.

Social Workers:

- Assess clients' social and environmental factors, such as housing and support systems.

- Provide case management, connect clients with resources, and address discharge planning.

- Collaborate with other professionals to address social determinants of health.

Nutritionists/Dietitians:

- Assess clients' nutritional needs and develop meal plans.

- Address any nutritional deficiencies that may impact recovery and well-being.

Peer Support Specialists:

- Share their personal recovery experiences and provide guidance and support to clients.

- Act as role models and advocates for clients' recovery journey.

Pharmacists:

- Collaborate with medical professionals to ensure safe and effective medication management.

- Educate clients about medications, potential interactions, and side effects.

Administrative Staff:

- Coordinate appointments, manage records, and facilitate communication between team members.

Effective interdisciplinary collaboration involves regular communication, case conferences, and shared decision-making. Each role contributes its expertise to create a comprehensive and personalized treatment plan that addresses all aspects of a client's well-being. This collaborative approach improves the quality of care and enhances clients' chances of successful recovery while attending Live Free Recovery.

Effective Communication and Teamwork Among Staff Members in a Substance Abuse Treatment Detox Program in NH:

Establishing effective communication and teamwork among staff members is crucial for providing quality care and ensuring a supportive environment at Live Free Recovery. Here's an outline of strategies to achieve this:

Clear Communication Channels:

- Create clear channels for communication, both formal (meetings, emails) and informal (chat platforms, quick updates).

- Ensure all staff members are aware of these channels and know when to use each one.

Regular Team Meetings:

- Schedule regular team meetings to discuss client progress, treatment plans, and challenges.

- Encourage open dialogue and the sharing of insights and perspectives.

Collaborative Decision-Making:

- Involve relevant team members in decision-making processes to ensure diverse viewpoints are considered.

- Seek input from different disciplines when developing treatment plans.

Shared Documentation:

- Use a centralized system for documenting client information, progress notes, and interventions.

- Ensure all staff members have access to updated and accurate records.

Cross-Training:

- Provide opportunities for staff members to learn about the roles and responsibilities of their colleagues.

- Cross-training enhances understanding and promotes empathy among team members.

Interdisciplinary Case Conferences:

- Organize regular case conferences involving various disciplines to discuss complex cases and treatment strategies.

- Foster collaboration and encourage creative problem-solving.

Respectful Communication:

- Promote a culture of respectful and professional communication among staff members.

- Address conflicts or disagreements through constructive conversations.

Active Listening:

- Encourage active listening during interactions among team members.

- Ensure everyone has the chance to express their ideas and concerns.

Feedback and Reflection:

- Encourage feedback on team dynamics, communication, and collaboration.

- Reflect on successes and areas for improvement as a team.

Clear Roles and Responsibilities:

- Define and communicate each team member's roles and responsibilities clearly.

- Avoid assumptions and ensure everyone knows their specific contributions.

Team-Building Activities:

- Organize team-building activities to foster positive relationships and improve teamwork.

- Activities can include workshops, retreats, or team outings.

Conflict Resolution Training:

- Provide training on conflict resolution techniques to address disagreements professionally and constructively.

Celebrate Achievements:

- Recognize and celebrate team achievements, milestones, and successes.

- Positive reinforcement boosts morale and team cohesion.

Supportive Leadership:

- Leaders should model effective communication and teamwork, setting an example for staff members.

- Provide resources and support to enhance staff communication skills.

Encourage Learning and Growth:

- Support ongoing professional development and encourage staff to learn from one another.

- Learning from different disciplines enriches the team's knowledge base.

By implementing these strategies, Live Free can foster a culture of effective communication and teamwork among staff members. This collaborative approach ultimately contributes to the program's success in providing comprehensive and compassionate care to clients.

Examples of Case based discussions on collaborative problem-solving at Live Free

Case 1: Addressing Client Resistance

Situation: A client has been resistant to participating in group therapy sessions and has shown reluctance to engage in any treatment activities. The client's lack of engagement is impacting their progress in the detox program.

Discussion Points:

Interdisciplinary Discussion: As a team, discuss the possible reasons for the client's resistance. Consider medical, psychological, and social factors that could contribute to their behavior.

Collaborative Assessment: Assign team members from different disciplines (e.g., therapist, nurse, social worker) to conduct a comprehensive assessment of the client. This assessment can provide a holistic understanding of the client's needs and barriers.

Treatment Plan Modification: Collaboratively modify the client's treatment plan to address their resistance. Consider adjusting the therapy approach, exploring alternative activities, or providing additional support.

Team Support: Designate a team member to establish a supportive rapport with the client. Collaborate on strategies to motivate the client and encourage their active participation.

Regular Check-Ins: Establish a schedule for interdisciplinary check-ins to monitor the client's progress and make necessary adjustments to their treatment plan.

Case 2: Co-occurring Disorders and Medication Management

Situation: A client with a history of substance abuse also presents symptoms of anxiety and depression. The medical team has prescribed medication to manage these

co-occurring disorders, but there is concern about potential interactions with withdrawal management medications.

Discussion Points:

Team Discussion: Convene an interdisciplinary meeting involving the medical doctor, psychiatrist, and nurse to discuss the client's medication regimen and potential interactions.

Pharmacist Consultation: Consult with the facility's pharmacist to review the medication plan and identify any potential interactions or adverse effects.

Client Education: Collaboratively develop a plan to educate the client about their medications, including potential side effects and interactions. Involve therapists or counselors to support the client's understanding.

Monitoring and Communication: Establish a system for regular communication between the medical team and the counseling team to monitor the client's response to medications and overall progress.

Integrated Care: Work together to integrate therapeutic interventions that address both substance abuse and co-occurring disorders. Collaborate on counseling strategies that complement the medication management plan.

Case Conferencing: Schedule regular interdisciplinary case conferences to review the client's progress, medication adjustments, and any necessary modifications to the treatment plan.

These case-based discussions illustrate how interdisciplinary collaboration enhances problem-solving and client care within a substance abuse treatment detox here at Live Free. By bringing together diverse expertise and perspectives, teams can develop effective strategies to address complex challenges and provide comprehensive support to clients.

INFECTION PREVENTION AND CONTROL

All employees are required to participate in infection prevention and control training on an annual basis. This study guide is designed to assist in preparing employees to perform in a way that protects patients, employees, students, and visitors from spreading pathogens and communicable diseases to one another.

Bloodborne Diseases Bloodborne diseases are diseases that are spread by contact with infected blood and other infectious body fluids.

Transmission of bloodborne pathogens, including HIV, Hepatitis B virus and Hepatitis C virus, may occur if infectious blood or body fluids contact the mucous membranes of the eyes, nose, or mouth. They can be transmitted by needlesticks and puncture wounds or cuts from other contaminated sharps. Non-intact skin also provides a way to contact these organisms. This is especially true if you have abrasions, cuts, rashes, or burns on your hands and you touch blood, other potentially infectious materials, or a contaminated surface with your bare non-intact hands. These pathogens can be present long before the infected person shows any signs of the disease. Sometimes they are present without the patient or the employee developing signs of the disease.

Contaminated objects can transmit Hepatitis B, as the virus can live on inanimate objects for up to four (4) weeks. The HIV virus, however, cannot live outside the body. The pathogens that cause bloodborne diseases may be present in:

• Blood
• Body fluids which has visible blood
• Semen, vaginal secretions, cerebrospinal fluid, synovial fluid, plural fluid, pericardial fluid, amniotic fluid
• Blood tinged saliva in dental procedures unfixed tissue or body organs other than intact skin
• Organ cultures, HIV containing culture media, or similar solutions
• Blood, organs, and tissue from experimental animals infected with HIV or HBV
• Items contaminated with any of the above. (An item is considered to be contaminated if it is, or is being suspected of being, soiled with blood or other infectious materials.) (Only blood, semen, vaginal secretions, and breast milk have been shown scientifically to transmit HIV.) Bloodborne pathogens may enter your body in a variety of ways including:
• Through open cuts, nicks, skin abrasions, dermatitis, and acne, as well as the mucous membranes of your mouth, eyes or nose
• By touching an object soiled with infectious material and then indirectly transferring the infectious material to your mouth, eyes, nose, or open skin lesion
• An accidental injury that results in a puncture or cut of your skin by a sharp object soiled with infectious material (for example, a needle, knife, broken glass, dental wires, etc.).

Surfaces such as walls, floors, counters and furniture that are contaminated with infectious material are a major danger for spreading diseases such as hepatitis B. The hepatitis B virus can survive on surfaces for up to four (4) weeks. Infectious materials such as serum or plasma, without visible signs, can soil surfaces and objects. This is why we use standard housekeeping procedures for cleaning and disinfecting of all equipment and work surfaces outside of the host and on an environmental surface. Hepatitis B is a much stronger and more viable virus than HIV.

Some of the bloodborne diseases that healthcare employees can be exposed to on the job include:

• Hepatitis B (HBV)
• Hepatitis C (HCV)
• Human Immunodeficiency Virus (HIV), the virus that causes AIDS The most common and the most contagious of these bloodborne diseases is Hepatitis B (HBV).

The other infection that is becoming of great concern to hospital employees is Hepatitis C and as in the past human immunodeficiency vims (HIV) that causes AIDS.

Hepatitis B (HBV)

Hepatitis B is an inflammation of the liver that can lead to cirrhosis and death. Hepatitis B (HBV) is a major risk for health care workers. It is estimated that 1 to 1.25 million persons in the U.S. have chronic Hepatitis B and are potentially infectious to others. It affects about 8,500 health care workers each year. Studies show the infection rate for Hepatitis B from a contaminated needle, a common mode of transmission, is as high as one in six. Symptoms include weakness, fatigue, anorexia, nausea, abdominal pain, jaundice (yellow skin), fever, headache, vomiting, diarrhea, decreased appetite, and generalized muscle aches.

Hepatitis B vims may be transmitted when a person's mucous membranes or breaks in the skin are exposed to an infected person's blood, semen, vaginal secretions, or other potentially infectious materials. Of those who are infected with hepatitis B, 1/3 will have no signs, 1/3 will have mild, flu-like illness, and 1/3 will have severe symptoms of the illness.

The signs of severe clinical hepatitis B include: jaundice (yellowing of the skin and eyeballs), dark urine, extreme fatigue, loss of appetite, nausea, abdominal (belly) pain, joint pain, rash and fever.

The Hepatitis B virus may be spread by sexual or other contact with semen, vaginal secretions, blood, and other body fluids of an infected person. Hepatitis B can also be spread from a pregnant woman to her unborn child. Health care workers can control the spread of Hepatitis B and protect themselves by acting as if EVERY patient they come in

contact with has the disease. (Remember, 2/3 of infected people either do not have signs or have signs that can be mistaken for flu!)

By using Standard Precautions, which will be discussed later in this module, health care workers can protect themselves from illnesses such as Hepatitis B. Using Standard Precautions and becoming vaccinated is the best way to protect yourself from the Hepatitis B virus. Employees whose job description requires that they come into contact with blood and body fluids may consider to have the vaccine. (The Hepatitis B vaccine does not protect against other bloodborne diseases.) Hepatitis B vaccine is used to immunize people of all ages against infection caused by all subtypes of Hepatitis B virus. There is no danger of getting Hepatitis B from the vaccine, because no human substances are used to make it. At this point, we do not know how long the protection lasts, or whether periodic booster doses will be needed. Antibody levels that develop from the vaccine drop steadily over time.

Up to 50% of adults who develop enough antibodies with the vaccine will have low or no antibody levels 7 years after the vaccination. However, it appears that they still are protected against infection and clinical disease from the Hepatitis B vims. Human Immunodeficiency Virus (HIV) A person who is HIV positive (HIV+) is infected with the human immunodeficiency virus. This virus causes Acquired Immune Deficiency Syndrome (AIDS). Being HIV+ does not mean that the person has AIDS, or that they will become seriously ill soon. The virus may be inactive for periods of time, sometimes for several years. During this time, an infected person may have no signs of disease.

It is estimated that 36.7 million cases worldwide, 1.1 million cases in the United States and 106,585 in the state of Florida. The HIV virus attacks the immune system. It eventually affects the body's ability to fight off "opportunistic infections" which are caused by organisms that usually do not cause disease in people who have healthy immune systems. People infected with the HIV virus are also more likely to develop contagious diseases such as tuberculosis, because the immune system is not able to fight them off.

A person infected with HIV may have the following characteristics:

• Carry the virus for years without developing any signs
• Suffer from flu-like symptoms of fever, diarrhea and fatigue
• Develop HIV-related illnesses such as nervous system problems, cancer, Pneumonia, tuberculosis, and opportunistic infection HIV is spread through contact with infected blood, semen, and vaginal fluids.

HIV is not spread by casual contact such as touching or working around patients who are infected.

The main behavior that transmits HIV is sexual contact. Vaginal, penile, rectal intercourse, and/or sharing of needles during I.V. drug abuse also transmit the virus. Occupational needlestick injuries show the rate of infection, after being stuck with an HIV contaminated needle, is one in 300. Health care workers can help control the spread of HIV and protect themselves by acting as if EVERY patient they come in contact with is infected with the vims. (Remember, patients may carry the virus for years without developing any signs, or the signs can be mistaken for other health problems! Early on when an individual is exposed, and prior to any symptoms, a person is 1,000 times more infectious. Yet when tested prior to developing antibodies the test will be negative.)

By using Standard Precautions, which will be addressed later in this module, health care workers can protect themselves from infections such as HIV.

Hepatitis C Virus (HCV)

Hepatitis C Virus is spread mainly through blood transfusions and intravenous drug abuse. It resembles Hepatitis B in that it attacks the liver. Symptoms of active HCV are milder than those of HBV - or may not even be present. However, HCV is more likely to cause chronic carrier state and more likely to lead to cirrhosis, liver cancer, and death.

AIRBORNE DISEASES

Airborne diseases are spread by breathing in air which has droplets or droplet nuclei (5mm or smaller in size), that can cause airborne disease.

Some examples of airborne diseases include:

• Tuberculosis
• Chicken-pox
• Measles
• Shingles in a person whose immune system is weak There are many ways to protect staff and other patients from airborne diseases.
• Patients who have airborne diseases will be discharged and/or transferred to another facility until there are free from the airborne disease.
• Staff will be notified any airborne diseases to ensure proper care is given to individual.

Tuberculosis(TB) Tuberculosis

(TB) is an infectious disease that occurs most often in the lung. TB is a serious and growing threat to everyone. Some TB infections are treatable with drugs. There are strains of the

disease that are resistant to most drugs now available. Although anyone can get TB, there are some groups that are at a greater risk than others. These high-risk groups include: low socio-economic levels without a strong social support system, the homeless, the elderly, those who live in nursing or retirement homes, IV drug users, migrant workers, and those who live in areas where the disease is common.

In addition to a positive TB skin test the patient may have one or more of the following symptoms if infected with TB:

- Productive cough
- Coughing up blood
- Fever and chills
- Night sweats
- Recent weight loss

Patients who are HIV (AIDS) infected may have TB without showing these typical signs. TB is most commonly spread by breathing in the airborne droplet nuclei <5 microns. Organisms transmitted in this matter can be suspended in air for long periods of time and can be dispensed in air currents. An important way to control the spread of tuberculosis is to find out early who has been exposed to the disease. Persons can have a positive tuberculosis skin test (PPD) without being infectious with TB. Headrest employees are required to have a tuberculin skin test or chest x-ray prior at time of pre-employment health screening.

Any client suspected of having tuberculosis should be put on air-born precautions right away and be prepared for transfer to a medical facility for further evaluation and/or treatment.

Droplet Precautions

Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (5mm or larger in size). Droplets are generated from the person primarily during coughing, sneezing, or talking. Droplets usually travel short distances of 3 ft. or less.

Diseases that are spread by droplets include:

• Invasive Haemophilus influenza type b disease, including meningitis, pneumonia, epiglottis and sepsis • Invasive Neisseria meningitides disease, including meningitis, pneumonia, epiglottitis and sepsis
• Diphtheria (pharyngeal)
• Mycoplasma pneumonia
• Pertussis
• Pneumonic plague
• Streptococcal pharyngitis, pneumonia, or scarlet fever in infants and young children
• Adenovirus
• Influenza
• Mumps
• Parvovirus
• Rubella

EXPOSURE CONTROL PLAN

The Occupational Safety and Health Act (OSHA) defines occupational exposure as "reasonably anticipated skin, eye, mucous membrane, or parenteral [piercing the skin] contact with blood or other potentially infectious materials that may result from the performance of an employee's duties." The OSHA regulations require the organization to develop an Exposure Control Plan and to make it available to all employees.

The Exposure Control Plan is in the Infection Prevention and Control Manual and the plan is available to all employees. Be sure to read the Exposure Control Plan. It has important information that will help you protect yourself from getting diseases that you might be exposed to because of your work. The Exposure Control Plan lists tasks and procedures, which could cause you to be exposed to infectious diseases. Let this list serve as a reminder for you to protect yourself when doing these tasks or procedures. Because we do not always know what diseases or pathogens a patient may have, we need to learn to lower our risk and protect ourselves. We need to act as if EVERY patient has an infectious disease such as hepatitis, malaria, syphilis, and HIV/AIDS. (This behavior is part of Standard Precaution, which is discussed in detail later in this module.) It is harmful and may be life threatening not to protect ourselves from these diseases or pathogens.

There is no way to tell with certainty that any person is free of Bloodborne disease. Any person can be infected without being aware of the infection. The infected person may not have any signs or symptoms of disease. We cannot make safe judgements about absence of infection by appearance, age, sex, socioeconomic level, or any other factor. The best way for health care workers to protect themselves from exposure to bloodborne infections is to treat ALL patients as if they were infected with Hepatitis B, Hepatitis C, HIV, or other

bloodborne diseases. Some major ways to reduce the risk of exposure to bloodborne organisms on the job are:

Engineering Controls

Engineering controls are physical or mechanical systems designed to stop hazards before they start. Examples of engineering controls are: self-sheathing needles, bio-safety bags, sharps disposal containers, appropriate hand washing facilities.

Personal Protective Equipment(PPE)

Personal Protective Equipment is intended to protect you from contact with possible infectious materials. Examples of such equipment include: gloves, masks, protective eye wear, fluid resistant gowns, resuscitation bags and other resuscitation devices.

To be effective, personal protective equipment must be fluid resistant and help prevent blood or other potentially infectious materials from passing through to the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, and other mucous membranes. This protection should be effective under normal conditions of use for the length of time for which it will be used.

Some general guidelines for selection and use of protective equipment are:

• The employee must be taught to use it properly.
• Appropriate protective equipment must be used each time a task is done.
• The equipment must be free of flaws that would make it unsafe.
• Gloves must fit properly.
• If infectious materials go through the protective equipment, remove it as soon as possible and wash the exposed intact skin surface with an antimicrobial soap for 10 minutes.
• When the task is complete, remove all protective equipment and place it in the appropriate place or container for washing, decontamination, or disposal.

Once personal protective equipment has been used, it must be properly disposed of. Disposable items (for example gloves, masks, fluid resistant gowns,) should be handled as follows:

• If items are visibly contaminated and could cause dripping with blood or other body fluids, they are disposed of in red plastic bags for medical service waste disposal.
• If items are not contaminated and cannot cause dripping, splattering or splashing, they are disposed of in regular trash.

HOUSEKEEPING PRACTICES

• When cleaning up broken glass, do not pick it up with gloves or bare hands. Use tongs or a brush and dust pan.
• Spill kits may be used for blood and body fluid spills.
• Do not place contaminated laundry on the floor. Handle contaminated laundry as little as possible. Do not hold up to the body. Place all contaminated laundry in blue laundry bags.
• Place ALL sharp items in a sharp's container.
• Clean up contaminated areas first with soap and water (while wearing PPE) follow with a EPA registered disinfectant or a fresh solution of 5.25% of sodium hypochlorite mixed 1:10 with water.
• All bio-medical waste will be placed in red bags that have a biohazard symbol on it. Red bags will be located for disposal in various locations.

Sharps container must be properly closed when line indicates FULL, for pick-up.

EMPLOYEE WORK PRACTICES

Employee work practices are specific procedures that are aimed at reducing the chances of exposure to infectious material. Examples of employee work practices are:

Handwashing: Comply with current CDC hand hygiene guidelines in order to reduce the risk of healthcare acquired infections.

The generally accepted correct handwashing time and method is a 10-15 seconds vigorous rubbing together of all soapy surfaces followed by rinsing in a flowing stream of water. If hands are visibly soiled, more time may be required. Handwashing should occur after every patient contact, each time gloves are removed, and when skin or mucous membranes come in direct contact with blood or other body fluids. Handwash with an antimicrobial soap or flush eyes and mucous membranes immediately with water for 10 minutes in the event direct contact with blood or other body fluids. Purell handwashing stations are available on each unit.

Needlesticks: Avoiding injuries from needlesticks and other sharps: use only safe needle devices, do not bend, hand-recap, shear or break contaminated needles or other sharps; and dispose of sharps promptly in puncture-resistant, leak-proof containers.

Personal hygiene: Do not eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses, where you may be exposed to potentially infectious materials; avoid petroleum-based lubricants that may "eat" through latex gloves; do not keep food or drinks in refrigerator, freezers, cabinets, or on shelves, counter tops or bench tops where possible infectious materials may be present.

STANDARD PRECAUTIONS

Standard Precautions are meant to protect workers from biohazards and is inclusive of Body Substance Isolation and Universal Precautions. Headrest has adopted Standard Precautions as its isolation technique for all patient care that is based on the idea that "Anything that's wet and not yours is potentially infectious!"

Three basic principles apply in Standard Precautions:

1) Strict hand washing technique is used in all cases of contact with patients, blood/body fluids, secretions, excretions and contaminated items. Wash hands after removing gloves.

2) Contaminated needles and sharps are handled and disposed of according to policy and procedure.

3) Personal protective equipment that is adequate and appropriate is used. The type of protective equipment appropriate for a given task depends on the expected exposure.

* If you expect to be splashed, sprayed, or spattered with droplets of infectious material, use a mask, eye protection, and fluid resistant gown, gloves.

SIGNS AND LABELS The universal biohazard symbol shown below is used on all containers of medical waste, refrigerators, and freezers that hold blood or other infectious material. There are several ways to warn that a piece of equipment or material is contaminated or possibly contaminated. You can attach a biohazard symbol or a warning label, or put it in a red bag or red container. Also, you should always treat all blue bagged linen as contaminated.

EXPOSURE INCIDENTS

When an employee is exposed to blood or potentially infectious body fluids the employee should: • Remove all contaminated clothing as soon as possible (The employee's supervisor will provide alternate clothing).

• Immediately wash or flush contaminated skin with antimicrobial soap and water for 10 minutes. If you obtained a needlestick squeeze/milk the area of blood and then wash for 10 minutes.

• Employees are responsible for reporting incidents to their supervisors immediately after they happen and reporting to Employee Health immediately.
• You and the source will be tested for HIV, HBV after the consents and counseling is completed.
• You will be seen by the workmen's compensation physician for an evaluation and any treatment. You will receive a written opinion in 15 days.
• The protocol that will be followed is detailed in the exposure control plan.

REPORTING EMPLOYEE SIGNS OF DISEASE

Employees who have any of the following signs of disease should contact the Clinical and/or Executive Director of Headrest: eye infection (conjunctivitis); signs of respiratory illness; skin rashes, open lesions, cold sores; recent exposure to chickenpox, mumps, measles, whooping cough; cast, and/or bandages that prevent effective hand washing. Employees who feel that they are infectious or who are too sick to work are encouraged not to come to work.

INFECTION PREVENTION AND CONTROL TEST

1. What type of personal protective equipment (PPE) is needed when performing a task when touching of human blood/body fluid may occur?

a. Gloves

b. Mask Goggles

c. Gowns

d. All the above

2. What is the correct response to clean up a spill containing blood/body fluids?

a. Call your supervisor

b. Call 911

c. Put on gloves, wipe up spill (utilize spill kit_ then disinfect with an EPA registered disinfectant and/or a 1:10 sodium hypochlorite (bleach)

3. The best way to protect yourself from Hepatitis B is to be vaccinated and utilize Standard Precautions with all patients.

TRUE FALSE

4. Good handwashing techniques keep you from transferring contamination to other areas of your body or the environment.

TRUE FALSE

5. Every time you remove your gloves you must wash your hands with soap and running water.

TRUE FALSE

6. Never pick up broken glass with your hands. Use tongs or a brush and dust pan.

TRUE FALSE

7. Blood is the only body fluid that can carry blood-borne diseases.

TRUE FALSE

8. HIV can live on inanimate objects for up to 4 weeks.

TRUE FALSE

(Infection Prevention and Control Test Continued)

9. Hepatitis B virus (HBV) hand Human Immunodeficiency virus (HIV) are spread through:

a. Casual contact or contact with toilet seats, doorknobs, etc.

b. Exposure to blood/body fluids by percutaneous exposure (needlesticks) and/or mucous membrane (mouth or eye) exposures.

10. Any task that involves human blood/body fluid, tissues and/or a needle or sharp contaminated with human blood/body fluids is a task where there is a chance of exposure to HB R HIV.

TRUE FALSE

11. Standard Precautions are utilized based on the premise that any contact with human blood/body fluids is potential infectious risk.

TRUE FALSE

Your Name _____

ETHICAL DECISION MAKING TRAINING FOR CRISIS COUNSELORS

Ethical decision making for crisis counselors consists of ten steps:

(1) Identify the ethical concern within the context of the disaster

(2) Consider personal (crisis counselor's) beliefs and values, skills and knowledge

(3) Identify the code(s) of ethics involved

(4) Determine possible ethical traps

(5) Frame a preliminary response

(6) Consider the consequences

(7) Prepare an ethical resolution

(8) Get feedback/consultation from other crisis counselors

(9) Take action

(10) Review the outcome.

Step 1- Identify the ethical concern within the context of the disaster.

During this step, the crisis counselor identifies an ethical dilemma that s/he is faced with, which might be unique to the disaster event (e.g., location, duration, magnitude). It also would involve providing crisis counseling in this or another state or country, with diverse cultures, religious/spiritual values, etc.

Example: A crisis counselor receives a phone call from Russia, subsequent to a terrorist attack and the death of many Russian civilians (children, women, and men). You have overheard one of the other crisis counselors requesting that the survivors who received crisis counseling make themselves available to tell their story on video. According to this crisis counselor, the video tapes would be used by the relief organization to encourage donations for the people affected by the terrorist attack. One of the local women started crying and asked not to be recorded when telling her story. Our potential callers/clients have the right to refuse the use of their calls/recordings for any reason they chose.

Step 2- Consider personal (the crisis counselor's) self, beliefs and values, skills and knowledge.

During this stage, the crisis counselor needs to assess the

(a) self - does s/he have the ability to deal with his/her own stress and internal conflict as well as his/her emotions so that s/he can be calm, and is able to focus and be action oriented
(b) beliefs and values - about him/herself, others, the world and religious/spiritual values to see that they do not interfere with their ethical decision making process
(c) skills and knowledge - having the crisis counseling and crisis management skills needed to meet the needs of the disaster affected individual, family and community.

Example: The crisis counselor, being aware of the importance of relief organizations procuring donations, felt upset that these survivors were being used to get funding, rather than to meet their needs.

Step 3- Identify the code(s) of ethics involved.

During this step, the crisis counselor identifies the code(s) that applies to this ethical dilemma. Familiarity with the ACA Code of Ethics is important in this step. If a copy of the ACA Code of Ethics is available, it might also serve as an additional resource to identify the codes impacted.

Example: the ACA Code of Ethics clearly states: A.1.a. Primary Responsibility – The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients (APA, p. 3). B.1.b. Respect for Privacy – Counselors respect client rights to privacy. Counselors solicit private information from clients only when it is beneficial to the counseling process (ACA, p. 7). C.1 Knowledge of Standards – Counselors have a responsibility to read, understand, and follow the ACA Code of Ethics and adhere to applicable laws and regulations (ACA, p. 9). C.3.b. Testimonial – Counselors who use testimonials do not solicit them from current clients nor former clients nor any other persons who may be vulnerable to undue influence (ACA, p. 10).

Step 4- Determine possible ethical traps.

There are several traps that crisis counselors might struggle with and need to assess, to assure that they are not interfering with ethical decision making:

(a) **the common objectivity trap** - is s/he (the crisis counselor) overidentifying or over-invested with the trauma affected person, family, community?
(b**) the value trap** - the crisis counselor's personal values about who should be served (e.g., children over adults, young adults over the elderly, etc.) how to provide services (using the same services regardless of the needs of the disaster affected individual, family , community), (c) **the circumstantiality's trap** - the belief that crisis counseling is a unique

circumstance (e.g., magnitude of the disaster, lack of resources and support services, functioning in another country, etc.) and traditional values and practices do not need to be followed (d) **the traditional trap** - historically s/he (the crisis counselor) has not done it that way before (e.g., in previous disasters, or in the office, etc.)
(e) **the role trap** - functioning outside their role as crisis counselor (e.g. I know how to do Eye Movement Desensitization and Reprocessing [EMDR], so I can do more than crisis counseling here, etc.) and beyond their skill level (e.g., I have never been trained in Critical Incident Stress Debriefing [CISD], but I have read about it, and I can learn as I go along, etc.); (f) the "that's what we do in the USA" trap - providing services using American frame of reference rather than looking at the cultural, historical, ecological, etc., setting
(g) **the who will benefit trap** - limiting the services to those that the crisis counselor perceives as benefitting and being deserving of crisis counseling, such as women and children versus soldiers; and (h) the vicarious trauma trap - the perception that what s/he (crisis counselor) is doing is not making any difference, is not helpful.

Example: The crisis counselor assessed the different ethical traps and decided that providing crisis counseling in Russia does not justify video taping survivors who did not want to be video taped, and justifying such behavior with public donations allowing additional teams to be deployed in the future.

Step 5- Frame a preliminary response.

After having identified the crisis counselor's personal self, skills, and knowledge as well as personal beliefs and values, in addition to having identified the ACA Code(s) of Ethics that apply to the ethical traps, s/he (crisis counselor) will develop a preliminary response for how to deal with the situation.

Example: The crisis counselor believed that it was her responsibility to talk with the other two crisis counselors and remind them that their expectations of survivors did not follow the ACA Code of Ethics.

Step 6- Consider the consequences.

During this step, the crisis counselor is to assess, using an eco-systemic view, what consequences the preliminary ethical decision might have, i.e., if there are any possible adverse reactions for the individual, family, and/or community affected by the disaster.

Focus also needs to be upon determining what consequences the preliminary ethical decision might put upon the crisis counselor and/or other crisis counselors and/or first responders.

Example: The crisis counselor realized that addressing her ethical concerns with the other two crisis counselors might result in difficulty in working together and in delivering quality services.

Step 7- Prepare an ethical resolution.

After all consequences have been assessed and the crisis counselor has determined that the consequences from his/her ethical decision making are in the best interest of the disaster affected individual, family, and community, as well as within the skill and knowledge level of the crisis counselor and appropriate for the disaster affected country, s/he prepares the ethical resolution.

Example: The crisis counselor concluded that her decision to talk with the other two crisis counselors was in the best interest of the terrorist affected Russian survivors.

Step 8- Get feedback/consultation from other crisis counselor(s).

Following the ethical resolution, the crisis counselor communicates his/her decision to his/her fellow crisis counselors and if appropriate, consults with local agencies/organizations that they are in partnership with. In addition, they might also choose to consult with the relief organization that deployed them to the disaster. At Headrest, you will always debrief with a Clinical Director after having to call 911 for any client calling the hotline. However, it is important to know that you are supported by your team and immediate supervisor before making a decision. You are not alone.

Example: Since no other crisis counselors were accessible to the crisis counselor other than the two who had engaged in the recording/video taping for donation practice, she contacted her own relief organization, who agreed with her, and voiced concerns about the situation.

Step 9- Take action.

If no concerns were raised after the crisis counselor's consultation, she/he will act according to the ethical decision made.

Example: The crisis counselor requested a meeting with the other two crisis counselors, and reported her concern and the consultation she had engaged in before setting up this meeting. The crisis counselors' response was to be open to the feedback, thanked the crisis counselor for reminding them of their code of ethics and then said: "We didn't know, and we never would have done this in the USA, but it seems different in Russia, especially, since Russia has no established code of ethics for counselors/mental health professionals."

Step 10- Review the outcome.

After the crisis counselor has acted on the ethical decision, she/he needs to assess/review the outcome of the decision, with a desire to learn from the process and improve future

ethical decision making. This process also includes getting feedback or reviewing the impact of the ethical decision on the disaster affected individuals, families and the community. Information should also be gathered from the local agencies/organizations they are in partnership with, as well as their relief organization. This review will be important to the crisis counselor, as well as other crisis counselors, allowing for lessons learned at the disaster site, and can be something passed on to other crisis counselors at their own and other relief organizations.

Example: The crisis counselor reported feeling good about the other two crisis counselors' responses to her feedback. She was surprised that they chose not to use their ACA Code of Ethics to guide them in their work as crisis counselors in another country. She did report that she felt good about the process and outcome and will address ethical concerns in the future using the ethical decision making model.

Summary

It is important to remember that crisis counselors should be guided by the ACA Code of Ethics as they respond to disasters, and often faced with complex and unique ethical challenges. However, the ACA Code of Ethics cannot guarantee ethical behavior.

Moreover, the Code cannot resolve all ethical issues encountered by the crisis counselor or capture the complexity involved in doing crisis counseling during and immediately after disasters while striving to make responsible choices. Rather, the ACA Code of Ethics sets forth ethical principles, standards and values to which crisis counselors aspire and by which their actions while doing crisis counseling can be judged, making an ethical decision model for crisis counselors essential.

Ideas and Research You Can Use: VISTAS 2010 6 Conclusion This ten step model is expected to be of help to crisis counselors as they work during and after disaster situations. This is not an easy task, as disasters are characterized by rapid change and a high degree of uncertainty. The implications of crisis counselors using this ethical decision making model is a standard of conduct and service delivery which is in the best interest of the disaster affected individuals, families and communities on the local, national and international level.

References American Counseling Association. (2005). ACA Code of Ethics. Alexandria, VA: Author. Bronfenbrenner, U. (1987). Ecology of the family as a context for human development: Research perspectives. Developmental Psychology, 22(6), 723-742. Washington, DC: American Psychological Association

CRISIS COUNSELOR ETHICAL DECISION-MAKING QUIZ

Instructions: Please Circle Your Answer (True or False) to the following statements.

1. Before offering advice to a caller in crisis, I should consider my own ethical values, beliefs and knowledge around their specific situation.

TRUE FALSE

2. It is a bad idea for me to seek consult with other hotline counselors before making important decisions or outside referrals.

TRUE FALSE

3. I should not have to consider the callers culture, geographic location, or ethnic background when offering advice or solution.

TRUE FALSE

4. When making an ethical decision, I should consider the client (caller), the family, and the community.

TRUE FALSE

5. According to the ACA code of Ethics; Primary Responsibility – The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

TRUE FALSE

6. We do not have to follow up on outcomes or decisions made. All callers/clients should follow our suggestions and we hope for the best.

TRUE FALSE

7. The ACA cannot guarantee ethical behavior.

TRUE FALSE

8. One of the Ethical traps a hotline counselor should be careful not to fall into is called the Traditional Trap – “We have always done it this way before”

TRUE FALSE

9. We must always consider the consequence of our advice/suggestions/referrals to our callers or potential clients.

TRUE FALSE

10. Ethics can be defined as moral principles that govern a person's behavior or the conducting of an activity

TRUE FALSE

Staff Signature:_____ Date:_____

Supervisor Signatrue:_____ Date:_____

Unique Needs of Persons Served Training

Note: This training is an overview of working with individuals with unique needs. It is intended to provide a basic understanding of how to work with people who have a variety of unique needs and the challenges associated with special needs.

Appropriate procedures and practices that are in accordance with federal and nationally recognized guidelines regarding working with people who have unique needs provide the foundation for offering appropriate services for persons served.

Please read through this brief overview about individuals with unique needs. After completing this overview, complete the questionnaire that follows.

This questionnaire will provide an opportunity for you to test your knowledge regarding working with people with unique needs and is intended to improve your ability to conduct services in a professional manner.

Individuals with Special Needs Overview

When working with people who have unique needs one must consider a wide variety of physical or medical challenges. Staff education in the field has become vital in the quest to provide quality services. Staff attitudes and perceptions of individuals receiving services can either assist or hinder the process. Lack of awareness from staff regarding individuals who have unique needs including physical disabilities and medical conditions may be a detriment to the treatment processes.

Individuals seeking a variety of services may be embarrassed, might be depressed, angry or confused, and may easily walk away from services because of inefficient or judgmental treatment by staff. The demeanor of staff should include respect for the client and verbal comments should be carefully presented so as not to negate the process. When providing services for people with unique needs it may be necessary to include a wide variety of community and medical resources.

Unique physical needs

Hearing loss is one of the most prevalent chronic conditions in the United States and affects millions of people. People who have hearing loss may be embarrassed about their condition and pretend to hear or understand something they don't. They may find it difficult or be unable to converse over the phone and be unable to follow conversations

when there are two or more people talking. When working with a person who experiences hearing loss you should always face them when speaking to them and do not chew gum or hide your mouth. The person should be seated away from sources of environmental noise such as the air conditioner or fan. Do not seat the individual facing bright lights or windows where a glare will make it difficult to see the faces of others.

Use visual aids if possible, including key words that are written or picture symbols and keep paper and pencil handy for the person to use if needed. Use facial expressions or gestures to give useful clues or cues.
To get someone's attention you might touch them lightly on the shoulder or wave your hand.

Never touch someone who has already indicated they do not wish to be touched. Repeat yourself if necessary and be patient, positive and relaxed. If there is an interpreter speak to the individual and not the interpreter. If the person uses an assisted hearing device ensure that it is present and working. Assistive hearing devices often pick up background noises so minimize environmental noises.

Working with an individual who is visually impaired can feel awkward and many are unfamiliar with how to provide services in an efficient way. Following some general tips can make assistance more comfortable for both staff and the individual with vision challenges. Talk to the individual in a normal tone of voice. Many staff members mistakenly speak louder than normal. Accept what the person can do without calling undue attention to it, such as dialing a phone, using a watch to tell time, or signing their name.

When offering assistance to an individual who is **visually impaired** speak to them directly. Identify yourself to the individual so they know of your presence and be sure to tell the person who else is present in the room. Offer help but never assume they need assistance. When assisting an individual who is visually impaired to move to another location allow them to take your arm.

Do not grab their arm as you might startle or frighten them, and always avoid unnecessary touching of the individual. Walk at a normal pace but pause when stepping up or down or give them verbal prompts.
It may help to walk half a step ahead of the person with visual impairment and increase that distance when going up or down stairs.

Always tell the person when you are coming to steps and whether they are descending or ascending. Go in front of the person when entering doors or narrow passages as they are more likely to run into door frames when they go ahead of you. If it is necessary for the person with vision impairment to move to the left or right in order to avoid something tell them quietly and never push them. Tell the person when you are coming to

something that they might trip over. Never leave a person who is blind in an open area, lead them to the side of the room or to a chair. When assisting them to a chair simply place their hand on the back or arm of
the chair. If you have to leave the person for a moment, tell them you
are leaving so that they know you are no longer there. Some individuals
with visual impairment use assistive devices. A magnifier, special lighting, or a larger font on paperwork can be utilized for someone who is
partially visually challenged. A white cane might be utilized for effective
mobility. A service animal such as a guide dog may be used to help a
person with more severe visual impairment be independently mobile. If
there is a service animal present do not pet the animal or feed the
animal.

When working with someone who uses a **wheelchair** for mobility it is important to consider what the person feels like when everyone around them is standing. It can be uncomfortable to have to look up for extended periods of time and can create anxiety when staff and others hover over the person.
Staff should be seated when working with a person using a wheelchair. Never assume the person needs your help in moving the wheelchair, many people are completely mobile in their chair
without assistance. If it is necessary for you to assist the person, grip the wheelchair firmly and lean into the wheelchair to begin movement. Move slowly and steadily being careful of any bumps or changes in surface. Never tilt a wheelchair with someone in it without alerting the individual, and never lift a wheelchair off of the ground completely with someone seated in the chair. Never tilt a motorized wheelchair as it may damage the chair and the person could fall over.

When working with someone who has a **medical diagnosis** such as Hepatitis or HIV/AIDS it is important to understand the condition and the possible risks. The better educated staff members are, the more likely they will take precautions necessary and avoid unnecessary stereotypical thinking regarding the medical diagnosis. When possible communicable diseases are present staff should be educated on all safety protocols for body fluid clean up, specimen collections, and prevention/control of communicable disease.

You should always use all personal protective equipment that has been provided to you. You should always refer to your agency’s policies and procedures regarding universal precautions and take the initiative to attend all training related to safety. Universal precautions include a staff perception that all body fluid is suspect and should be treated accordingly regardless of whether information confirming communicable disease is present or not, which will eliminate any tendency to treat a client differently than any other client.

Summary
With proper education staff will provide effective quality services to individuals who experience unique needs. Staff should always refer to company policy and procedure

and any regulations provided while utilizing techniques in the professional provision of services. The strategies listed above should never take to place of any individualized plan that has already been created for a specific individual.

Unique Needs of Persons Served Questionnaire

Please answer the following questions by selecting the most appropriate letter or respond to the
statements by selecting yes or no following the question/statement.

1. Hearing loss is a unique physical need that affects many people and speaking loudly with clients should be standard procedure for all staff.

__ Yes _ No

2. When working with a client who has hearing loss you should:

a. Always face the person when speaking to them.
b. Face the person toward the window so they can see you.
c. Speak directly to the person even if there is an interpreter.
d. Both A and C.

3. A person who experiences vision impairment should always have a representative who
will sign paperwork and explain written documents.

__ Yes _ No

4. When providing services for a person who is vision impaired you should:

a. Make sure there is water and food for their service animal.
b. Always take the person by the hand when moving from one location to another.
c. Always identify your presence in the room and speak to them directly.
d. All of the above.

5. It is acceptable to lift a wheelchair over a curb if 2 or more staff members are present.

__ Yes _ No

6. A person is being served by your agency and has been determined to be HIV positive.
You should take extra precautions for someone who has tested positive for HIV.

__ Yes _ No

NAME:_____ DATE:_____

Rights of the Person Served Training© 1

Note: This training is an overview of rights of the person served within a human service setting. It is intended to provide a basic understanding of guidelines and practices for all employees and meet the CARF accreditation standards for training for all employees. It is not intended to be a substitute for

competency-based training requirements. Please read through this brief overview on Rights of the Person Served.

After completing this overview, complete the questionnaire that follows. This questionnaire will provide several scenarios that can occur in organizations in the area of Rights of the Person Served and are intended to improve your ability to conduct services in a manner that respects the basic rights of those you serve.

Rights of the Person Served Overview

Explicit policies and procedures in the area of basic rights of the persons, who are served by human service organizations, are the foundation for protecting persons against abuse or mistreatment by organizations or persons acting for the organization. The majority of persons who enter human service organizations are receiving treatment or assistance for conditions that may increase their vulnerability to potential abuse or behavior that may not be in the best interest of the person served. Most states have specific legal and regulatory guidelines in the areas of the rights and responsibilities of the person served.

Recent federal regulations (the Health Insurance Portability and Accountability Act (HIPPA) have strengthened the rights of consumers of health care services through a federal mandate. Many human service organizations also belong to associations that develop rights that are specific to certain areas of providing services. Overall “rights” provide basic guidelines through which persons and organization scan measure and monitor the level of how people are treated throughout the provision of services.

Organizations that are attempting to become CARF accredited, or who are maintaining CARF accreditation, are required to adhere to a specific set of guidelines and standards regarding the rights of persons served. These are usually in addition to other regulatory requirements in the area of “rights” and many times cover some of the same areas.

This tutorial will provide a brief overview of the CARF “Rights of the Persons Served”, as an introduction to the standards of practice in this area.

RIGHTS OF THE PERSONS SERVED

A standard right of all human service organizations is the right to consent for treatment. All persons entering your organization for assistance should give their consent for treatment prior to any services/interventions being provided. When gaining consent, there should be a full explanation of the type of services to be provided and the possible risks involved.

In an emergency situation that is life threatening, consent can be obtained following the resolution of the immediate crisis. All persons have the right to be involved in all aspects of their service planning.

Service planning should not be provided in a “one size fits all” manner, although many of the services an organization provides will apply to all participants. If some goals apply to all participants, the individual’s strengths, abilities, needs, and preferences should be taken into account regarding the application of the goals and the interventions and practices used.

All persons also have the right to receive services in a manner that is responsive to each person’s unique characteristics, needs, and abilities. It is important that each person’s individual characteristics be recognized and respected.

Each person participating in services has the right to know how their records may be reviewed. Access may be through a review with a professional staff member, or with a designated third party advocate who possesses adequate skills and knowledge to conduct a review with a client. Some records, such as an individual plan, progress notes, or transition plan may be open and available for review at any time.

An organization’s policies and procedures should provide the levels and procedures of record review. All persons have the right to be treated free from any type of abuse. Physical punishment, threatening behavior, or exploitation of persons in any manner is a violation of the right to be free from abuse. A verbal comment that references a sexual act is considered an abuse of rights. Any exploitation of persons served for financial gain is also not appropriate.

All persons entering your services should have the right to express his or her preferences regarding choice of a service provider, regardless of whether the system can offer a choice or not in some situations. Any crisis intervention procedure, including seclusion or restraint, is required to have explicit policy and procedures in place protecting the person served should a crisis occur. All persons entering services have a right to know if seclusion and/or restraint is used by the organization, even if it is used on an emergency basis only.

All persons served have the right to know the guidelines regarding confidentiality within the

organization. The use of an authorization/release of information request should be explained in detail and follow specific regulatory guidelines at all times.

Rights of the Person Served Questionnaire (1)

Please answer the following questions by circling yes or no.

1. Your organization employs three male counselors. A client enters your organization and is upset

because she requested a female counselor and was assigned a male counselor. Were her rights

violated?

YES NO

2. A person enters your organization in crisis. After a quick assessment, a nurse or counselor assists

the person with the identified problem through a brief intervention. Following the crisis a full

assessment is provided and the client signs consent to be treated. Was this person's rights

violated by not signing a consent for treatment prior to the initial brief intervention?

YES NO

3. A staff member in your organization wants to help out several clients who are not able to

purchase sodas and treats due to lack of funds. She organizes an outing and takes three clients to her house to rake leaves and pays them $5 each for several hours of work. The clients are very appreciative and enjoyed the outing and can now buy sodas for the week. Were these client's rights violated?

YES NO

4. Several staff members are talking in a hallway about a movie they saw the previous evening. The discussion involves a description of some explicit sexual scenes that were in the movie. Clients are in a classroom waiting for a class and overhear much of the conversation. Have the client's rights been violated?

YES NO

5. Each person who enters your organization is given a standardized sheet that indicates the goals and specific objectives that have to successfully completed in order succeed in the program. All the goals and objectives are based on the latest research and are proven to

be effective in significantly improving the quality of life of those who participate. Each client signs a consent form, freely agreeing to the standardized goals and objectives that are stated. Is this process a violation of the client's rights?

YES NO

Name:_____ Date: _____

CONFIDENTIALITY AND HIPAA

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a) Summary

b) References

Section 1: Introduction

Course Contributors

This course was written by Amira Samuel, J.D. Ms. Samuel is a trial attorney in New York City. In her practice, Ms. Samuel focuses on making the law and legal concepts accessible to her clients while advising them on their rights and responsibilities. Ms. Samuel is a graduate of the Benjamin N. Cardozo School of Law, a graduate of the University of California at Santa Cruz, and a Certified Mediator with the New York Peace Institute.

The course was reviewed by Lisa Clark, J.D. Ms. Clark is a 1989 graduate of the University of Pennsylvania Law School and has received her Master's and undergraduate degrees from Harvard Divinity School and Yale University, respectively. Ms. Clark practices in the area of health care law with an emphasis on hospital representation, Medicaid, managed care contracting, and general regulatory compliance including licensure, accreditation, and certification. She has additional experience with quality of care and pay for performance, HIPAA, EMTALA, and general regulatory compliance. Ms. Clark is a frequent speaker on health care regulatory matters.

Additional information about the 2013 HIPAA Mega Rule was added in consultation with Rebecca Reynolds, EdD, RHIA, Associate Professor Chair of Health Informatics and Information Management at the University of Tennessee Health Science Center.

About This Course Consumers entrust professionals with very personal information and the government has enacted stringent laws to protect the information consumers reveal. The consequences of revealing personal consumer information, even inadvertently, can be severe. This course is designed to provide basic information regarding the principles of confidentiality along with specific information related to the Health Insurance Portability and Accountability Act (HIPAA) governing privacy and security and include updated information about the HIPAA mega rule that went into effect in March 2013. In this training, you will learn what confidentiality is and what HIPAA requires of mental health professionals like you. This course will specifically define what personal health information is, the ways in which this information must be protected, and best practices for maintaining client confidentiality. A variety of practice questions throughout the course will give you an opportunity to think critically about the topics covered and apply what you have learned. This course is designed for mental health professionals at all levels.

NOTE: This course is not intended as legal advice for any individual provider or situation. If you, please review the resources listed in the references section of this course and consult with your company's legal and compliance team.

Section 2: Confidential Information

Genna and Paul's Flub

Genna and Paul are mental health providers at the Bright Project. Genna has been supervising Paul and co-counseling Mila, who has been suffering from anxiety. Mila has made it very clear to Paul and Genna that she does not want anyone to know that she sought therapy. Genna and Paul typically speak in a counseling room before their sessions with Mila about Mila's prognosis and treatment plan. However, all the counseling rooms were occupied during their scheduled meeting this week, so before meeting with Mila, Genna and Paul sit in the staff kitchen and discuss Mila's treatment method. Over the course of their conversation, Dylan, a secretary in the office comes in to the staff kitchen and takes her lunch break. Though Dylan overhears the treatment plan and the various symptoms that Mila has been suffering from, Paul and Genna think nothing of this because Dylan is a staff member and has access to all of Mila's files.

Later that week, Bright Project has a continuing education training with the compliance and

legal department and Paul and Genna realize they have violated HIPAA by discussing Mila's case in the staff kitchen. Over the course of the training, Paul and Genna learn that a reasonable HIPAA violation that was not willful can still result in a $50,000.00 fine. They are both very nervous about the potential penalties.

What could Genna and Paul have done differently?

As a threshold matter, Genna and Dylan should not discuss personal health information in

common areas, even those that are in their office. Paul and Genna should have known that

when it comes to certain information, rules of confidentiality apply among office staff as much as they do between health care providers and perfect strangers.

HIPAA provides privacy and security protections for health information to ensure the

confidentiality of health information. HIPAA was recently amended to provider greater privacy protections to individuals by the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009.

In January 2013, HIPAA was again expanded and reinforced with the release of the HIPAA Mega Rule, also called the Final Rule. The Mega Rule made the biggest modifications to HIPAA since its enactment in 1996. It creates tougher enforcement actions, sets new limits on use and disclosure of PHI, adds individual rights and protections, and broadens the

scope of HIPAA to include Business Associates (BAs). The Final Rule went into effect March 26, 2013 with a compliance date of September 23, 2013.

This course provides an introduction to some key requirements of the Mega Rule.

What Is Confidentiality?

Confidentiality means that data or information is not made available or disclosed without authorization. It includes information developed by the healthcare professional based on her/his evaluation/observation.

Confidential Information

In behavioral health care practice, the following information is generally considered to be confidential:

- Services provided
- Billing information
- Results of tests/procedures
- Interventions utilized
- Demographic information
- Dates of service
- Family and social information
- Financial Information
- Diagnoses

Protected Health Information

HIPAA Privacy regulations safeguard protected health information (PHI). PHI is defined as individually identifiable health information and it includes:

- Name
- Geographic subdivisions smaller than a state (street address, city, county, zip code, geocodes)
- All elements of a date related to the client except for the year (including birth date,

admission date, discharge date, date of death)

• Telephone number, fax number, email address

• Social Security number

• Account number, insurance number

More information that is considered PHI:

• License number, certificate number

• Vehicle ID

• Device number

• URL, IP address

• Biometric ID

• Facial photograph and comparable images and any other unique identifier or code

• With the Mega Rule, the genetic information of individuals and their family members is

now considered to be protected health information PHI can be information that is discussed, written, kept, and transmitted electronically or on paper. It can be documented in many places.

For example:

• Medical records (intake information, assessments, treatment records, etc.)

• Billing records

• Utilization review data

• Administrative data

The HIPAA Mega Rule set a time limit on PHI. Individual PHI is protected for 50 years after a

person's death. After 50 years, individually identifiable health information is no longer

protected.

Other privacy laws may have other names for PHI. For example, the privacy regulations

applicable to substance abuse providers (discussed in more detail in Section 3) call PHI "Patient Identifying Information," defined as information that could reasonably be used to identify an individual.

Confidential Information Review

Please indicate whether the following statements are True or False:

PHI includes demographic information, family/social information, diagnoses, services, interventions, dates of service, billing and financial information, and results of tests/procedures.

TRUE FALSE

• True (Correct! All of the information listed is considered confidential information in behavioral health care practice.)

• False (Incorrect. All of the information listed is considered confidential information in behavioral health care practice.

If you'd like to review a list of confidential information, according to HIPAA, PHI stands for "Personal Health Information."

TRUE FALSE

• True (Incorrect. PHI stands for "Protected Health Information" as defined by HIPAA.)

• False (Correct! PHI stands for "Protected Health Information" as defined by HIPAA.)

PHI includes a long list of individually identifiable health care information including (but not limited to) such things as name, address, telephone number, social security number, fax number, insurance number, and email address.

TRUE FALSE

• True (Correct! All of the information listed is classified as PHI.)

• False (Incorrect. All of the information listed is classified as PHI. If you'd like to review a list of protected health information, please refer back to the Protected Health Information screen.)

Who is Liable?

The Mega Rule extended HIPAA so that Business Associates (BAs) of Covered Entities are now liable for compliance. BAs are outside workers or contractors who need access to PHI to fulfill their functions. HIPAA makes BAs responsible for safeguarding PHI and monitoring

their own subcontractors. Moreover, the Mega Rule states that anyone who “creates, receives, maintains, or transmits PHI on behalf of a Business Associate” is considered a BA.

This means that the HIPAA obligations and restrictions flow downstream and “stick” to PHI wherever it goes.

Breach Notification

Before the final rule, breaches of PHI were only reported if the disclosure was considered to cause significant harm to the affected individual. Under the Mega Rule, affected individuals, the government, and in some cases the media must be notified of any breach unless the covered entity conducts a risk assessment and proves there is a low probability of disclosure. Additional resources on breach notification are available from the Center for Democracy and Technology (See “References”).

Tiered Penalties

The Mega Rule strengthened enforcement of HIPAA regulations by putting into place a tiered system of penalties for non-compliance. Penalties for individual violations range from $100 to $50,000 and can add up to $1,500,000 per violation for all violations of a similar type in a calendar year. Penalties are increased when violations are not corrected within a specific time frame.

Tiered Penalties

• Did not know and would not have known: $100-$50,000 per violation

• Violation due to reasonable cause: $1,000-$50,000 per violation

• Violation due to willful neglect and corrected within 30 days: $10,000-$50,000 per violation

• Violation due to willful neglect and not corrected within 30 days: $50,000 per violation

Section 3: HIPAA Privacy Rule

Privacy Rule

The Privacy Rule has a lot of specific requirements that fall under two major concepts:

• Concept 1

HIPAA grants individuals access to the information created and maintained about them by their health care providers, with some exceptions.

• Concept 2

HIPAA governs the disclosure/release of an individual's PHI. The disclosure or release of PHI is prohibited except under certain circumstances. For example, disclosure is permitted for treatment purposes when you have the client's consent or when disclosure is allowed by law. Note that HIPAA specifically protects psychotherapy notes and gives them additional legal protection.

Patient Authorization/Consent under the HIPAA Privacy Rule

Under HIPAA, no authorization (consent) is needed to use or disclose PHI for treatment purposes, payment purposes, or health care operations. But client authorization (consent) is required for disclosures of certain types of information:

• Federal regulations applicable to substance abuse providers.

• State mental health and substance abuse laws require consent prior to the disclosure of most information.

• HIPAA requires consent for three main types of disclosure: most disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures in which the Covered Entity receives any type of payment.

When in doubt, get consent!

State Laws

Did you know some other laws and/or regulations might take precedence or preempt HIPPA?

Each state has laws, rules, and/or regulations governing confidentiality of health care information and it is important for you to be familiar with your state requirements. State laws

may protect the privacy of medical information generally and/or may protect specific types of

medical information, such as substance abuse records or mental health records.

HIPAA Privacy Rule and Preemption

HIPAA establishes a floor for protecting confidential medical information. It is designed to work with other existing federal and state privacy laws, such as laws relating to substance abuse or mental health treatment. As a health care provider, you are required to comply with both federal and state laws regarding confidentiality. State laws may impose greater restrictions on what you can and cannot do with a client's confidential medical information. Where a state law provides greater privacy protections to a client, state law will take precedence over HIPAA.

It is important to understand preemption, as it has a direct bearing on whether you must follow HIPAA or other laws and regulations covering confidentiality and release of health information.

Here are the basics of preemption:

▪ If a state or federal law or regulation grants the client greater access to

her/his PHI, then it will preempt HIPAA.

▪ If a state or federal law or regulation gives client health information greater protection from disclosure, then it will preempt HIPAA.

An Example of Preemption

One example of this concept of preemption is the Federal Regulations on Confidentiality of

Alcohol and Drug Abuse Patient Records (42 CFR Part 2).

Members of the U.S. Congress believed that individuals were deterred from seeking substance abuse treatment due to the stigma and fear of prosecution. Therefore, in the early 1970's, they enacted legislation that gave substance abuse patients a right to confidentiality. These regulations are very detailed and specific. They generally apply to programs that receive federal assistance and provide alcohol or drug abuse diagnoses, treatments, or referrals for treatment.

Most behavioral health care providers who offer substance abuse programs are familiar with and follow these federal regulations. However, you must ensure that you are also following the HIPAA regulations. There are also privacy laws that relate to a particular condition, such as HIV/AIDS, mental health, and reproductive health. These laws may affect HIPAA compliance as well, and the protective measures they establish should be considered alongside HIPAA's so that a preemption analysis can be done.

HIPAA Privacy Rule Review

Select the correct regulation that you would follow for the statement below:

HIPAA treats a medical record number as PHI but the substance abuse (SA) regulations do not as long as the number does not consist of or contain numbers which could be used to identify the client from sources external to the treating program. Which regulation do you follow in this instance if you are a substance abuse provider?

A. HIPAA (You are right, the correct response is HIPAA. Since HIPAA gives the client greater

protection from disclosure, it must be followed.)

B. SA Regulations (Sorry! The correct response is HIPAA. Since HIPAA gives the client

greater protection from disclosure, it must be followed.) Select the correct regulation that you would follow for the statement below:

HIPAA allows for disclosure of some information with a subpoena; however, the SA regulations do not allow disclosure with a subpoena unless a court has issued an order following a hearing to show cause. Which regulation do you follow in this instance if you are a substance abuse provider?

A. HIPAA (Sorry! You are incorrect, the correct answer is SA Regulations. Since the SA

regulations give the client greater protection from disclosure, it must be followed.)

B. SA Regulations (You are right, the correct response is SA Regulations. Since the SA

regulations give the client greater protection from disclosure, it must be followed.)

Section 4: The Minimum Necessary Rule

What Does it Mean?

The minimum necessary rule refers to the practice of limiting the disclosure of PHI to the extent practicable to a “limited data set” or, if needed, to the minimum amount of information necessary to accomplish the purpose for which disclosure is sought.

Under HIPAA, a “limited data set” is defined as PHI that excludes certain information, such as:

• Names

• Postal addresses other than town/city, state, and zip code

• Telephone numbers

• Fax numbers

• Email addresses

• Social Security numbers

• Medical record numbers

• Health plan beneficiary numbers

• Account numbers

• Certificate/license numbers

• Vehicle identifiers and serial numbers, excluding license plate numbers

• Device identifiers and serial numbers

• Web universal resource locators (URLs)

• Internet Protocol (IP) address numbers

• Biometric identifiers, including finger and voice prints

• Full-face photographic images and any comparable images

The Minimum Necessary Rule applies to internal access and use by staff. Staff should have access to and use only the minimum necessary to perform their duties. For example, the individual hired to schedule client appointments does not need access to client's entire record.

Exceptions to the Minimum Necessary Rule

Except in limited circumstances, you must abide by the Minimum Necessary Rule when disclosing or requesting PHI. There are certain situations where the Minimum Necessary Rule does not apply, such as:

• Disclosures to or requests by a health care provider for treatment purposes

• Disclosures to the individual who is the subject of the information

• Uses or disclosures made pursuant to an individual's authorization

• Uses or disclosures required for compliance with HIPAA

• Uses or disclosures that are required by other laws

• Uses or disclosures required by the HIPAA Administrative Simplification Rules

• Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the HIPAA Privacy Rule for enforcement purposes

• Uses or disclosures that are required by other law

Would You Do?

Minimum Necessary Rule Review

Read the scenarios below carefully and then select the best answer.

You receive a call from staff at a local hospital stating that they need information regarding a former client of yours who is scheduled for surgery. They fax you a release of information form which only authorizes the release of medications, but the person on the phone is asking for dates of treatment and diagnoses. How would you respond?

A. Tell them everything they want to know since the client is scheduled for surgery. (That is incorrect. Your duties do not require you to have access to that level of information and it is a violation of the minimum necessary standard.)

B. Release information regarding medications only. (You are correct. You have received an authorization form and you are limiting the information released to only that which is authorized.)

C. Refuse to tell them anything. (That is incorrect. You have received an authorization form to release medication information.)

You work in the billing department of your agency and while you are processing claims, you notice the name of someone you know. Since you are curious, you decide to investigate and you pull their medical record and read it. Is this appropriate?

A. Yes (Sorry, you are not correct. This example does not meet the Minimum Necessary Rule because you do not need this information in order to perform your job duties.)

B. No (Correct. This example is not a situation that meets the Minimum Necessary Rule because you do not need this information in order to perform your job duties. Therefore, it represents a violation of the patient's privacy.)

Several staff members use the same computer terminal to access PHI in electronic medical records. Some of the staff members use the computer to access PHI for billing purposes and some of the staff members use the computer to access PHI for quality assurance purposes. Is this permissible?

A. This is never permissible. (Incorrect. This situation is permissible as long as each staff member has access to only the "minimum necessary" PHI to perform her/his job function.)

B. This is permissible if staff only access the information needed to perform their job duties. (Correct. This is permissible as long as each staff member has access to only the "minimum necessary" PHI to perform his or her job function.)

Section Summary

As you can see from the second scenario on the previous screen, it is important that agencies take reasonable measures to safeguard against internal access that is inappropriate. However, each staff person, once trained regarding the minimum necessary rule, also has an obligation as a condition of employment to abide by it!

The Minimum Necessary Rule refers to the practice of limiting the disclosure of information to that information reasonably necessary to accomplish the purpose for which disclosure is sought. The "minimum necessary" is defined as a "limited data set," or if needed, the minimum amount of information needed to accomplish the intended purpose of a disclosure. The implementation specifications for this provision require a health care provider to develop and implement policies and procedures appropriate for its own organization that reflect the entity's business practices and workforce.

The Minimum Necessary Rule applies to access to and use of client information internally by staff. Staff should have access to, and use, only the minimum necessary to perform their duties.

Section 5: Notice of Privacy Practices

What is Included in the Notice of Privacy Practices (NPP)?

Under the HIPAA Privacy Regulations, each health care provider must have a document that describes how information about the client is used by the agency and when the agency will disclose/release it without the client's authorization. Notices of Privacy Practices must be kept up-to-date and revised to incorporate any changes to HIPAA regulations such as the Mega Rule.

A Notice of Privacy Practices (NPP) includes:

• Examples of how you use information for purposes of providing treatment, obtaining payment, and health care operations.

• A description of disclosures of privileged information.

• Disclosures made to a personal representative.

• Disclosures made with authorization of a personal representative.

• Uses and disclosures that a consumer can object to (e.g. others present, pharmacy Pick up).

• Uses/disclosures that do not require authorization and those that a consumer may not object to (e.g. subpoena, court order, infections reported to health department, suspected abuse, duty to warn).

• Substance abuse records/information and how they are handled.

• An explanation of rights.

The HIPAA Mega Rule

The following are some new rights and restrictions in the mega rule that must be listed on NPPs: Prohibition on the sale of PHI

The Mega Rule prohibits disclosures of PHI through which the Covered Entity receives any type of remuneration, directly or indirectly.

Prohibition on use or disclosure of genetic information

Under the Mega Rule, “health information” now includes the genetic information of individuals and their family members.

Right to opt-out of fundraising Individuals now have the right to opt-out of having their PHI used for fundraising purposes.

Right to restrict sharing of PHI for out-of-pocket services People who pay for services out-of-pocket may instruct providers not to share PHI with health plans. This restricted PHI must be clearly marked to prevent accidental use or disclosure!

If you haven’t read your organization’s NPP, you probably should. It will help you understand

your agency's policies about confidentiality.

Section 6: Client Rights and Release of Information

Client Rights

To the right are the rights that clients are guaranteed under the HIPAA Privacy Regulations.

• Request Accounting

Request an Accounting of Disclosures. This would be a list or account of disclosures made that the client would not be aware of (e.g. they had not signed a release of information form).

• File a Complaint

A consumer can file a complaint internally with your office as well as with the Secretary of the United States Department of Health and Human Service.

• Receive a Copy

Receive a Copy of Notice of Privacy Practices.

• Access to Designated Record Set (“DRS”)

Access to DRS. At a minimum, this includes the medical record and billing information. This includes the right to inspect and copy. The Mega Rule also gives individuals the right to request and receive health records in an electronic format when it is reasonable for Covered Entities to do so.

• Request Amendment

Request Amendment to DRS. This request does not have to be granted, but you should have a written procedure that describes the process.

• Request Restrictions

A client can request that the provider restrict/limit use or disclosures of PHI when carrying out treatment, payment, or health care operations. However, the provider does not have to agree to the request, except for certain requested restrictions on disclosures to health plans.

• Request Communications

A client can request that the provider communicate with them in an alternate way or at an alternate location (e.g. only send mail and phone calls to office not home). A provider must accommodate reasonable requests.

Release of Information Authorization Form

A HIPAA compliant release of information authorization form must contain the core elements shown below.

• Client's name.

• A description of the information to be disclosed such as attendance, drug screen results, discharge summary, etc.

• Name or specific identification of person (or class of person) authorized to make the disclosure.

• Name or specific identification of person (or class of person) to whom to make the disclosure.

• A description of the purpose of the disclosure (the client can state “at the request of The individual” and this is sufficient if s/he is initiating the request and doesn’t want to specify the purpose).

• An expiration date or event.

• Signature of the individual/client (if signed by someone other than the client, it must include a description of that individual’s authority to act for the client).

• Date of the signature.

Release of Information Form

In addition to the core elements reviewed previously, the authorization form must contain statements adequate to place the client on notice of all of the following:

• The client’s right to revoke the authorization in writing.

• The ability or inability to condition treatment, payment, enrollment, or eligibility for

benefits on the authorization.

• The potential for information disclosed pursuant to this authorization to be subject to

re-disclosure by the recipient. The regulations also state that the authorization form must be written in plain language and that the client must be given a copy of the signed authorization form if the health care provider seeks an authorization from the client.

Client Rights and Release of Information Review

Let's have a quick pop quiz! (I know you love these)

When you are ready, take a look at the Release of Information Form to see if it meets the

minimum requirements under HIPAA.

How did you do? Congratulations if you noticed that the expiration date/event was missing!

The expiration date/event is a common missing element.

Client Rights Review

A patient requests that you only call her on her cell phone and asks you not to leave a message

if she does not pick up. Do you have to comply?

YES NO

• Yes, as long as you can reasonably comply with those conditions (Correct. Under HIPAA,

a health care provider must make a reasonable accommodation to comply with a

client's request to restrict the way in which s/he is contacted.)

• No (Sorry, you are not correct. Under HIPAA, a health care provider must accommodate

a client's reasonable requests to communicate with her/him in an alternate way or at an

alternate location.)

Section 7: Electronic and Mobile Devices and HIPAA

Technology and the Risk of Disclosure

Health care professionals are increasingly using new technologies such as tablet devices,

laptops, Blackberries, iPhones, and iPads to perform administrative tasks and communicate with clients and patients. There is no prohibition against the use of these

mobile devices under HIPAA or other confidentiality laws. Nevertheless, these devices pose a high risk of disclosure because data may be more easily disclosed to unauthorized third parties. Accordingly, special care should be taken when using these devices. Encryption is a way to provide greater protection to electronic information. In fact, HIPAA provides a safe harbor to encrypted data, which means that it considers encrypted data secure and does not require notification of clients when a device containing their PHI is lost or stolen.

Whenever possible:

• Don’t store sensitive data on wireless devices.

• Ensure that data is encrypted.

• Enable password protection on wireless devices, and configure the lock screen to

appear after a brief period of inactivity.

• Activate the remote wipe feature of wireless devices that contain personal information.

Electronic and Mobile Devices Review

A health care professional uses an iPad to receive and send email to clients, as well as to note

the names, phone numbers, and test results of clients in order to telephone the clients at night.

Is this appropriate?

YES NO

A. Yes (Correct. There is no prohibition on a health care professional using an electronic

mobile device under HIPAA or other confidentiality laws, but special precautions should

be taken to ensure that the additional risks of disclosure when using such a device are

addressed through extra security precautions.)

B. No (Sorry, you are not correct. There is no prohibition on a health care professional

using an electronic mobile device under HIPAA or other confidentiality laws, although

special precautions should be taken to ensure that the additional risks of disclosure

when using such a device are addressed through extra security precautions.)

Section 8: Best Practices and Review

Being Familiar with Terms

• Locked and Secure: Keep medical records room locked and secured.

• Minimum Necessary: Only access consumer information you need to do your job. Limit this information to the minimum necessary.

• Out of Sight: Keep consumer records and other documents containing PHI out of sight. Do not leave them lying around, and if they used in a meeting, make sure to remove them at the end of the meeting.

• Monitor Faxes: Monitor faxes containing PHI or confidential information. Try to keep fax machines in areas that are not generally accessible.

• Shred, Shred, Shred: Documents with PHI or confidential information to be discarded should be shredded. Do not just put them in the regular trash.

Best Practices for Privacy and Security

• Don’t talk about consumers in public areas or where you could be overheard, such as elevators or parking lots.

• Don’t share client information on social media websites.

• Use a secure computer password that changes periodically.

• Protect your computer passwords. Never share this password or give it to anyone and never write it down in a location where it can be found.

• Don’t access PHI that you do not need to see to perform your job duties.

• Don’t leave areas that contain PHI unlocked.

• Don’t include PHI in email unless it is encrypted or you are using a secure email system.

• Minimize the amount of information kept on portable devices and consider encrypting such information.

• Log off of the computer and any other open files that contain PHI or confidential information when not in use.

• Keep computer screens out of eye sight of others.

• Don’t throw papers with patient information away in the trash can.

• If you see any other staff violating these best practices, don’t just ignore it, instead give them a helpful/gentle reminder. If appropriate, report the violation.

• Report problems/violations.

Best Practices Review

A staff person whom you supervise clinically finds you in the staff break room and starts describing a counseling session he had with a client today so that he can ask your advice. How would you handle the situation?

A. Let him describe the details so that you can provide him with guidance. (Incorrect. You should not discuss confidential information in public/open areas.)

B. Politely remind him that you are in a public area and ask him to accompany you to your office so that you can discuss this in private. (Correct. You should not discuss confidential information in public/open areas.)

C. Ask him to get authorization from the client before he discusses it any further. (Incorrect. Given your role as a clinical supervisor, the client would not have to consent to this type of disclosure/use of information.)

You are the personnel director of your agency and receive a phone call from a clerical staff person wanting to file a complaint of unsafe working conditions. In the call, the staff person describes a situation in which a client became verbally abusive to her, she was frightened, felt threatened, and there was no one else around to assist. She provides the client’s name and diagnosis and well as a copy of the client’s demographic information.

Is there any confidentiality violation evident in this scenario?

A. Yes (Correct. It violates the Minimum Necessary Rule in that the staff person should not have shared all of the PHI (diagnosis) with the personnel director.)

B. No. (Incorrect. It violates the Minimum Necessary Rule in that the staff person should not

have shared all of the PHI (diagnosis) with the personnel director.)

Review

What are the two major concepts of the Privacy Rule?

Grant individuals access to the information created and maintained about them by their health

care providers and prevent the unauthorized disclosure or release of the information.

What rights are consumers granted under the HIPAA Privacy Rule?

Receive a copy of the NPP; access to DRS; request amendment to DRS; request restriction on

communications; request an accounting of disclosures; and file a complaint.

Section 9: Conclusion

Summary

This course has given you an overview of HIPAA confidentiality requirements. Now that you

have finished reviewing the course content, you should have learned:

• How to describe protected health information.

• How to explain confidentiality and the requirements of the HIPAA Privacy Rule for

protecting and releasing information.

• How to identify best practices for compliance with HIPAA.

References

U.S. Department of Health and Human Services: www.hhs.gov. Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191. 42 U.S.C. §

1320d-9 (2010). See www.hhs.gov for more information.

Health Information Technology for Economic and Clinical Health Act (HITECH). P.L. 111-5, div. A, Title XIII, Sec. 13111, Feb. 17, 2009, 123 Stat. 242. 42 U.S.C. § 156 (2011).

Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under

the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules, Fed. Reg. 2017- 0107345. CFR Parts 160 and 164 (2018) Available online at www.federalregister.gov, search term: “HIPAA Modifications.” www.cdt.org. Center for Democracy and Technology (Search term: Health Privacy).

CONFIDENTIALITY AND HIPPA TRAINING

FINAL TEST

1. Which of the following violates the “minimum necessary” rule?

a) Disclosure required by law.

b) Disclosure to the Department of Health and Human Services.

c) Disclosure to a family member.

d) Disclosure for treatment purposes.

2. The Serenity Center has a Notice of Privacy Practices (NPP) that describes how the Center uses patient information. The NPP specifically explains confidentiality. What else, if anything, must the NPP include?

a) The only thing that the NPP must include is how information is used by the agency. The Serenity Centers NPP is sufficient.

b) The NPP must include state law restrictions on the use of information.

c) The NPP must include information regarding when the Center will disclose and release information without the clients authorization.

d) The NPP needs to include a specific disclaimer about the use of mobile devices to communicate with clients.

3. The use of mobile devices for the performance of administrative tasks is prohibited by confidentiality laws, but not by HIPAA.

True

False

4. Kiva disclosed information about a consumer to the Department of Health and

Human Services. Under what circumstances is this permissible?

a) The disclosure is permissible only if Kiva obtained the consumers informed consent.

b) The disclosure is permissible only if it is required under the Privacy Rule for enforcement purposes.

c) The disclosure is permissible only if there was a prior unlawful disclosure and Kiva is reporting the violation.

d) The disclosure is permissible only if it does not violate the “minimum necessary” rule.

5. Suzette wants to revoke her authorization form. How can she do this?

a) She can only do this once her authorization form is expired.

b) She should do this in writing.

c) She can do this at any time and by any method.

d) She must be evaluated by the practitioner to ensure there is no risk and then she can revoke authorization.

6. A driver’s license number is considered PHI.

True

False

7. Under what circumstance would state law preempt HIPAA?

a) State law would preempt HIPAA if it provided more stringent safeguards than HIPAA.

b) State law only preempts HIPAA when applied to substance abuse treatment programs.

c) State law does not preempt HIPAA unless it explicitly says so in the state statute.

d) State law would preempt HIPAA only with respect to the clients right to access information.

8. What is a limited data set under HIPAA?

a) Information that includes a consumers postal address, name, or telephone number.

b) Protected Health Information that excludes information such as address, social security number, and health

c) plan beneficiaries.

d) Information disclosed to practitioners.

e) Permissible disclosures to substance abuse providers.

9. A client has the right to request an amendment to his or her designated record set, but a provider does not need to grant the request.

True

False

10. Which of the following items must an authorization form contain?

a) Expiration date

b) Signature

c) A description of the information to be disclosed

d) All of the above

NAME:_____ DATE:_____

SUPERVISOR:_____ DATE:_____

Van Safety Driver Information

1. Use vehicle checklist

When entering the vehicle, use the checklist to determine that all safety features are reachable, check mileage and gas and log in book, check log for registration a nd insurance, use client transportation list (if applicable) to ensure all clients are accounted for, check headlights, seatbelts, mirrors, etc.

2. Identify Safety Features

Each vehicle has specific safety features that include first aid kits, fire extinguisher s and roadside safety tools. The vehicle checklist used every time a driver uses a c ompany vehicle will detail and help the driver identify where these items are.

3. Drive Careful and Cautious

Drivers must always use caution and exclude all distractions. No cell phones shoul d be used will driving company vehicles. Drivers should abide by all traffic and spe ed regulations. GPS directions, if needed, should be given via audio. Drivers must adjust according to weather conditions. If a phone call needs to occur, drivers mu st pull the vehicles over.

4. Follow Accident Procedure

The below accident protocol Below, you will find the Accident Protocol which outlines what to do in case of any emergency or accident. All drivers must review and pass driver safety test before they are permitted to drive any company vehicle.

Vehicle Safety Features This is a list of all items featured on all company vehicles used for the transportation of clients:

• First Aid Kit/Narcan

• Jumper Cables

• Flashlight

• Spare Tire

• Tire Iron

• Spare Tire Jack

• Fire Extinguisher

Driver: Start Miles: Start Fuel: End Fuel: Location:

Driver Safety and Procedure

Information

Accident Protocol

✓ Staff and client safety are our number one priority.

✓ Know Where Your Vehicle Documentation and Safety Equipment Are Located.

✓ Vehicle information; insurance card and registration will be placed in the glove box of vehicle.

✓ All safety procedure documents are located in transportation book.

✓ Familiarize yourself with the location of fire extinguisher and first aid kit.

1. Stop

If involved in an accident, DO NOT leave the scene until speaking with the other driver, the police, or both.

2. Stay Calm

Keep as calm as possible, avoid any urge to react with anger or aggression, especially when another driver might behave irrationally.

3. Safety of Clients and Staff are Vital

After being involved in a minor accident, be sure to move the vehicle safely to the side of the road out of traffic, having all occupants exit vehicle to safety. Be sure to use client passenger checklist to ensure all clients are accounted for. If the vehicle cannot be moved and no injuries have occurred, driver and passengers should remain inside vehicle with seat belts fastened until emergency services arrive. Turn on hazard lights and if safe, place cones, flares, or warning signs.

4. Call for Medical Assistance

Call for emergency medical assistance if anyone involved in the accident is bleeding, feels

lightheaded, or is suffering any physical injury. Always proceed with caution and call for help. Unless someone is specifically trained in emergency medical procedures, wait until the help arrives before attempting to move a person or perform emergency aid.

5. Contact the Police

Calling the police from the site of a crash is the best possible action. If the driver cannot personally contact police, they must instruct someone else to do so. Police officers will address traffic infractions and tak notes for the incident report.

6. Vehicle Information

Provide police with vehicle information; registration and insurance card in glove box. Also, provide your driver's license.

Accident Protocol (continued)

7. Do Not Admit Fault

Do not discuss specific details of the accident with anyone except the police directly. Be polite, but do not admit fault to the other driver or the police, ever if the driver's actions led to the accident.

8. Contact Your Direct Supervisor

When first available, call your direct supervisor and update them on the situation. The direct supervisor will collect all the information you have.

9. Photograph and Document the Incident

Take pictures of all damage done to the company vehicle and any vehicle involved in the incident. Be sure to include photos that reveal the overall context of the accident such as road conditions, intersection, traffic signs or lights, etc.

10. Record in writing all pertinent information involving the incident including:

• The date and time of accident, a description and exact location of the accident scene, and any recollection of your vehicles handling or mechanical function prior to the accident.

• Name, addresses, telephone numbers, vehicle info, drivers license number, insurance information and insurance carrier of all parties involved.

• Names, address, and general contact info of any witnesses

• Names and badge numbers of police officers involved, where to obtain the police report of incident, and any tickets or citations.

Person-Centered Planning Training© 2

Note: This training is an overview of Person Centered Planning. It is intended to provide a basic understanding of person centered planning guidelines and practices for all employees, and meet the CARF accreditation standards for training for all employees. It is not intended to be a substitute for competency-based training requirements.

Please read through this brief overview on Person Centered Planning.

After completing this overview, complete the questionnaire that follows.

This questionnaire is intended to improve your understanding of the

concept of Person Centered Planning.

ORIGINS

Person Centered Planning has its origins in the disability activist

movement of the 1960's and the early 1970's, which culminated in a

congressional act of congress (The Rehabilitation Act of 1973) that

included a provision that forbid discrimination on the basis of disability.

Ideas that grew out of the experience of disability activists resulted in a

growing movement to move away from dependence on "professionals" as

the experts on determining the needs of persons served; to persons

determining what best served their needs. The following represents an example of these two views:

Question Rehabilitation View Person Centered View

• Where is the problem located?

• Within the person Iin the environment and the

• way services work (or don't work)

• What is the solution?

• Professional intervention Removal of barriers,

• advocacy, consumer control,

• self-advocacy

• Who is the person? Patient/Client Person/Citizen

• Who is in charge? The professional The citizen

• What defines success?

• Maximum functioning as judged by the professional

• Independent living, being in control of your life regardless of how much assistance you need.

ASSUMPTIONS ABOUT PERSON CENTERED PLANNING

1. All people, with or without disabilities, share the same basic needs.

As human beings, all of us are concerned about having experiences

throughout our lives that provide us with:

a. Autonomy and independence

b. Individuality

c. Love and acceptance through participation within a family

and community

d. Stability and continuity

e. Continuous growth and learning

f. Community status

g. Security with respect to personal finances and protection of legal and human rights.

2. Description of disability is only relevant to the extent that the disabling condition complicates the fulfillment of human needs. What disabled people do not have in common with non-disabled people is the independent ability and means to create conditions, situations, and experiences in their lives to meet some or all of their basic human needs.

3. The form of help and the ways it is designed and arranged

determines whether or not people get their basic needs met. For example, it is common to hear phrases such as “Jim needs medication.” Re-wording this statement so that it is consistent with person centered planning would be: “Jim, like all of us, needs to be

able to concentrate in order to learn more effectively. His disability interferes with his ability to learn in several specific ways.

Medication may be one form of assistance that might help him learn more effectively.”

4. The goal of the human service systems is to join forces with natural unpaid support networks (families, friends, neighbors, coworkers, citizen advocates, etc.) to create conditions and support for people with disabilities that enable them to live within their

local communities. Services should be designed and delivered to enhance each person’s capacity for growth and to convey the conviction that each person can participate in a valued role within the community.

ELEMENTS OF PERSON CENTERED PLANNING

1. The individual’s needs, desires, and accommodations for communication will be made to maximize his/her ability for expression.

2. The individual’s choices, preferences, and abilities are respected.

3. Potential issues of health and safety are explored and discussed to

determine if there is a role for other persons to provide additional information.

4. All planning meetings are scheduled at a time and location convenient to the individual and the persons the individual chooses to participate.

5. The individual identifies, in collaboration with others, the strategies and supports to achieve desired outcomes.

6. Exploration of the potential resources for supports and services to be included in the individual’s plan are considered in this order:

a. The individual

b. Family, friends, and significant others

c. Resources in the community

d. Public funded and supports available to all citizens

7. Person centered planning includes regular opportunities for individuals to provide feedback.

8. The individual's support network is explored with the person to determine who may best help him/her create a plan, and a plan is developed for achieving desired outcomes.

PERSON-CENTERED PLANNING 2 QUESTIONAIRE

Please answer the following questions by selecting true or false.

1. Person Centered Planning has its origins in an act of congress, which spurred disability activists to develop advocacy-based approaches to treating people's problems and disabilities.

 True False

2. A "rehabilitation" approach provides for experts, who have been trained to know what's best for disabled individuals, to utilize years of education and training in developing treatment that meets the needs of the individual, while a "person centered" approach relies on the a system of support to assist the individual in determining how best they fulfill their human needs.

 True False

3. "John needs to take his medication in order to reduce his symptoms and function better within his community" would be a person centered approach to assisting someone with fulfilling their human needs.

 True False

4. The goal of the human service systems is to join forces with natural unpaid support networks (families, friends, neighbors, co-workers, citizen advocates, etc.) to create conditions and support for people with disabilities to live within their local communities.

 True False

5. The following are all elements of person centered planning:

a. The individual's choices, preferences, and abilities are respected.

b. The individual's support network is explored with the person to determine who may best help him/her plan, and a plan is developed for achieving desired outcomes.

c. The individual identifies, through the directives of the professional provider, the

strategies and supports to achieve desired outcomes.

d. Regular opportunities for individuals to provide feedback are available.

☐ True ☐ False

NAME:_____ DATE:_____

SUPERVISOR:_____ DATE:_____

Aggression Management and Communication Skills

Course Description:

The overall goal of this program is to familiarize the participant with ways to effectively manage aggression through effective verbal and non-verbal communication, by learning and implementing diffusion strategies as well as de-escalation techniques and skills

GOAL 1: OBJECTIVES

1. Participants will gain an understanding of signs and aspects of aggression.

2. Participants will be familiar with effective verbal and non-verbal communication.

3. Participants will learn about various diffusion techniques and de-escalation techniques.

4. Participants will improve ability to keep clients safe on a consistent basis.

Managing Aggression

The effective handling of aggression is one of the most demanding aspects of working in Behavior Health. It is an area where good interaction and communication skills are required.

• The majority of situations where there is a potential for violence can be handled through communication.

• Aggression: any behavior that is perceived by the victim as being deliberately harmful and damaging either psychologically or physically.

Goal: Prevent aggression from escalating into actual physical violence.

People may become aggressive for a number of reasons, including:

• Frustration Unfairness, perceived or real

• Humiliation Immaturity

• Excitement Learned Behavior (it get results)

• Reputation Means to an end

• Decoy Duty

• Mental Illness (i.e. Paranoia, psychosis, delusions)

Signs of Aggression:

• Standing tall

• Red faced

• Raised voice

• Rapid breathing

• Direct, prolonged eye contact

• Exaggerated gestures

• Tensing of muscles

Additional signs of aggression:

• Any major change in behavior that varies from what is normal for the person

• Clenched fists

• Focusing/narrowing of the gaze

• Tight jaw/facial muscles

• Increased agitation and disturbance in behavior (e.g. pacing)

Risk Factors to Consider:

• Is the person facing a high level of stress? (e.g. recent bereavement, pending court date)

• Does the person seem to be under the influence of drugs or alcohol?

• Does the person have a history of violence?

• Does the person have a history of psychiatric illness?

• Has the person verbally abused staff in the past?

• Has the person threatened staff with violence in the past?

• Has the patient experienced trauma?

Communication

Communication: a two-way process that relates to verbal interaction (listening, speaking, and hearing), and non-verbal interaction (interpretation and observational skills – looking and seeing).

To minimize communication problems:

• Use language appropriate to the person (his/her language if possible; use interpreter where

• necessary)

• Take time to communicate

• Check that you are understood

• Encourage and give feedback

• Conversation should take place at an appropriate time and place (whenever possible)

Aggression Management and Communication Skills Training

Common inhibitions to effective communication:

• Noise

• Language (native lang./demeaning lang.)

• Perception and prejudice

• Intrusion of personal space

• Communication: We cannot necessarily avoid or overcome all these barriers, but we need to

find ways of minimizing them.

Noise:

• Major distraction

• Hard to hold a discussion against noisy background

• Speaking loudly can be misinterpreted as yelling

Language:

• Express yourself in as direct and explicit manner as possible

• Avoid emotive language (Words used deliberately to create an emotional impact or response)

• Avoid demeaning language/belittling

• Find assistance for a person who does not speak the same language as you.

• Perception and Prejudice: everybody has a unique background and history with influences and

• experiences that form our way of looking at the world.

❖ Recognize our prejudices

❖ Work around prejudices of others

❖ Maintain professional attitude (not allowing our perceptions to get in the way of duties

and responsibilities to others, particularly in promoting equal opportunities)

❖ Not to let our prejudices influence the way we communicate

Intrusion of personal space:

• Avoid standing too close to the person

• Amount of space required for a person differs based on gender, familiarity, culture, mood, etc.

• In addition, standing too close to an angry individual can make the person feel unsafe, and make

YOU unsafe.

• Step-Kick distance Non-verbal communication: Staff should be aware of non-verbal messages that how how a person is feeling or may respond.

De-escalation Prevention Steps

Recognize:

• Anger is a choice of a range of behaviors that could be used to get what one needs in a situation.

• It is a behavior that has benefit for its user.

• Anger can get people the attention they need, escape things they don't want to do, gain control

over another person/situation

• Pump them up when they are feeling small/insignificant

Perform a quick self-assessment:

❖ Can I avoid criticizing and finding fault with the angry person?

❖ Can I avoid being judgmental?

❖ Can I keep myself removed from the conflict?

❖ Can I try to see the situation from the angry person's pt of view or understand the need s/he is

trying to

❖ satisfy?

❖ Can I remember that my job is to keep the peace and protect the client and staff?

Recognize Early Warning Signs: Many incidents can be prevented by recognizing subtle changes in behavior.

-Quiet people may become agitated

-Loud, outgoing people may become quiet and introspective.

Commenting on the changes may open up conversation and minimize frustration/buildup

Diffusion Strategies

Before anything else happens:

• Staff should seek to defuse the situation

• People that are out of control are under the influence of an "adrenal cocktail"

• Do nothing to escalate state of mind

• Be prepared to defend yourself

Seek to:

• Appear confident

• Display calmness

• Create some space

• Speak slowly, gently and clearly

• Lower your voice

• Avoid staring

• Avoid arguing and confrontation

• Show that you are listening

• Calm the person and assure she/he feels heard before trying to solve the problem

Adopt a non-threatening body posture:

• Use a calm, open posture (sitting or standing)

• Reduce direct eye contact (may be taken as a confrontation) without affirmative acknowledgment

• Allow the person adequate personal space

• Keep both hands visible

• Avoid sudden movements that may startle or be perceived as an attack

• Avoid audiences (when possible) – an audience may escalate the situation

TO DO:

• Give clear, brief, assertive instructions

• Explain your purpose or intention

• Negotiate options

• Avoid threats

• Move towards a “safer place” (i.e. avoid being trapped in

• Ensure your non-verbal communication is non-threatening:

• Consider which techniques are appropriate for situation

• Pay attention to non-verbal clues (i.e. eye contact)

• Allow greater body space than normal

• Be aware of own non-verbal behavior (posture and eye contact)

• Appear calm, self-controlled, and confident without being dismissive or over-bearing

De-Escalation Techniques

1. Technique #1: Simple Listening

Sometimes all an angry person needs is for someone to take the time to allow them to vent his/her anger and frustrations. Simply listen to what he/she is saying, give encouragers (i.e. uh-huh, yes, go on, etc.).

2. Technique #2: Active Listening

…really attempting to hear, acknowledge and understand what a person is saying. A genuine attempt to put oneself in the other's situation. LISTENING…not only to the words, but the underlying emotion as well as the body language.

3. Technique #3: Acknowledgement

…occurs when the listener is attempting to sense the emotion underlying the words. Relaying that you understand what a person is feeling helps the person to release that feeling.

4. Technique #4: Allow Silence

…although many find silence unbearable, sometimes the angry person may need the time to reflect or think.

5. Technique #5: Agreeing

…often when people are angry about something, there is something true in what they are saying. When attempting to diffuse someone's anger, it is important to find that truth and agree with it.

6. Technique #6: Apologizing

…an excellent de-escalation skill! …Not for an imaginary wrong, but a sincere apology for anything in the situation that was unjust; a simple acknowledgment that something occurred wasn't right or fair. It is possible to apologize without accepting blame.

7. Technique #7: Inviting Criticism

The final skill…The listener should simply ask the angry person to voice his/her criticism of the listener

(What am I doing wrong that makes you so angry at me? Tell me, I can take it. Don't hold anything back. I want to hear about everything you're angry about.).

8. Technique #8: Develop a Plan

Have a plan before one is needed. Think about options of what you could do before such a circumstance occurs. Decisions made before a crisis occurs are more likely to be more effective/rational than those thought of "on the fly".

WHEN NOTHING WORKS

There may be occasions, particularly with the mentally ill, when the listener is unsuccessful. Your safety and the safety of others should always be of primary concern.

NEVER THREATEN unless you are prepared to take the next step:

Once you have made a threat, or given an ultimatum, you have ceased all negotiations and put yourself in a potential win-lose situation.... and for safety's sake, you must be the winner. However, your rapport will suffer, leading to potential future problems, fear, or distrust from those you interact with daily.

Last resort.

De-escalation Closure

De-escalation is a very difficult and humbling skill.

• You cannot be unsure of your own pride or self-esteem.

• You must be able to control your own anger.

• You must be able to see the bigger picture.

• You must be willing to practice what you've learned.

Aggression Management Quiz

1) Name 5 signs of Aggression

_____

_____

_____

_____

_____

2) Name 2 risk factors to Aggression

_____

_____

3) Anger is a choice in a range of available behaviors. (circle one)

True False

4) Explain how Perception and Prejudice can inhibit Communication.

_____

_____

_____

5) Staring a client down is a sign of being in charge and can help to calm an aggressive person. (circle one)

True False

6) Apologizing to an angry client simply validates their anger and perpetuates a stressful situation. (circle one)

True False

Alc 303.03 Education.

(a) The required education shall consist of at least 46 hours covering the 4 domain areas, to include

at least:

(1) Sixteen hours of education in ethical responsibility inclusive of:

a. Substance use recovery services;

b. Ethical boundaries; and

c. 42 CFR Part 2 and HIPAA confidentiality laws;

(2) Ten hours of education in advocacy inclusive of:

a. Substance use recovery issues; and

b. Six hours of education of suicide prevention training;

(3) Ten hours of mentoring and education training inclusive of:

a. Substance use recovery issues; and

b. Three hours of mental health and co-occurring training; and

(4) Ten hours of recovery and wellness training inclusive of:

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a. Substance use recovery issues; and

b. Three hours of HIV and AIDS training.

(b) At least 50% of the required education shall be provided, sponsored, or approved by:

(1) The board or the licensing body of any state within the IC&RC;

(2) National Association for Alcoholism and Drug Abuse Counselors – The Association for Addiction Professionals (NAADAC);

(3) New Hampshire Training Institute on Addictive Disorders;

(4) New Hampshire Center for Excellence on Addiction;

(5) AdCare Educational Institute of New England;

(6) NHTI – Concord Community College;

(7) New Hampshire Alcohol and Drug Abuse Counselors Association; or

(9) The NH department of health and human services bureau of drug and alcohol services

(BDAS).

(c) No more than 25% of the required education described above shall be obtained by the applicant

online. This maximum shall not apply to educational hours obtained as part of an online college program

or from an online training that is live and simultaneously interactive.

(d) One college credit shall be equivalent to 15 contact hours.

Alc 303.04 Criteria for Initial Reciprocity Based Licensure or Certification.

(a) Applicants for initial certification as a CRSW who are currently certified recovery support

workers in another jurisdiction within the IC&RC shall be certified by the board upon completion of the

application requirements in Alc 304.01 – Alc 305.

(b) Applicants for initial certification as a CRSW who are certified recovery support workers in a

jurisdiction outside the IC&RC shall be eligible for certification in New Hampshire, provided that:

(1) The application requirements are equal to or more stringent than those outlined in this

chapter; and

(2) The applicant complies with the application requirements described in Alc 304.01 – 304.04.

Readopt with amendment Alc 304.01 through Alc 304.04, effective 10-13-16 (Document #12001), to

read as follows:

Alc 304.01 Procedures for Applying for Initial Certification as a Recovery Support Worker. An

applicant for certification as a recovery support worker shall arrange for the board's office to receive:

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(a) A completed, signed, and dated "Initial Certification Application as a Recovery Support Worker"

form provided by the board and further described in Alc 304.02;

(b) The additional materials described in Alc 304.04;

(c) Payment of the certification fee as described in Alc 317; and

(d) A criminal history records check form and fingerprint card or live scan document, requesting

both a New Hampshire and a federal records check, in accordance with the procedure specified by the NH

department of safety at Saf-C 5700, Operation of the Central Repository: Criminal Records, with the

required fee. The fee for the criminal history records check shall be submitted using a separate payment.

Alc 304.02 Application Form. The applicant shall furnish the following information on the

application form "Initial Certification Application as a Recovery Support Worker" provided by the board:

(a) The applicant's full legal name;

(b) Any other names ever used by the applicant;

(c) The applicant's date of birth;

(d) The applicant's current employer;

(e) The applicant's current employers address, business email, and phone number;

(f) Using the "yes" and "no" spaces provided, whether or not the applicant:

(1) Has any pending criminal charges;

(2) Has made a plea agreement relative to any criminal charge;

(3) Has been convicted of a felony or misdemeanor in this or any jurisdiction;

(4) Has any license or certification under revocation, suspension, or probation in another state

or territory of the United States; and

(5) Is currently on probation or parole in New Hampshire or in any other state or territory of

the United States;

(6) Has engaged in work with individuals with substance use or integrated co-occurring

disorders in a manner harmful or dangerous to them or the public;

(7) Has practiced fraud or deceit in procuring or attempting to obtain this certification;

(8) Has engaged in sexual relations with, solicited sexual relations with, or committed an act

of sexual abuse against or sexual misconduct with, a current or past participant or minor;

(9) Has failed to remain free from the use of any controlled substance or any alcoholic beverage

to the extent that the use impairs the applicant's ability to engage in work with individuals with

substance use and integrated co-occurring disorders with safety to the public;

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(10) Has engaged in false or misleading advertising;

(11) Has disciplinary action(s) pending in another state or territory of the United States;

(12) Has a mental disability which impairs professional ability or judgment; and

(13) Is currently or has previously been authorized in another jurisdiction to provided recovery

support work;

(g) If the applicant has answered any of the questions in Alc 304.02(g) in the affirmative provide a

detailed written explanation of the circumstances surrounding the "yes" answer and include any

restitution(s) or remedial action(s);

(h) List the private and public settings in which the applicant completed the paid or volunteer work

experience required by Alc 303.02;

(i) List the sources of the education required by Alc 303.03;

(j) The applicant's physical home address;

(k) The applicant's home telephone number or cellular phone number;

(l) The applicant's home mailing address;

(m) The applicant's personal email address;

(n) Pursuant to RSA 161-B:11 and RSA 330-C:20, I, the applicant's social security number for the

purpose of child support enforcement compliance with RSA 161-B:11; and

(o) The applicant shall sign and date the "Initial Certification Application as a Recovery Support

Worker" below the following statement:

"The information provided on this application form and in the materials, I have provided to

support my application is true, accurate, and complete to the best of my knowledge and belief.

I acknowledge that, pursuant to RSA 641:3, the knowing making of a false statement on this

application form is punishable as a misdemeanor. I have read and understand the laws, rule,

and ethical standards for Recovery Support Workers and if I am certified I will abide by those

laws, rules, and ethical standards as defined in Alc 500."

Alc 304.03 Meaning of the Applicant's Signature. The applicant's signature on the "Initial

Certification Application as a Recovery Support Worker" form shall mean that:

(a) The applicant confirms that the information provided on the "Initial Certification Application as

a Recovery Support Worker" form and submitted by the applicant to support his or her application is true,

accurate, and complete to the best of his or her knowledge and belief; and

(b) The applicant acknowledges that knowingly making a false statement on the "Initial Certification

Application as a Recovery Support Worker" form shall be punishable as a misdemeanor under RSA 641:3.

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Alc 304.04 Additional Materials to be Submitted. The additional materials to be submitted by an

applicant for initial certification shall be:

(a) The test scores from the examination described in Alc 305 submitted to the board directly from

the testing institution;

(b) A photocopy of the applicant's:

(1) High school diploma;

(2) Certificate of general educational development or equivalent credential issued by a state

department of education;

(3) Any other certificate showing that the applicant has earned the equivalent of a high school

diploma; or

(4) A transcript showing completion of a college degree program indicating education beyond

a high school diploma;

(c) The completed, signed, and notarized form required by the New Hampshire division of state

police for the issuance and transmission to the board of the applicant's state and federal criminal conviction

reports;

(d) On a fingerprint card furnished by the board or live scan document, the set of fingerprints required

by the New Hampshire division of state police for the issuance of the applicant's state and federal criminal

conviction reports;

(e) Unless the information is available only on a secure website, an official letter of verification sent

directly to the board from every jurisdiction which has issued a license, certificate, or other authorization

to practice recovery support or other work supporting treatment of individuals with substance use and

integrated co-occurring disorders stating:

(1) Whether the license certificate or other authorization is or was, during its period of validity,

in good standing; and

(2) Whether any disciplinary action was taken against the licensee, certificate, or other

authorization to practice;

(f) A written description of the circumstances if the applicant has checked the “yes” space for any of

the “yes-no” questions on the “Initial Certification Application as a Recovery Support Worker” form;

(g) Proof of compliance with any current orders described in Alc 302.01(b)(3) dated within 60 days

of the date of submission of the “Initial Certification Application as a Recovery Support Worker” form;

(h) The “Supervised Work Experience Report Form” from each of the private and public employer(s)

for whom the applicant performed paid or volunteer work evidencing compliance with the work experience

required by Alc 303.02 shall require:

(1) Supervised work experience of at least 500 hours in duration;

(2) The supervised work experience to be:

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a. Be paid or volunteer in nature;

b. Involve direct services to clients;

c. Be performed under the supervision of an individual approved by the board to supervise CRSW's; and

d. Be performed in one or more of the following private or public settings:

1. A detoxification program;

2. A substance use counseling program;

3. A substance use treatment program; or

4. In the substance use aspect of a healthcare, social service, or other direct service program; and

(3) The supervised work experience to include:

a. Monitoring by the supervisor of the performance of the person being supervised; and

b. Record keeping and note taking by the supervisor which is sufficiently detailed to permit accurate later assessment of the work of the individual being supervised and accurate completion of the "Supervised Work Experience Report Form" as described in Alc 313.06;

(i) Photocopies of all certificates of completion showing compliance with the training requirement in Alc 303.03, attaching additional sheets as necessary to provide the following information if it does not appear on the certificate:

(1) The name of the applicant;

(2) The title of the training;

(3) The name of the training provider;

(4) The date(s) and number of hours of the training;

(5) If the training does not meet the requirements set forth in Alc 303.03(b), a description of the topic(s) covered by the training, in the form of a brochure or description issued by the training provider;

(6) The signature of the training instructor or a representative of the provider or sponsoring or approving organization, together with the title of the person signing the certificate of completion; and

(7) A list of the domains covered by the training;

(j) The "Supervision Agreement" further described in Alc 313.09; and

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(k) The "Applicant Evaluation Form" described in Alc 313.10.

Readopt with amendment Alc 305.01, effective 10-13-16 (Document #12001), to read as follows:

Alc 305.01 Examination and Examination Procedures.

(a) The examination to be passed for initial certification as a CRSW shall be the IC&RC written "Peer Recovery" (PR) examination.

(b) Applicants intending to take the IC&RC written peer recovery examination shall apply to and take the examination with the IC&RC.

(c) Applicants for certification shall request the IC&RC submit proof they have received a passing score on the "Peer Recovery" examination directly to the board.

Readopt with amendment Alc 304.05, effective 10-13-16 (Document #12001) and renumber as Part 306, to read as follows:

PART Alc 306 BOARD’S PROCESSING OF APPLICATIONS FOR INITIAL CERTIFICATION AS A RECOVERY SUPPORT WORKER

Alc 306.01 Processing of Applications for Initial Certification.

(a) Pursuant to RSA 330-C:20, III the board's office shall submit the release form described in Alc

304.04 (c), the fingerprints described in Alc 304.04(d), and the payment described in Alc 304.01(d) to the

division of state police for the purpose of obtaining the applicant's state and federal criminal conviction

reports.

(b) The application for initial certification shall be considered complete when:

(1) The board’s office has received:

a. A completed, signed, and dated “Initial Certification Application as a Recovery

Support Worker” form pursuant to Alc 304.02;

b. The additional materials described in Alc 304.04;

c. The applicant’s state and federal criminal conviction reports transmitted to the board

by the division of state police; and

d. Any additional information or documents which the board has requested pursuant to

(c) below; and

(2) The treasurer has transacted the applicant’s check, or money order in payment of the total

certification fee.

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(c) If the board, after receiving and reviewing the application materials submitted by the

applicant and the applicant's state and federal criminal conviction reports, requires further information

or documents to determine the applicant's qualification for certification, the board shall:

(1) So notify the applicant in writing within 30 days; and

(2) Specify the information or documents it requires.

(d) The application shall be denied if the applicant has not submitted all documents required pursuant

to Alc 306.01(b) within 120 days of the receipt by the board's office of the completed "Initial Certification

Application as a Recovery Support Worker" form.

(e) The board shall issue the recovery support worker certification or a written denial of the

application within 60 days of the date that the application is complete.

(f) An applicant wishing to challenge the board's denial of an application for initial certification

shall:

(1) Make a written request for a hearing in accordance with Alc 200; and

(2) Submit this request to the board:

a. Within 60 days of the board's notification of denial; or

b. If the applicant is on active military duty outside the United States, within 60 days of

the applicant's return to the United States or release from duty, whichever occurs later.

Readopt with amendment Part Alc 306, effective 10-13-16 (Document #12001) and renumber as Part

307, to read as follows:

PART Alc 307 INITIAL LICENSURE AS A LICENSED ALCOHOL AND DRUG COUNSELOR

Alc 307.01 Scope. The rules in Alc 306, Alc 307, and Alc 308 shall not apply to applicants applying

for reciprocity-based LADC licensure under Alc 309 unless otherwise specified in Alc 309.

Alc 307.02 Eligibility Requirements for Initial Licensure as a Licensed Alcohol and Drug Counselor.

(a) The board shall issue an initial license as a licensed alcohol and drug counselor to an individual

who:

(1) Has committed none of the acts or omissions described in RSA 330-C:27, III for which the

applicant has not made sufficient restitution as follows:

a. Restoration of the person or entity injured by the individual to his, her, or its original condition;

b. A restitution acknowledged by the injured person or entity to be sufficient;

c. Correction of the deficiency in the individual which led to the act or omission;

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d. A restitution ordered in disciplinary action taken by the board; or

e. Restitution ordered in disciplinary action taken by a regulatory body of another state or territory of the United States;

(2) Is of good character, as evidenced by:

a. Information provided on the “Application for Initial Licensure as an Alcohol and Drug Counselor or Master Alcohol and Drug Counselor” form pursuant to Alc 313.02 or in the additional materials reviewed by the board regarding any criminal convictions, pending criminal charges, and plea agreements;

b. Information provided on the “Application for Initial Licensure as an Alcohol and Drug Counselor or Master Alcohol and Drug Counselor” form pursuant to Alc 313.02 or in the additional materials reviewed by the board regarding any restitution made for any acts or omissions described in RSA 330-C:27, III;

c. Information provided on the “Application for Initial Licensure as an Alcohol and Drug Counselor or Master Alcohol and Drug Counselor” form or in the additional materials reviewed by the board regarding any remedial action taken with respect to mental disability; and

d. Official letters of verification and training requirements set forth in Alc 308.04(d), if

any;

(3) Has met the education requirements set forth in Alc 307.03;

(4) Has met the training requirements set forth in Alc 307.04;

(5) Has accumulated the supervised work experience specified in Alc 307.05;

(6) Has been found competent in substance use counseling [or recovery support work] as shown by ratings described in Alc 313.06(e)(9), meeting the following standards based on all

"Supervised Work Experience Report Form" required to cover the individual's entire work experience:

a. No "not acceptable" ratings on any of the core functions; and

b. At least one rating per core function which is not a rating of "no opportunity for supervision";

(7) Has passed the examination specified by Alc 308.01(a) and otherwise complied with the examination procedures of Alc 308.01; and

(8) Has complied with the application procedures set forth in Alc 312.

(b) The board shall waive an applicant's felony conviction, if any, if the applicant has corrected the

deficiency which led to the felonious act or omission.

(c) The board shall consider the following when determining if waiving the criminal act or omission

shall be appropriate:

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(1) The applicant's explanation of the offense(s) or omissions;

(2) The applicant's written explanation of the steps taken to make restitution;

(3) Compliance with probation or parole, if applicable;

(4) Payment of fines or restitution, if applicable; and

(5) Compliance with any plea agreement or settlement agreement made with any court, board,

or other supervising entity, if applicable;

(d) If the board determines, after considering all the information about the conviction or omission,

that it does not impair the applicant's ability to conduct, safety, the practices for which the applicant seeks

licensure the board shall issue the waiver.

Alc 307.03 Educational Eligibility Requirements.

(a) Pursuant to RSA 330-C:17, I, eligibility for initial licensing as a licensed alcohol and drug

counselor shall require an individual to have:

(1) Graduated with one of the academic degrees stated in (b) below;

(2) Received the required drug and alcohol use education stated in (c) below; and

(3) Received the supervised practical training in drug and alcohol counseling stated in (d)

below.

(b) The qualifying academic degrees shall be:

(1) An associate's degree in substance use counseling, addiction studies, or equivalent

program; or

(2) A bachelor's degree in clinical mental health, social work, psychology, substance use

counseling, addiction studies, or human services from a college or university accredited by:

a. The Commission on Institutions of Higher Education of the New England Association

of Schools and Colleges; or

b. Any other accrediting body recognized by the Council for Higher Education

Accreditation.

(c) The required drug and alcohol use education shall:

(1) Total at least 300 hours, including:

a. Six hours of education in confidentiality;

b. Six hours of education in the 12 core functions;

c. Six hours of education in ethics;

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d. Six hours of education in HIV and AIDS;

e. Six hours of education in suicide prevention; and

f. The remaining 270 hours covering the 18 categories of competence as described in Alc 313.10(j)(1)-(18); and

(2) Be received:

a. As part of the academic program; or

b. In a program given, sponsored or approved by:

1. The board or the licensing body of any other state within the IC&RC;

2. National Association for Alcoholism and Drug Abuse Counselors – The Association for Addiction Professionals (NAADAC);

3. New Hampshire Training Institute on Addictive Disorders;

4. New Hampshire Center for Excellence on Addiction;

5. AdCare Educational Institute of New England;

6. NHTI – Concord Community College;

7. New Hampshire Alcohol and Drug Abuse Counselors Association;

8. The NH department of health and human services bureau of drug and alcohol services (BDAS); or

9. Any public or private agency or institution providing training in the practice of substance use counseling and recognized by the Council for Higher Education Accreditation.

(d) No more than 25% of the required education shall be obtained by the applicant online. This

maximum shall not apply to educational hours obtained as part of an online college program or from an

online training that is live and simultaneously interactive.

Alc 307.04 Training Eligibility Requirements. The required supervised practical training in alcohol

and drug use counseling shall:

(a) Total at least 300 hours;

(b) Cover training in the 12 core functions, with a minimum of 10 hours of supervised practical

training received in each of the 12 core functions;

(c) Supervised practical training that includes direct and indirect supervision; and

(d) Be received:

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(1) In an internship or practicum; or

(2) At the site of, and as part of, the supervised work experience as described in Alc 301.01(k)

and as descried in Alc 307.05.

Alc 307.05 Supervised Work Experience Requirement.

(a) The required supervised work experience shall be of the following duration:

(1) For an individual holding an associate's degree, an accumulated 6,000 hours; and

(2) For an individual holding a bachelor's degree, an accumulated 4,000 hours.

(b) The supervised work experience shall:

(1) Be paid or volunteer in nature;

(2) Involve direct services to clients;

(3) Be performed under the supervision of an individual licensed by the board or authorized

by the regulatory board of another state to practice substance use counseling; and

(4) Be performed in one or more of the following private or public settings:

a. A detoxification program;

b. A substance use counseling program;

c. A substance use treatment program; or

d. In the substance use aspect of a healthcare, social service, or other direct service program.

(c) The supervised work experience shall include:

(1) Monitoring by the supervisor of the performance of the person being supervised; and

(2) Record keeping and note taking by the supervisor which is sufficiently detailed to permit accurate later assessment of the work of the individual being supervised and accurate completion of the “Supervised Work Experience Report Form” as described in Alc 313.06.

U.S.C. § 290dd-2; 42 C.F.R. § 2.11- 2.12). What Information Is Protected? 42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. How Can Protected Information Be Shared? Information can be shared if written consent is obtained through a Release of Information Form (ROI). A written consent form requires ten elements (42 C.F.R. § 2.31(a); 45 C.F.R. § 164.508(c)): 1) The names or general designations of the programs making the disclosure; 2) The name of the individual or organization that will receive the disclosure; 3) The name of the patient who is the subject of the disclosure; 4) The specific purpose or need for the disclosure; 5) A description of how much and what kind of information will be disclosed; 6) The patient's right to revoke the consent in writing and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice; 7) The program's ability to condition treatment, payment, enrollment, or eligibility of benefits on the patient agreeing to sign the consent, by stating: a. The program may not condition these services on the patient signing the consent; or b. The consequences for the patient refusing to sign the consent. 8) The date, event, or condition upon which the consent expires if not previously revoked; 9) The signature of the patient (and/or other authorized person); and 10) The date on which the consent is assigned. The consent form must also include the language: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:	
Case No.	CLSS-2024-01
Date Filled	2/16/24
Rec'd By	CM
Page	1 of 4
Tax Map#	569-006-000
Zoning District:	DT-E

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

○ Drug Treatment Center	○ Group Home, Small	○ Homeless Shelter
○ Fraternity/Sorority	○ Group Resource Center	○ Lodging House
○ Group Home, Large	◉ Residential Drug/Alcohol Treatment Facility	○ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 106 Roxbury St Keene, NH 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: 106 Roxbury, LLC	**NAME/COMPANY:** Live Free Recovery Services, LLC
MAILING ADDRESS: 106 Roxbury St Keene, NH 03431	**MAILING ADDRESS:** 106 Roxbury st. Keene, NH 03431
PHONE: (603) 438-3276	**PHONE:** (877) 932-6757
EMAIL: rgagne@livefreerecoverynh.com	**EMAIL:** rgagne@livefreerecoverynh.com
SIGNATURE: Ryan Gagne **DATE:** 2/16/24	**SIGNATURE:** Ryan Gagne **DATE:** 2/16/24
PRINTED NAME: Ryan Gagne **TITLE:** Owner/CEO	**PRINTED NAME:** Ryan Gagne **TITLE:** Owner/CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY:	**NAME/COMPANY:** Live Free Recovery Services, LLC
MAILING ADDRESS:	**MAILING ADDRESS:** 106 Roxbury ST Keene, NH 03431
PHONE:	**PHONE:** (877) 932-6757
EMAIL:	**EMAIL:** info@livefreerecoverynh.com
SIGNATURE: **DATE:**	**SIGNATURE:** Jennifer Houston, LICSW, MLADC **DATE:** 2/16/24
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Jennifer Houston **TITLE:** Clinical Director

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Residential services will be provided for men and women above the age of 18 who are struggling with substance use disorders. Peer recovery services, case management services, clinical services, and psychiatric services will be provided.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

There will be maximum of 28 clients at the building. There will be staff at the building 24 hours a day. There is an outdoor smoking area that the clients use throughout the day.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

The average length of stay is between 18 to 30 days.

City of Keene

3 Washington Street New Hampshire 03431

Congregate Living & Social Services Licensing Inspection Checklist

Name of Organization: Live Free Recovery

Address of Property: 106 Roxbury St

1)	Exterior	N/A
Notes:	Door at Roxbury St entrance cracked glass.	
2)	Hallways/Stairwells	N/A
Notes:	No concerns noted.	
3)	Storage/Closets	N/A
Notes:	No concerns noted.	
4)	Bathrooms	N/A
Notes:	No concerns noted.	
5)	Basement/Attic	N/A
Notes:	No concerns noted.	
6)	Kitchen/Food Prep Area	N/A
Notes:	No concerns noted.	
7)	Bedrooms/ Classrooms	N/A
Notes:	No concerns noted.	
8)	Common Areas	N/A
Notes:	No concerns noted.	
9)	Offices	N/A
Notes:	No concerns noted.	
10)	Electrical Systems	N/A
Notes:	No concerns noted.	
11)	Heating System	N/A
Notes:	No concerns noted.	
12)		
Notes:		

Date of Inspection: December 19, 2023	Inspector: Ryan Lawliss

City of Keene

FIRE DEPARTMENT

Office of the Fire Marshal

Office: 31 Vernon Street Keene, NH 03431

Telephone: (603) 357-9861 • **Fax:** 603-283-5668

KFDlifesafety@keenenh.gov

NOTICE OF VIOLATION AND ORDER TO CORRECT

Date of Inspection:	12/19/2023
Date of Notice:	01/16/2024
Occupancy:	Live Free Recovery Services 106 Roxbury Street, Keene, NH 03431
Owner:	106 ROXBURY LLC 106 ROXBURY ST KEENE, NH 03431

This Notice details the findings of the inspection conducted on 12/19/2023. Present at this inspection was Lt. Meghan Manke. The buildings were inspected for compliance with the minimum standard for existing buildings as required by the State Fire Code and State Building Code. The building was inspected for fire and life safety concerns. Other problems with the building may need to be addressed that are outside the scope of this inspection. This Notice reflects the violations that were observed at the time of the inspection. Other violations may exist that were not observed at the time of the inspection. In summary, the building is classified as Rooming/Lodging . Below is a breakdown of the observed Fire Code Violations. Pursuant to RSA 154:2, II(a), RSA 47:17, XVI, and City Code Section 42-1, you are hereby ordered to correct the below violations within 45 days of receipt of this Notice.

VIOLATIONS OF STATE FIRE CODE

NFPA 1 – 10.11.7 Grills on Decks For other than one- and two-family dwellings, no hibachi, gas-fired grill, charcoal grill, or other similar devices used for cooking, heating, or any other purpose, shall not be used or kindled on any balcony or under any overhanging portion or within 10 ft (3 m) of any structure.

OUTSTANDING FROM PREVIOUS:
Grill must be 10ft from building

NFPA 1: 4.4.3.1. Unobstructed Egress. In every occupied building or structure, means of egress from all parts of the building shall be maintained free and unobstructed.

Push bar needs repair on first floor, rear egress door

NFPA 10: 6.1.3.4. Extinguisher Placement. Portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means: 1) securely on a hanger intended for the extinguisher 2) In the bracket supplied by the manufacturer 3) In a listed bracket approved for such purpose or 4) in cabinets or wall recesses.

-Extinguisher missing from hanger by front door
-Mount extinguisher in tech office
-Extinguisher in community room out of date

NFPA 101: 8.3.4.1. Opening Protectives Every opening in a fire barrier shall be protected to limit the spread of fire and smoke travel.

Close penetrations in single bathroom at top of front stairwell

RSA 153:10-a. Smoke Alarms and Carbon Monoxide Detectors. MULTI-UNIT DWELLINGS AND RENTAL UNITS: Multi-unit dwellings and rental units shall be equipped with automatic fire warning devices.
Locations of Installation: Smoke alarms shall be installed in the following locations:
(1) On the ceiling or wall outside of each separate sleeping area in the immediate vicinity of the bedrooms.
(2) In each room used for sleeping purposes.
(3) In each story within a dwelling unit, including basements but not including crawl spaces and uninhabitable attics. In dwellings or dwelling units with split-levels and without an intervening door between the adjacent levels, a smoke alarm installed on the upper level shall suffice for the adjacent lower level provided that the lower level is less than one full story below the upper level.
Powering the Detectors: New and Existing Construction: All automatic fire warning devices in multi-unit dwellings, and all rental units shall be powered by the house electrical service (hardwired.)
Required Interconnection of the Detectors - New Construction and Existing Construction: When more than one smoke alarm is required to be installed within an individual dwelling unit or sleeping unit the smoke alarms shall be interconnected in such a manner that the activation of one alarm will activate all of the alarms in the individual unit. The alarm shall be clearly audible in all bedrooms with all intervening doors closed and also taking into account any ambient noise. Interconnection within the unit is required, not within the building. Wireless interconnection systems are permitted.

Missing smoke detectors in following areas:
-old manager office
-Room 4
-Room 3 (battery only)

CORRECTION OF VIOLATIONS OF STATE CODES

Due to the severity of these violations, you are hereby ordered to correct these violations within 45 days of receipt of this Notice; a reinspection will be conducted on 45 days from this Notice. City Code Sec. 42-1(a).

If a violation is unable to be correct within the timeframe provided, within 45 days of receipt of this Notice, you must provide an action plan to correct those violations. A corrective action plan may be sent to: KFDlifesafety@keenenh.gov.

APPEALS

If you disagree with Notice, you may appeal to the Keene Fire Chief, or his designee, **within 10 days of the date of your receipt of this Notice**. City Code Sec. 42-32; RSA 31:39-c, I. Your appeal must be sent to: KFDlifesafety@keenenh.gov.

If, following the Keene Fire Chief's or his designee's review, you disagree with the decision of the Keene Fire Chief or his designee, you may appeal the Keene Fire Chief's decision to the City of Keene's Board of Appeals **within 15 days of your receipt of the Fire Chief's decision**. RSA 674:34, I; City Code Sec. 2-741 - 2-743.

A request for a variance from or exception to the State Fire Code may be made to the State Fire Marshal. RSA 153:4-a, I; N.H. Admin. R. Saf-C 6005.04. Such a request may be made via: https://www.nh.gov/safety/divisions/firesafety/documents/variance-request-form.pdf. A copy of any request for a variance or exception made to the State Fire Marshal shall be mailed to the City of Keene Fire Department, 31 Vernon Street, Keene, NH 03431.

FURTHER INFORMATION

If you have any additional questions or concerns, do not hesitate to contact me at the contact information below.

MEGHAN MANKE
mmanke@keenenh.gov
FIRE PREVENTION OFFICER

CERTIFICATION OF DELIVERY

I, MEGHAN MANKE, certify that I delivered this Notice to the Owner listed above on via:

- ☐ Certified Mail
- ☐ In-Hand Delivery

Signature:

ATTACHMENTS

This Notice includes the following attachments:

Page intentionally left blank

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled_____
Rec'd By_____
Page _____of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

- ☐ Drug Treatment Center
- ☐ Fraternity/Sorority
- ☐ Group Home, Large
- ☐ Group Home, Small
- ☐ Group Resource Center
- ☐ Residential Drug/Alcohol Treatment Facility
- ☐ Homeless Shelter
- ☐ Lodging House
- ☑ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 298 Main Street, Keene NH 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Peak Healthcare at Keene	**NAME/COMPANY:** Alpine Healthcare Center
MAILING ADDRESS: 2420 Knapp Street, Brooklyn NY, 11235	**MAILING ADDRESS:** 298 Main Street, Keene, NH 03431
PHONE: 6033527311	**PHONE:** 6033527311
EMAIL: zmargulies@recover-care.com	**EMAIL:** mcastor@alpine-hc.com
SIGNATURE: Zisha M **DATE:** 02/27/2024	**SIGNATURE:** Zisha M **DATE:** 02/27/2024
PRINTED NAME: Zisha Margulies **TITLE:** CEO	**PRINTED NAME:** Zisha Margulies **TITLE:** CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY: N/A	**NAME/COMPANY:** PHC SNF Management LLC
MAILING ADDRESS:	**MAILING ADDRESS:** 2420 Knapp Street, Brooklyn, NY 1123
PHONE:	**PHONE:** 7189423483
EMAIL:	**EMAIL:** mcastor@alpine-hc.com
SIGNATURE: **DATE:**	**SIGNATURE:** Zisha M **DATE:** 2/27/2024
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Zisha margulies **TITLE:** CEO

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

1. Alpine Healthcare is an 85 bed long term care and short term care healthcare facility at 298 Main Street, Keene, NH.

2. Alpine Healthcare provides healthcare services to a range of residents. Alpine Healthcare provides all aspects of daily living care needs to its residents, including but not limited to care from Licensed Nursing Assistants, Registered Nurses, Licensed Practical Nurses, Certificed Medication Assistants, Social Work, Physical Therapy, Occupational Therapy and Speech Therapy as deemed necessary by the residents medical plan of care.

3. Alpine provides services to its residents 24 hours a day, 7 days a week. Alpine has capasity for 85 residents at one point in time with typical staff of 120 staff on varied shifts and in varied departments.

4. Alpine provides Long Term and Short Term Healthcare to its residents with varied lengths of stay.

5. Peak Healthcare at Keene, LLC. 298 Main Street, Keene, NH, 03431, 603-352-7311

6. Peak Healthcare at Keene, LLC. 298 Main Street, Keene, NH, 03431, 603-352-7311

7. Please see attached Licenses

8. Plans- Alpine Healthcare currently holds Life Safety, Facility Assessment, Staff Training, Clinical Policy and Procedure, Building Management System and Emergency Protection Plans to encompass Operations and Management Plans.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

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2. Alpine Healthcare provides healthcare services to a range of residents. Alpine Healthcare provides all aspects of daily living care needs to its residents, including but not limited to care from Licensed Nursing Assistants, Registered Nurses, Licensed Practical Nurses, Certificed Medication Assistants, Social Work, Physical Therapy, Occupational Therapy and Speech Therapy as deemed necessary by the residents medical plan of care.

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SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

Alpine provides Long Term and Short Term Healthcare to its residents with varied lengths of stay.

Licenses

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: ALPINE HEALTHCARE CENTER
Located at: 298 MAIN ST
KEENE NH 03431

To Operate: Nursing Home

This annual license certificate is effective under the conditions and for the period stated below:

License#: 04458
Effective Date: 10/01/2022 Expiration Date: 09/30/2023
Administrator: MELISSA CASTOR
Medical Director: HARIS BILAL, MD

Total Number of Beds: 85

Chief Legal Officer

State of New Hampshire

Board of Examiners of Nursing Home Administrators

Authorized as

Nursing Home Administrator

Issued To

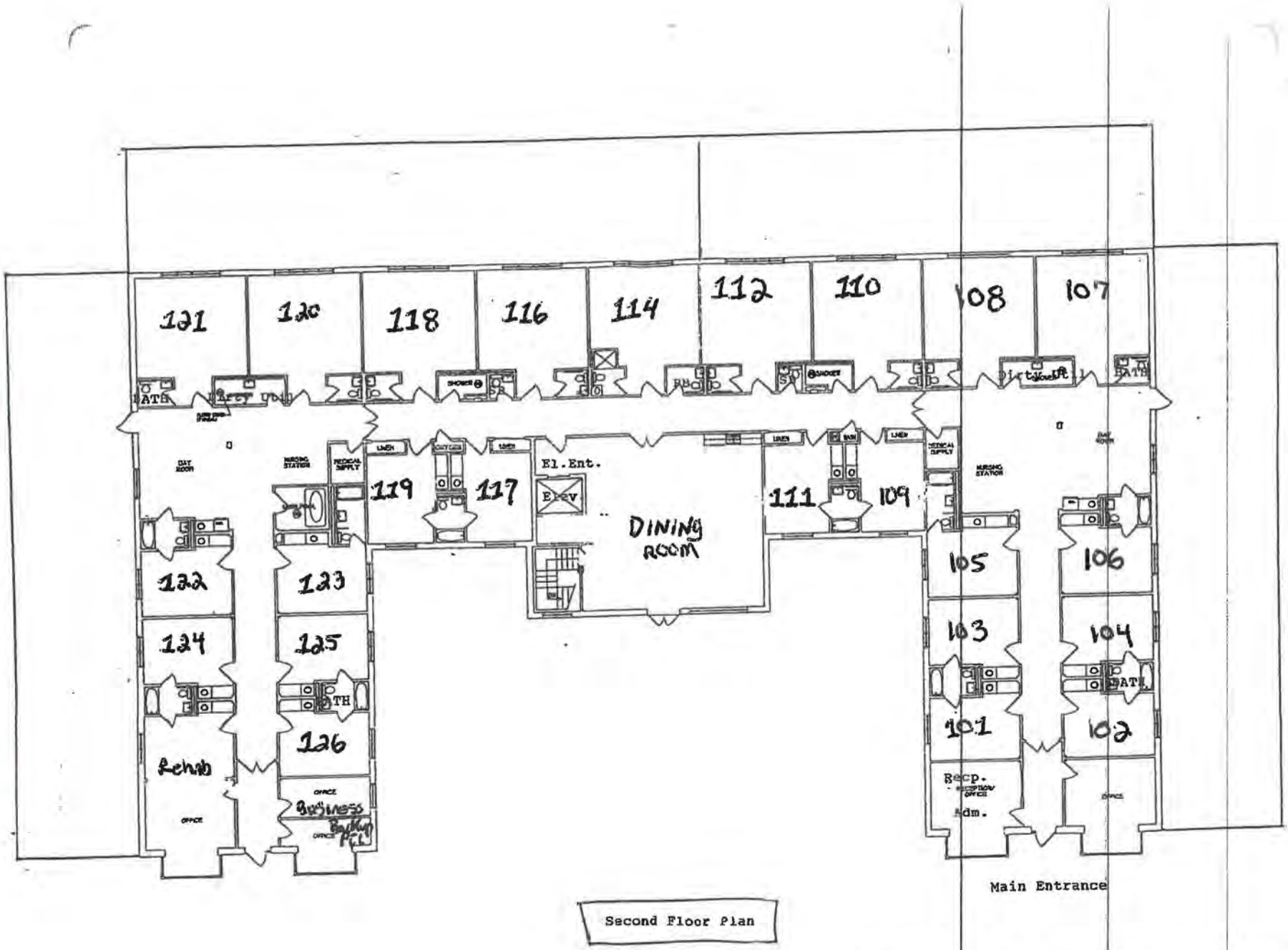
MELISSA LEIGH CASTOR NHA

License Number: 3856
Current

Issue Date: 03/02/2022

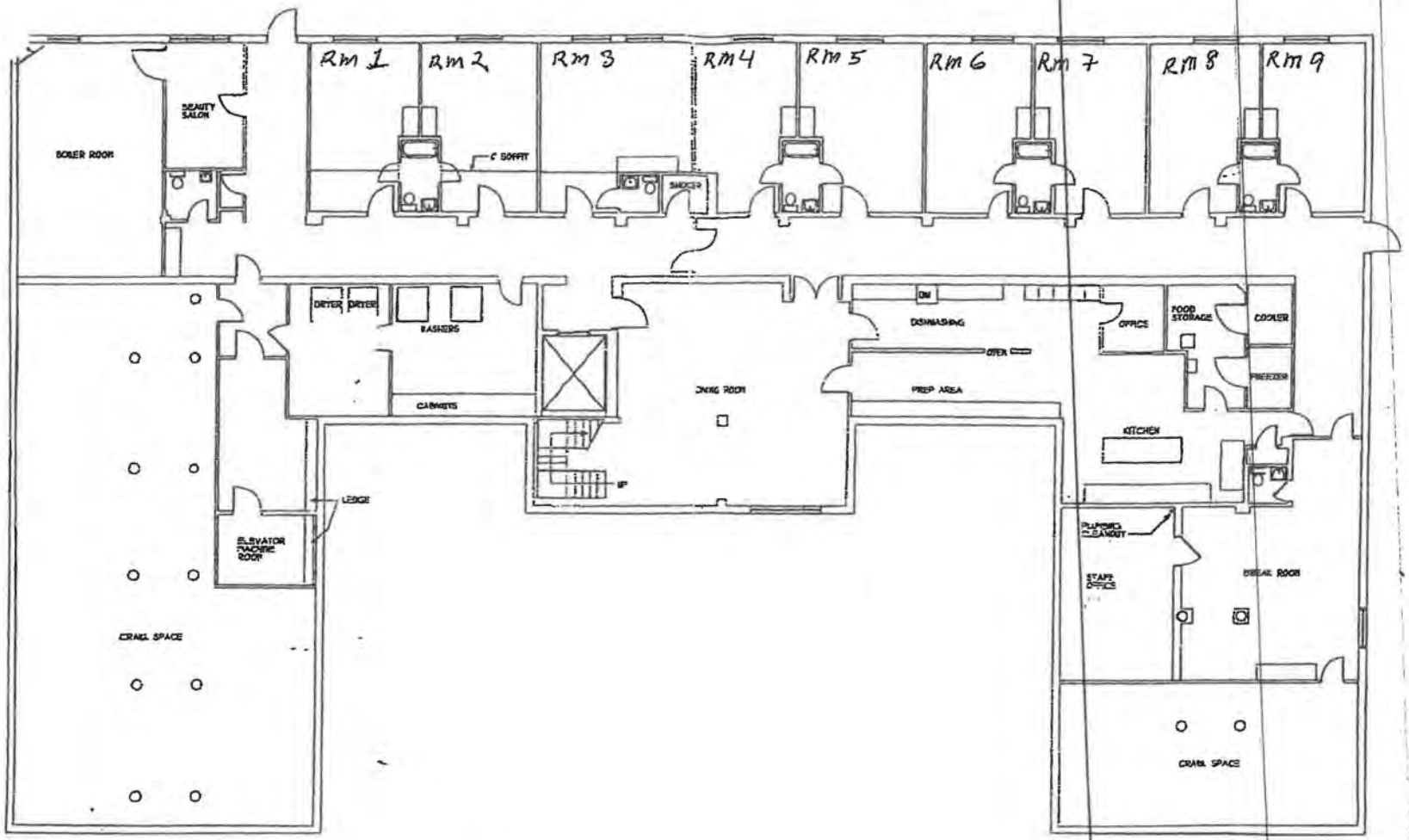
Expiration Date: 12/31/2024

Floor Plans



Second Floor Plan

total Square footage: 26,805 Sq ft
Skilled : 4151 Sq ft
LTC : 8556 Sq ft



1 FIRST FLOOR PLAN
SCALE: 1/8" = 1'-0"

Emergency Preparedness Plan

Contents within Plan:

Security

Life Safety

Neighborhood relations

Emergency Response

Health and Safety

ALPINE
HEALTHCARE CENTER

Center Emergency Preparedness Plan (EPP) 2023

Center Name: Alpine Healthcare Center
Address: 298 Main Street Keene, NH 03431
Phone Number: 603-352-7311

This document outlines the center's integrated approach to emergency preparedness. When appropriate, the center team contacts local emergency response services officials and other healthcare providers, to participate in collaborative and cooperative planning efforts. This Emergency Preparedness Plan is reviewed and updated annually, and on an as-needed basis.

IMPORTANT NOTE: After this document has been reviewed completed by the center Emergency Preparedness Leadership Team, it must be saved electronically on Central and printed and stored in multiple, unlocked locations that may be accessed by center staff.

SAFETY PHILOSOPHY

This center is committed to operating in a manner that promotes the safety, health, and well-being of our staff while providing the quality care to all of our customers. We strive to continually develop, promote, and enforce safe work practices and provide a healthful working environment consistent with established federal, state, and accreditation requirements. This center encourages team cooperation and collaboration with local, tribal, regional, state and/or federal emergency preparedness officials to participate in an integrated response during disaster and emergency situations.

Information contained in the Emergency Preparedness Plan (the "Plan") is based on available best practices. The Plan has been prepared as guidance for emergency response and crisis management. It cannot be assumed that the Plan takes into consideration all potential events, scenarios, and/or circumstances. As a result, the Plan is designed to be flexible based on the specific and unique circumstances, conditions, and/or events related to any emergency situation. Notably, while the Plan has been developed consistent with legal authority, the experiences and judgments of those responsible for local leadership and implementation of the Plan will determine how best to utilize it in an emergency situation. This center does not make any guarantees or representations related to the absolute sufficiency and comprehensiveness of the Plan, and notes that additional information/steps may be required in the event of an actual emergency.

Throughout this document, the terms "disaster" and "emergency" are used. Emergency is defined as a serious, unexpected, and often dangerous situation requiring immediate action; disaster is a sudden event, such as an accident or a natural catastrophe, that may cause great damage or loss of life. This Plan is written to address both types of events. The term "staff" is also used, to reference center employees, contract personnel, regularly scheduled volunteers and medical professionals that provide service to center residents and patients.

Table of Contents

I. EPP GENERAL STATEMENT/PURPOSE

THE PURPOSE OF THIS PLAN IS TO PROVIDE GUIDELINES FOR THE CENTER TO:

A. Respond effectively during disasters/emergencies;
B. Reduce human vulnerability to adverse effects of the disaster or emergency;
C. Reduce environmental and structural vulnerability to adverse effects of the disaster/emergency;
D. Provide care and services to the center's residents/patients during an emergency and/or an evacuation;
E. Identify staff responsibilities during an emergencies;
F. Provide timely and effective communication;
G. Provide for recovery after the emergency.
H. Comply with relevant legal authority and guidance including but not limited to: Life Safety Codes, OSHA's Employee Emergency Action Plans (29 CFR 1910.38), CMS guidelines, elements of the Nursing Home Incident Command System (NHICS), and any pertinent state/local requirements.

II. SCOPE OF PLAN

A. THIS CENTER HAS THE POTENTIAL OF BEING AFFECTED BY, BUT NOT LIMITED TO, THE FOLLOWING EMERGENCIES:

1. Threats to security;
2. Utility failures;
3. Weather conditions,
4. Structural damage from fires or explosions;
5. Chemical spills; and
6. Community disasters.

B. THESE SITUATIONS MAY REQUIRE:

1. Suspension of routine processes (further described below);
    i. Center employees performing non-routine tasks should understand the task completely. If a staff member does not know how to safely perform the task, the employee is guided to ask their department head for instructions on how to safely perform the task. If the department head is not aware of the task's safety considerations, the department head will contact the Director of Employee Safety for guidance.
2. Triage;
3. Decision-making regarding evacuations and sheltering-in-place;
4. Evacuation of residents/patients, visitors and personnel; and
5. Acceptance of unscheduled admissions.
    i. The Center only accepts admissions within its scope of care unless directed by a regulatory agency.
6. Searching for resident off premises during a community-wide emergency.

C. THIS PLAN IS DEVELOPED SPECIFICALLY FOR THIS CENTER BASED ON A SITE-SPECIFIC HAZARD VULNERABILITY ASSESSMENT, AND INCLUDES:

1. A developed and tested incident management process, including the center's communication plan;
2. A corresponding analysis of the resources of the center;
3. Center-specific planning and response tools for emergency management; and
4. Elements that promote collaboration and interoperability, and communication with state, local, tribal and community resources.

This center provides a copy of this completed plan to the local Emergency Management Services on an Annual Basis, and as necessary.

Refer to: Appendix 1: Hazard Vulnerability Assessment (HVA)

III. GENERAL GUIDELINES

A. WHEN POSSIBLE, THIS CENTER TAKES ADVANTAGE OF AVAILABLE LEAD-TIME BEFORE EMERGENCIES. STAFF SHOULD:

1. Immediately report all potential emergency and/or disaster situations to the Center Executive Director (CED) or designee and the Center Nurse Executive (CNE).
   i. Notify additional department heads or designees as instructed by the CED.
2. CED/designee: Notify the Regional Vice President of Operations (RVP) of any potential emergency situation. Provide a copy of this completed plan to the local EMS.
3. Keep a radio/television tuned to an emergency weather channel or other Emergency Alert System broadcaster on at all times.
4. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, communication plan and contact information.
5. Locate the emergency and protective action supplies. Replenish if necessary.
6. Clear corridors of obstructions.
7. Reassure residents/patients, visitors, and team members.
8. Assist in the Incident Commander (see below) determinations regarding the number and mix of employees necessary if emergency is activated.
9. Notify the CED, CNE, or designee of the potential staffing and supply needs.
10. Conserve resources (e.g., water, linen, supplies, etc.)
11. Keep phone lines free of personal calls.
12. Ensure a supply of food and water is available for residents/patients and staff in collaboration with the Dining Services Director.
    i. The center acknowledges during a disaster, visitors may be present. The center's first priority for water and food distribution is to staff and residents.
    ii. Note: Water can be used indefinitely as long as container intact. Dates do not imply expiration.
13. Be sure resident census is updated and accurate.
14. Estimate the number of ambulatory and non-ambulatory residents, and identify residents on transmission based precautions that will need cohorting or segregation from other residents.
15. Identify residents with communication impairments and limited English proficiency, and plan for interventions to provide effective communication, such as interpreter services, large print or translated materials.
16. Centers with pets or resident service animals should consider the pets/animals in any emergency situation - i.e. food, water, care needs, and handling/controlling the animal.

B. NOTIFICATION and INCIDENT COMMANDER (f.k.a. Emergency Director)

1. During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the CED/Designee arrives. This person immediately contacts the CED/Designee.
2. When on-site, the CED/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. Refer to Appendix 22 for the center succession plan.
3. The Incident Commander is responsible for activation, implementation, and termination of the Emergency Preparedness Plan, staff assignments, patient oversight and associated documentation.
4. The Incident Commander is responsible for contact, and collaboration with, as appropriate:

i. Department heads;
ii. RVP;
iii. Residents' and responsible parties;
iv. State Licensing Board;
v. Local, tribal, regional, state or federal emergency management officials; and
vi. State Ombudsman Office.

C. LEVELS OF EMERGENCY

After determining that an emergency situation exists, the Incident Commander declares an emergency. The levels of emergency are:

1. ***Alert.*** Disaster possible; increased awareness. CED or designee notified;
2. ***Stand By.*** Disaster probable, ready for deployment. All department heads notified;
3. ***Activate.*** Disaster exists, deployment. Department heads or designees report to Center; and
4. ***Stand Down.*** Disaster contained, resumption of normal activities.

D. NOTIFICATION OF PLAN

Residents are notified of the EPP via a statement in the Admission Kit and a posting in the Center. The Center Executive Director requests time to review the EPP during Resident Council meetings.

Refer to Posting GHC 5408 in SmartWorks and the Emergency Preparedness Compliance Guide.

IV. COMMAND AND CONTROL

A. The Incident Commander coordinates activities in the center.

B. All staff are generally considered to be essential for the duration of a declared emergency.

C. Emergencies are typically managed from a central location, identified as the Emergency Operations Center.

Refer to:

Appendix 2: Building Construction and Life Safety

Appendix 3: Center Administrative Staff Contact List

Appendix 4: Emergency Operation Center Designation

V. COMMUNICATION PLAN

Communication Procedures during COVID-19

The Center will inform residents, resident representatives, and families of those residing in facilities, by 5:00pm the next calendar day (or sooner if required by state law), following the occurrence of a single confirmed infection of COVID-19, or three or more residents or staff with a new onset of respiratory symptoms occurring within 72 hours of each other. The information will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered. The Center will include any cumulative updates for residents, resident representatives, and families, at least weekly or by 5:00pm the next calendar day (or sooner if required by state law), following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified or whenever three or more residents or staff experience a new onset of respiratory symptoms within 72 hours of each other.

Procedures for Non-COVID-19 Communications Plan

During emergencies, this center uses primary and alternate means of communication. Landline telephone and cell phones are primary means; email, and text messaging are alternate means for communication efforts. (Two-way radio communications are used where required to communicate with the local EMS during a regional emergency.)

A. INTERNAL

1. The Incident Commander is responsible for communicating the initial and ongoing situation status with the center's department heads and Regional Vice-President (RVP) of Operations or designee.
2. The RVP or designee is responsible for communicating the status of any emergency to area/division leadership and appropriate corporate staff.
3. Center staff attempt to use simple, precise language when communicating during an emergency. Codes are not used.

Refer to:
Appendix 5: Area Administrative Contact List
Appendix 6: Company Contacts

B. EXTERNAL

The Incident Commander is the key spokesperson for the center and:

1. Notifies and communicates with regulatory and community agencies and resources regarding the center's occupancy, status, needs and ability to provide assistance;
2. Notifies/self-reports incidents involving fire, death, and/or serious bodily injury in accordance with federal and state guidelines.
3. Facilitates access to radio/TV or other media and issues news releases, statements and/or advisories in collaboration with Area/Division/Corporate leadership.
   a. Center employees do not communicate directly with the media; rather, all communication is provided via centralized communications. (Refer to Appendix 6.)

C. CRISIS PUBLIC RELATIONS: STAFF MEMBERS, VOLUNTEERS, CONTRACTORS, PHYSICIANS, FAMILY OF RESIDENTS AND COMMUNITY (INCLUDING OTHER LONG TERM CARE FACILITIES, AS APPOPRIATE)

1. In advance of a crisis or disaster situation, the center works to ensure that staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand that the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations.

D. COMMUNICATION WITH RESIDENTS, FAMILY MEMBERS AND OTHERS

1. This center uses the Genesis HealthCare CareLine as the emergency contact number (866-745-2273) as alternate communication in addition to primary telephone numbers for the residents' responsible parties and family members for contact during an emergency.
2. Based on direction from the CED/Incident Commander, residents, responsible parties and family members are notified as soon as possible when there is an emergency declaration at the center by center staff in person, via telephone, and through use of the Genesis CareLine. This communication includes patients who are included in census but outside of the center at the time of the emergency (i.e., at external physician appointments, dialysis, etc.). If the center determines that additional alternate communication methods are needed, the Incident Commander works with company resources to obtain support, equipment and services.
3. If the center determines that it has additional surge capacity (see below), local EMS and other long term care providers are notified of such capacity.
4. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts, and to assist patients in receiving the care they need. In addition, while the HIPAA Privacy Rule is not suspended during an emergency, the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the privacy rule.
    a. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices.
    b. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures, and apply administrative, physical and technical safeguards of the HIPAA Security Rule to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy if possible, and disclosures are limited to the minimum necessary to accomplish the purpose.
    c. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

Refer to:
Appendix 7: Emergency Resources and Contacts
Appendix 8: Additional Resources

VI. INTERNAL FUNCTIONS

A. THE CENTER TAKES ADVANTAGE OF LEAD-TIME BEFORE EMERGENCIES:

1. Staff should notify the CED or designee and CNE of all potential emergency situations.
2. Keep a radio/television on at all times (if possible) and tuned to an emergency weather channel or other Emergency Alert System broadcaster.
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, emergency supplies, communication plans and appropriate contact information, with staff, visitors, volunteers and onsite contractors. Staff are monitored through use of the staffing schedules (updated as needed), and volunteers, visitors and others are monitored using the visitor log (typically kept in the reception area).
    i. Locate the emergency supplies; replenish if necessary. Refer to **Appendix 12: Emergency Supplies and Location of Critical Equipment**.
        a. The following equipment is available at this center: wheelchairs, walkers and canes, portable/folding chairs (for Staging Area), oxygen concentrators, IV poles, feeding pumps, suction machines, bedside commodes.
        b. The following medical supplies are available at this center; first aid supplies, gauze, bandages, alcohol, triple antibiotic ointment, disposable gloves, eye protection, disposable gowns, surgical masks, BioMasks, N95 respirators, saline eyewash solution, incontinence products, barrier cream, sanitizing wipes, hand sanitizer, medications, medication cups/straws, shelf-stable nutritional supplements, food thickener, bladder catheter supplies, sterile pads, first aid tape, syringes, stretch gauze, elastic bandages, glycerin swabs, normal saline, and insulin supplies.
4. Remind staff to remain calm and in control, for organized response and to reassure the residents.
5. Clear corridors of obstructions.

B. DEPARTMENT HEAD EMERGENCY RESPONSIBILITIES:

1. Train personnel on department responsibilities;
2. Assign on-call responsibility for emergency management;
3. Provide support as directed by the Incident Commander;
4. Assure emergency duties are assigned;
5. Assign duties to staff based on physical capabilities and competencies;
6. Maintain a current list of all employees and their phone numbers.
7. Identify staff interested in volunteering to work in receiving facilities if evacuation is initiated.
8. Determine the minimal number and mix of employees necessary if an emergency is activated.
9. Notify the CED, CNE, or designee of the potential staffing and supply needs.
10. Conserve resources (e.g., water, linen, and supplies).

C. EMERGENCY PROCEDURE: TAKE COVER

1. It is the Incident Commander's responsibility to monitor all threatening situations and determine when the **Take Cover Procedure** is initiated. Situations involving risk to residents, staff, and visitors due to events occurring inside and outside of the center are considered in the decision to **Take Cover**.
2. Upon making the decision to **Take Cover,** an announcement is broadcast over the center intercom system stating the following message:

i. **"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."**
   a. Staff, if it is safe to do so, assist residents to Areas of Refuge identified in Appendix 2 of this EPP. If unsafe, staff takes immediate cover.
   b. Residents who use wheelchairs and cannot get into the Take Cover position are positioned with wheelchairs facing a wall with wheels locked, and covered with linens to help protect from flying debris (time permitting).
   c. Staff, residents and visitors (as they are able to), get into the Take Cover position (see below).

3. Emergency Job Tasks – Take Cover
   i. CED/Incident Commander
      a. Direct all individuals to Take Cover.
      b. Be prepared to contact authorities if injuries and damages occur.
      c. Direct everyone to remain in the refuge area until the danger has passed.
         i. **An "All Clear, Take Cover is over" message is then paged to signal the Take Cover situation has ended.** Afterwards, the Incident Commander accounts for residents, staff, and visitors.
   ii. Nursing Staff
      a. Connect oxygen concentrators/tanks to residents requiring oxygen as needed.
      b. Take first aid supplies/medical supplies to designated Area of Refuge, time permitting.
      c. Relocate the residents to safe refuge and stay in close proximity of the residents while **taking cover**. Maintain transmission-based precautions as best as possible.
      d. Close drapes, blinds, doors, and windows (time permitting).
4. Upon broadcast of the Take Cover announcement, all staff immediately discontinues tasks they are working on and begin implementing their **Take Cover** responsibilities.
   i. Immediately relocate residents and visitors to bathrooms or interior hallways (refer to Areas of Refuge, Appendix 2) away from all windows and doors. Staff closes all drapes, blinds, and doors.
   IMPORTANT NOTE: If residents, visitors, and staff are directed to Take Cover in a hallway having a door or window at the end of the corridor, attempt to keep a distance of 30 feet (30') away from the door or window.

ii. Staff avoid areas with large ceiling spans. Small rooms or interior hallways away from windows and doors are suitable for **taking cover**.
iii. Upon relocating all residents to a safe refuge, the staff stays in proximity of the residents while **taking cover** as well.
iv. **Maintenance staff and Managers on Duty** should be prepared to activate Utility Shut-Off Procedures.
v. All *other* staff members immediately secure records, close drawers and cabinets, shut down electronic appliances, and report to the nearest Area of Refuge (refer to Appendix 2).
vi. If a situation allows for advanced warning, residents, staff, and visitors will be re-located a designated area providing optimum refuge.
   a. Upper floor occupants are moved to the basement or lowest level within the center.
   b. Priority is given to evacuating the highest floor first.
   c. Census is taken to account for all residents, staff, and visitors.
vii. Upon issuance of the All Clear announcement, residents are taken back to their rooms.

D. CED (OR DESIGNEE) ALL EMERGENCIES:

1. CEDs are responsible for execution of Transfer Agreements and/or Memorandums of Understanding (MOU) for patient care and transportation.
   i. Where possible, centers attempt to transfer residents to Genesis-affiliated centers, as this allows for usage of existing databases and continuity of care.
   ii. CEDs use Transfer Agreements and/or MOUs with non-affiliated centers, which are often mutual agreements, to arrange for patient care and services and evacuation transportation. (These agreements are activated after a decision has been made to evacuate.)
2. CEDs activate this Emergency Preparedness Plan when necessary. If applicable, the *National Criteria for Evacuation Decision-Making in Nursing Homes* is reviewed with the management team to evaluate whether to evacuate or Shelter-in-Place. The availability and duration of emergency power is considered when making such determinations.
3. The CED/Designee is the Incident Commander and is responsible for activating and coordinating all activities related to the emergency.
   i. Only the Incident Commander, in collaboration with the RVP and/or an authority with jurisdiction, can declare an evacuation.
4. The CED/Designee contacts the RVP and directs internal and external communication as described above.
5. The CED/Designee contacts the local EMS and collaborates on integrated response, as appropriate.
6. The CED/Designee contacts the Ombudsman, and communicates:
   i. How the residents will be sheltered;
   ii. When/If the residents will be evacuated; and
   iii. Where the residents will be sheltered.
7. The CED/Designee contacts the state licensing board.
8. The CED/Designee notifies the Medical Director and department heads.
9. The CED/Designee instructs staff to keep all doors closed in resident rooms, stairwells and functional rooms (storage, pantry, linen, etc.).

10. The CED/Designee instructs staff regarding suspension of non-essential services and procedures during emergencies.
11. The CED/Designee tracks the incident's progress and disseminates information to respective staff.
12. The CED/Designee determines involvement, appropriate tasks and roles of volunteers.
13. The CED/Designee establishes frequent communication with staff members, residents, and resident responsible parties.
14. The CED/Designee contacts vendors and others who may be needed for post-incident restoration and makes arrangements for services.
15. The CED/Designee completes NHICS Form 251, Center System Status Report to assess the center's damage.
16. The CED/Designee directs additional emergency documentation completion; refer to Appendices and Exhibits in this EPP.

Refer to Appendix 9: Transfer Agreements
Appendix 10: Short-term Evacuation Plan

E. CED (OR DESIGNEE) SHELTER-IN-PLACE (SIP): During emergencies the CED/Designee:

1. Meets with management team to discuss preparations for SIP.
2. Activates the center's SIP Plan as directed by area/divisional, regional, or corporate Leadership; and local authorities.
3. Notifies staff members, residents, and resident responsible parties of the decision to SIP.
4. Instructs individuals in the center to remain until it is safe to leave.
5. When it is safe, allows staff, volunteers, visitors, and vendors to communicate with their family members.
6. Oversees moves of residents to Areas of Refuge as necessary.

F. CED (OR DESIGNEE) EVACUATION: During emergencies the CED/Designee:

1. Activates the center's Evacuation Plan as directed by area, divisional, regional, or corporate leadership; or by local authorities. (Management team then notifies supervisors and staff.)
2. Meets with management team to finalize instructions for evacuation.
3. Coordinates evacuation efforts with local Emergency Management Agencies.
4. Notifies the following of the evacuation decision:
   i. the Genesis CareLine (866-745-2273) to determine bed availability;
   ii. residents and responsible parties of decision to evacuate. Communicates emergency phone numbers including alternate care center numbers;
   iii. the Medical Director; and
   iv. the receiving facility(ies) of the pending arrival.
5. Designates a staff member to monitor and complete the NHICS Master Resident Evacuation Tracking Log Form 255.
6. Notifies alternate care facilities of the pending arrival. Activates Transfer Agreements/MOU as necessary.
7. Secures the center and verifies that all electronics and computers have been turned off and unplugged.

8. Approves shut-down procedures for non-essential utilities and designates appropriate personnel to implement shut-down.
9. Verifies emergency supplies for transport.
10. Initiates recovery and re-entry efforts when deemed safe.

G. SENDING CENTER: ADMINISTRATION TASK LIST

1. Schedule additional staff to coordinate transportation.
2. Work with RVP to schedule transportation.
3. Update original evacuation report to reflect any changes; i.e., residents in hospital.
4. Review return plan with staff and ensure plan is followed.
5. Schedule additional staff to coordinate transportation.
6. Send supplies to receiving center as needed. Consider need to provide beds, wheelchairs, over bed tables, Oxygen, food, water, bathing materials, linens, means for privacy, medical supplies and continence supplies.
7. Communicate daily with receiving center CED on return status.

H. RECEIVING CENTER: ADMINISTRATION TASK LIST

1. Verify all local emergency services are available prior to resident transport.
2. Contact center staff and ensure adequate staff is available to meet the needs of the residents.
3. Schedule staff to prepare the building for residents and ensure adequate supplies for each department are available.
4. Verify local vendors and contractors are available i.e. food and nutrition services, housekeeping/laundry, dialysis, physicians, pharmacy, oxygen, gas stations, x-ray and lab services.
5. Coordinate the return schedule with Senior Vice President of Operations and RVP.

I. CENTER NURSE EXECUTIVE OR DESIGNEE (NURSING): ALL EMERGENCIES

1. During all emergencies nursing is responsible for:
    i. Coordinating resident care;
    ii. Coordinating communication with medical providers;
    iii. Printing and securing the following resident-specific documents:
        a. Admission Record (face sheet).
        b. MARs;
        c. TARs;
        d. Most recent monthly order sheet;
        e. Care Plan;
        f. Weight and VS Summary;
        g. Most recent 7 days of nursing notes;
        h. Most recent physician progress notes;
        i. Behavior Monitoring Form;
        j. Skin integrity report; and
        k. Patient-specific medications, treatment and feeding supplies, including adaptive equipment, special needs items and preventive devices for falls and skin breakdown.
    iv. Obtaining additional clinical staff in collaboration with the CED and Human Resources;
    v. Coordinating resident needs with food and nutrition services and materials management;

vi. Notifying pharmacy services of pending evacuation and alert for need to provide back-up medications;
vii. Communicating the status of care and resident conditions to the CED;
viii. Accounting for and keep track of residents and staff;
ix. Maintaining effective lines of communication with nursing staff members;
x. Preparing medications (one week supply if possible) for those residents going to alternate facilities, hospitals, or home.
xi. Verifying that all physician orders are current and have been obtained for residents.
xii. Updating and printing resident/patient census reports.
xiii. Estimating the number of ambulatory and non-ambulatory residents/patients for transportation and assistance purposes. Identify residents on transmission-based precautions that require cohorting or segregation from other residents.
xiv. Identifying residents with communication impairments, and associated planned interventions and updating resident care plans as necessary.

J. CENTER NURSE EXECUTIVE OR DESIGNEE (NURSING): EVACUATION TASK LIST

1. Designates Phase I and Phase II Evacuation Nurse Coordinators.
   i. Nurse Coordinator Phase I works to transfer the highest acuity residents, first, via ambulance if possible. Considers hospital transfers as appropriate.
   ii. Nurse Coordinator Phase II works to transfer lower acuity residents via the most appropriate methods available. Phase II residents may be moved to a staging area prior to evacuation. Staff members are designated to each of the vehicles to assist and care for the residents during the transport. Identifies patients that may be cared for by family/friends and arranges discharge.
2. Groups the residents according to unit, acuity, and those on transmission-based precautions and assigns staff members accordingly.
3. Prepares the lists of residents and receiving location(s) so staff can prepare clothing, supplies, medications, and any other items.
4. Completes the *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient. This tracking includes patients that are counted in the resident census, even if they are off-site at the time of the emergency.
5. Designates staff members to accompany each group.
6. Assists in coordinating transfer of all residents to alternate hospitals or other locations. Use *NHICS 255 Master Resident Evacuation Tracking Form.*
7. The Evacuation Nurse Coordinators or designees:
   i. Complete *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient, noting patient-specific supplies and equipment.
   ii. Collect patient-specific information (see above).
   iii. Collect the supplies as noted on NHICS 260 and supervise load of medications, supplies and administration records, as necessary, to accompany transport vehicle:
      a. A licensed nurse is assigned to safeguard controlled substances.
      b. If residents needing critical medications are deemed unsafe to carry their own medications, then a licensed nurse carries the medications.
      c. When necessary and appropriate, a separate cooler is provided for temperature-controlled medications.

iv. Contact the CNE of receiving center to inform him/her of the status of the evacuation.
v. Transfer residents from bed and transport in accordance with care plans.
vi. If possible and time-permitting, inspect the residents for:
    a. Proper attire for the weather.
    b. Identification (ID) wristbands (if applicable).
    c. Assistive devices including hearing aids, dentures, glasses, and prosthesis.
vii. Provide a change-of-shift (hand off) report, and include information regarding patients at risk for falls and elopement.
viii. Supervise resident evacuation from the building and the resident flow to transportation.

K. SENDING CENTER: NURSING TASK LIST

1. Provide the *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
2. Pack resident medical record, supplies, clothing, necessary personal items and medications. Inventory sheets are completed if there is ample lead-time.
3. Prepare/pack any special needs equipment or supplies as necessary. (For example: special size Foley/ostomy supplies, enteral feed formula, oxygen).
4. Load residents with assistance from transport crew.
5. Give report and narcotics/controlled medications to transport nurse/crew.
6. Provide the resident records to transport crew.
7. Provide a method for resident identification either via use of wristbands or use of photo identification.
8. **RESIDENT NEEDS IDENTIFICATION**
    i. The sending center nursing team reports significant resident information to receiving center in a verbal or written hand-off report, including (as applicable to each patient). Wristbands may be used for this purpose:
        a. Code status/Advanced Directives
        b. Potential for Fall Risk
        c. Potential for Elopement Risk
        d. Diagnoses
        e. Food, Medication and Other Allergies
        f. Thickened liquid consistency
        g. Diet consistency
        h. NPO Status
        i. Seizures
9. **MEDICATION MANAGEMENT**
    i. Medications are checked against the MARs to ensure all meds are accounted for per physician order before the residents are transported to the receiving center.
    ii. Narcotics/controlled medications are separated and provided to the transport nurse, who keeps control of the medications until arrival at the receiving center.
        a. The transport nurse and CNE or designee include the narcotic count sheet/MAR with each medication.
10. **SPECIAL NEEDS EQUIPMENT**
    i. The CNE/Designee uses the *NHICS 260 Individual Resident Evacuation Tracking Form* to identify special equipment or supplies needed during transport.
    ii. Pressure relief devices for residents identified with specific wound needs.

iii. When possible, special equipment or supply needs (i.e., positioning devices, oxygen (see below) and means of securing oxygen, nebulizers, gel pads, special size colostomy bags) are loaded on the transport vehicle prior to the residents.

11. **OXYGEN**
    i. Oxygen use is documented on the *NHICS 260 Individual Resident Evacuation Tracking Form*.
    ii. Residents requiring oxygen are transported by wheelchair with the oxygen tank secured to the chair. Chair wheels are locked to prevent rolling.
    iii. Extra oxygen tanks are secured to prevent movement.
    iv. Residents requiring oxygen may be transported separately due to limited number of wheelchair spaces on transporting vehicles.
12. **ENTERAL FEEDING**
    i. The CNE/Designee is responsible for ensuring that enteral feeding formula and supplies are packed.
        a. Formula, tubing and syringes are collected and packed for transport, and labeled with the resident name(s).
        b. If support is necessary (i.e. inadequate formula on hand), the CNE/Designee contacts the Regional Manager of Food and Nutrition Services for assistance.

L. TRANSPORTING CREW: NURSING TASK LIST

1. Find/Load first aid kit.
2. Ensure all transported supplies are labeled.
3. Inspect oxygen to ensure that it is secured for transport.
4. Upon arrival at the sending center, notify CED and CNE and obtain a copy of *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
5. Assist with loading assigned residents.
6. Check actual residents loaded against *NHICS 255 Master Resident Evacuation Tracking Form* to ensure accuracy.
7. Check for critical medications and equipment, snacks/drinks, clothing and belongings, and associated administration records (MARs and TARs).
8. Take report from evacuating center nurse and take possession of narcotics.
9. As time allows, document resident condition on departure.
10. Provide care/services as necessary during transport and document such services.
11. Contact the receiving center periodically to coordinate arrival time.
12. Report to the nursing team at the receiving center upon arrival and transfer resident medications, belongings, documentation, and supplies.

M. TRANSPORTING CREW NURSING POLICY AND PROCEDURE

1. OXYGEN
    i. The center uses *NHICS 260 Individual Resident Evacuation Tracking Form* to identify residents that require continuous or PRN oxygen. Residents with continuous or PRN oxygen needs are transported via wheelchair so the oxygen tank can be secured to the chair. During transport, the chair wheels are locked to prevent rolling. Residents using oxygen may be transported separately due to the limited number of wheelchairs spaces on transport vehicles.
    ii. Extra oxygen tanks are secured to prevent movement.

a. **Guidance for the Safe Transportation of Medical Oxygen for Personal Use**
   i. Vehicle operators take precautions to ensure that medical oxygen for passengers' personal use is handled and transported safely.
   ii. **For Transportation in the Passenger Area Task List/Instructions:**
      1. Only transport oxygen in a cylinder maintained in accordance with the manufacturer's instructions. The manufacturer's instructions and precautions are usually printed on a label attached to the cylinder.
      2. Before boarding, inspect each cylinder to assure that it is free of cracks or leaks, including the area around valve and pressure relief device. Listen for leaks; do not load leaking cylinders. Visually inspect the cylinders for dents, gouges or pits. A cylinder that is dented, gouged, or pitted should not be transported.
      3. Limit the number of cylinders to be transported on board the vehicle to the extent practicable.
      4. If transportation arrangements allow, the vehicle operator considers limiting the number of passengers requiring medical oxygen.
      5. Cylinders used for medical oxygen are susceptible to valve damage if dropped. Handle these cylinders with care during loading and unloading operations. Never drag or roll a cylinder. Never carry a cylinder by the valve or regulator.
      6. Do not handle oxygen cylinders or apparatus with hands or gloves contaminated with oil or grease.
      7. Secure each cylinder to prevent movement and leakage. "Secured" means the cylinder is not free to move when the vehicle is in motion. Each extra cylinder should be equipped with a valve protection cap.
      8. Oxygen cylinders or other medical support equipment are not stored or secured in the aisle. Make sure the seating of the passenger requiring oxygen does not restrict access to exits or use of the aisle.
      9. Since the release of oxygen from a cylinder could accelerate a fire, secure each cylinder away from sources of heat or potential sparks.
      10. Smoking or open flames (cigarette lighter or matches) are not permitted in the vehicle when medical oxygen is present.
      11. When the destination is reached, remove all cylinders from the vehicle as soon as possible.
   iii. **For Transportation in the a Cargo Compartment Task List:**
      1. Place each cylinder in a box or crate or load and transport in an upright or horizontal position.
      2. Protect valves from damage, except when in use.
      3. Secure each cylinder against movement.

2. NARCOTICS/CONTROLLED MEDICATIONS
   i. When necessary, narcotics/controlled medications are transported from the sending center to the evacuation center.
   ii. All narcotics/controlled medications should have the count sheet/MAR attached to the medication.

iii. A log listing the narcotics/controlled medications/MAR for each resident is sent to the receiving center. A copy is provided to the transporting nurse.
iv. A nurse completes a narcotic count with the receiving center nurse upon arrival.
v. All narcotics/controlled medications should remain in the possession of a nurse during transport.

3. ILLNESS OR DEATH ENROUTE
   i. If a resident/patient has a significant change in condition or expires during transport, the transporting vehicle diverts to the closest acute care center, if possible.
      a. If this is not possible, the transport crew alerts the receiving center and manages the patient situation until arrival.
4. DOCUMENTATION
   i. During transport, the transportation nurse/crew document resident conditions and status at the time of transfer and also documents medications administered, treatments given and any other information that is deemed pertinent.

N. NURSING: RECEIVING CENTER TASK LIST

1. On arrival take report from the transport nurse/crew and count narcotics/controlled medications.
2. Complete triage.
3. Pull original documents from the transport nursing documentation, make copies, and return original documentation to the sending center as soon as possible, and as appropriate.
   i. Give copies of the documentation from the sending center to medical records for retention to support continuity of care during the evacuation process.
4. Review MARs and TARs against documentation received from sending center to ensure all physician order changes were posted to these documents. Review other changes to identify orders for continuation.
5. Depending on appropriateness and availability, arrange for grief counselors to counsel evacuees.

O. NURSING: TRIAGE EVACUATION RECEIVING CENTER TASK LIST

If possible, set up stations for providing care as follows:

1. Station I: Complete the resident admission assessment including:
   i. Vital signs with pain assessment
   ii. Evaluate presence of infections
   iii. Weight
   iv. Height

   Provide resident belongings to receiving nurse along with resident assessment information.
2. Station II: Provide
   i. Hydration
   ii. Snacks
3. Station III:
   i. Transport resident and belongings to assigned room
   ii. Provide as-needed personal care

P. NURSING: SHELTER-IN-PLACE TASK LIST

1. Assist in moving residents to Area of Refuge (if indicated) and frequently monitor their conditions.

2. Connect oxygen concentrators/tanks to residents requiring oxygen.
3. Take first aid supplies/medical supplies to designated safe areas and initiate treatment.
4. Be prepared to assist as needed at the direction of the Incident Commander.

Q. NURSING: EXPANSION/SURGE OF RESIDENTS

1. Coordinate triage of casualties, if necessary.

Refer to Appendix 11: Triage of Casualties

R. MEDICAL DIRECTOR: ALL EMERGENCIES TASK LIST

1. If possible and appropriate, report to the center;
2. Provide assistance as appropriate, via telephone, electronically or in-person, during an external or internal emergency requiring medical evaluation and /or intervention and coordinate the activities of physicians as necessary;
3. Coordinate unplanned admissions resulting from external emergencies with the Center Nurse Executive;
    i. The center only accepts admissions within its scope of care unless directed by a regulatory agency.
5. Triage casualties;
6. Obtain additional medical resources in collaboration with the SVP/VP of Medical Affairs or Regional Medical Director; and
7. Assist center with transfer decisions and emergency orders if attending physician cannot be reached.

S. HUMAN RESOURCES AND SCHEDULING: ALL EMERGENCIES TASK LIST

Human Resources /Benefits Designee and Scheduler are responsible for scheduling and assembling adequate staff, in consultation with the CED/Designee:

1. Maintain current information all center personnel and volunteers with addresses and phone numbers for contact purposes;
2. Coordinate with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event that staff is needed in alternate locations;
3. Update the department heads with results of attempts to obtain staff. Confirm expected availability as well as the number of family members joining the staff members;
4. Coordinate, if necessary, transportation of the center staff to work;
5. Monitor the length of time each employee works during the declared emergency and provide adequate time off to rest and recover. Time worked should not exceed sixteen (16) hours over a 24 hour period if possible;
6. Identify areas where employees can rest and recover;
7. If necessary, work with regional Human Resources staff to contact other Genesis centers to obtain additional staff.

T. FOOD AND NUTRITION SERVICES: ALL EMERGENCIES TASK LIST

The Dining Services Director or designee:

1. Follows the Food and Nutrition Services Policies and Procedures, Food Service Emergency Plan and associated guidelines including a plan to obtain food and water in the event of an emergency;
2. Obtains additional staff in collaboration with Human Resources;
3. If power outage is likely, may set refrigerators and freezers to the lowest setting to preserve items for the longest possible time period.
4. Unplugs non-essential equipment.
5. Obtains supplies of food and water for residents/patients and staff;
6. Creates water supply:
    i. Fill tubs, pitchers, and as many containers as possible with water;
    ii. Bags as much ice as possible and stores bags in the freezers; and
    iii. If advanced warning is provided, purchases ice and stores in freezers;
7. Determines the numbers of residents, visitors, volunteers, and employees for whom food service may need to be provided.

8. Provides food service as appropriate and able. Refer to Exhibit 1 for Sample Emergency Menus.

U. FOOD AND NUTRITION SERVICES EMERGENCY EVACUATION GUIDELINES

The Dining Services Director/Designee:

1. Coordinates food service with the center Incident Commander, following the EPP.
2. Provides adequate snacks and fluids for each vehicle transporting residents.
   i. A sample snack menu, extended for consistency modified and Gluten-Free diets, has been developed for these purposes and may be customized as needed.
   ii. All therapeutic diets are waived during an emergency, with the exception of consistency-modified and Gluten-Free diets, as allowed by state regulations.
   iii. Packaged snacks and fluids (including thickened water) are provided in disposable containers or bags if possible, with labeling for consistency-modified and Gluten-free (when appropriate).
3. Gathers relevant vital resident and department records.
   i. Enteral feedings for residents are managed by nursing staff with support from the Dining Services Director/Designee.

V. SENDING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

If possible, the Dining Services Director or designee sends Food and Nutrition Services staff ahead to the receiving center(s) to prepare snacks and fluids for residents **on their arrival.**

1. Consult with the Regional Manager of Food and Nutrition directly to review plans for evacuation.
2. Dining Services Director makes plans for meals to be served prior to transport. (Note: Meals may be served inconsistently with the normal center schedule to ensure that residents are prepared and fed at designated departure times.)
3. Create/Print diet roster for distribution to receiving facilities.
4. Create/Print 2 tray card copies for each resident.
5. Prepare a simplified master list of shelf-stable snacks and liquids, including those for specific-consistency diets and thickened liquids; include disposable supplies (napkins, plastic cutlery).
6. Prepare and label snacks for consistency-altered diets (Dysphagia Advanced and Puree). A snack list identifying snacks for consistency-altered diets is included for transport.

W. RECEIVING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director and assigned staff arrive at the center in sufficient time to allow for inventory of food items to ensure nutrition needs of the residents.
2. The Dining Services Director/Designee prepares beverages and light snacks, including those appropriate for consistency-altered diets and thickened liquids to be provided upon evacuated residents' arrival to the center.

X. REHABILITATION SERVICES: ALL EMERGENCIES TASK LIST

1. The Director of Rehab or designee:
   i. Assists with triage, transfer, or evacuation of residents;
   ii. Obtains additional staff in collaboration with Human Resources; and
   iii. Directs rehab staff to assist on the units as required.

Y. MAINTENANCE SUPERVISOR: ALL EMERGENCIES TASK LIST

1. Gather emergency supplies. See *Appendix 12: Emergency Supplies Checklist*;

2. Evaluate the safety of the physical plant;
3. Coordinate emergency repairs;
4. Communicate the status of the center environment to the CED.
5. Make rounds of the center and grounds.
6. Secure potential flying debris (above, below, around, and in the center).
7. Check equipment for functionality.
    i. Monitor fuel supply for generator; and
    ii. Check that equipment and utilities are functioning properly.
8. Prepare all vehicles for evacuation if needed.
    i. Check fuel, oil, and water levels for each vehicle.
    ii. Move vehicles away from trees.
    iii. Prepare maps/obtain directions with evacuation routes and alternate routes for each vehicle. (Note: A paper map with all routes should accompany each vehicle.)
    iv. Load phone or other communication devices in each vehicle.
    v. Load first aid kit in each vehicle.
    vi. Identify storage space for medical and business records, medications, and equipment in each vehicle.
        a. Identify oxygen storage area, as needed, in each vehicle. Follow the guidelines above for oxygen transport in vehicles.
9. Transporting Crew/Maintenance: Administration TASK LIST
    i. Service van as necessary to include air conditioning, oil, gas, tires, fire extinguisher, safety belts, etc. are all in good condition by completing the Pre-trip Vehicle Safety Inspection Checklist. Check transport supplies and load them into the vehicle.
    ii. Identify route with maps for travel from evacuating center, to receiving center and back to original center as appropriate.
    iii. Identify van driver, licensed staff transporting evacuees, and schedule departure. Staff are made familiar with the use of safety devices in the vehicle.
    iv. Bring money or purchase cards in the event supplies are needed during for the trip.
    v. Load communication devices.

Refer to Appendix 12: Emergency Supplies and Location of Critical Equipment

Z. MAINTENANCE SUPERVISOR: EVACUATION TASK LIST

1. Secure the center and verify all electronics and computers have been turned off and unplugged.
2. Designate someone to stay behind, if deemed safe, to safeguard the center.
3. Activate shut-down procedures for non-essential utilities.
4. Work with responding emergency agencies on building security, traffic control, utility control, and elevator operations.
5. Make final rounds of the center and grounds.
6. Secure windows and other building openings.
7. Pull shades and close all drapes.

AA. MATERIALS MANAGEMENT (CENTRAL SUPPLY): ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain medical supplies;
2. Provide supplies and linens to the nursing units; and
3. Notify medical and medication suppliers of additional needs.

BB. SOCIAL WORK: ALL EMERGENCIES TASK LIST

1. Provide support and crisis intervention services for residents, residents' families, and staff;
2. Notify responsible parties and residents, as directed by the CED/Incident Commander of decisions to Shelter-in-Place or Evacuate, and resident status.
3. Review and update Advanced Directives.
4. Manage resident discharges and placement, if possible based on resident/responsible parties' requests, as necessary and appropriate.
5. Follow-up within 24 hours, if possible, to confirm care and services for discharged residents.

CC. SENDING CENTER: SOCIAL SERVICES TASK LIST

1. Contact families of evacuated residents to let them know the residents' location.
2. Assist CNE in supervising certified nursing assistants as they pack and inventory residents' belongings.
3. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment and care plan accordingly.
   a. For residents experiencing adjustment difficulty, follow up as indicated.

DD. RECEIVING CENTER: SOCIAL SERVICES TASK LIST

1. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment and care plan accordingly.
2. Assist CNE in supervising certified nursing assistants to ensure that resident's personal belongings are made available to each resident and inventoried in accordance with established procedures.
3. Notify Responsible Parties of resident arrival/admission.
4. Assess psychological/social needs to ensure needs and preferences are communicated to the interdisciplinary team.
   a. Follow up with status call to Responsible Party as soon as possible following admission.

EE. ADMISSIONS DEPARTMENT: ALL EMERGENCIES TASK LIST

1. Maintain a current list of residents;
2. Print face sheets if evacuation is possible;
3. Coordinate admissions with the CNE/CED;
4. Assist social services with contacting responsible parties; and
5. Report available transportation and receiving center capacities to the Incident Commander.

FF. ADMISSIONS DEPARTMENT: EVACUATION TASK LIST

1. Notify agencies with Center Transfer Agreements of the emergency situation and potential to evacuate;
2. Communicate resident information and status to the receiving center; and
3. Maintain a list that includes each resident name, and the time and place of each resident's transfer.

GG. BUSINESS OFFICE/PAYROLL: ALL EMERGENCIES TASK LIST

1. Manage payroll.

2. Provide the means to pay for food, supplies, and/or transportation.

HH. BUSINESS OFFICE/PAYROLL: EVACUATION TASK LIST

1. The Cash Handler secures the following items for evacuation: center petty cash, resident trust fund (RTF) petty cash, resident trust check stock, printed copy of most recent RTF Trial balances, imprest checkbook, payments to be deposited and, if applicable, purchase cards.
2. Turn off and unplug all computers.
3. Take laptop(s), if applicable.

II. ENVIRONMENTAL SERVICES: ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain linen in the event of an emergency.
2. Secure linens, blankets, trash can liners, mops, rags, buckets, trash cans, cleaning and disinfecting supplies, and toilet paper.
3. Place emergency orders for supplies.
4. Clear corridors of any obstructions such as carts, wheelchairs, etc.
5. Check equipment (wet/dry vacuums, etc.).
6. Unplug non-essential equipment.
7. Maintain sanitation considering best practices for infection control.

JJ. LAUNDRY: ALL EMERGENCIES TASK LIST

1. Close all laundry chutes.
2. Unplug non-essential equipment.

KK. MEDICAL RECORDS: EVACUATION TASK LIST

1. Prepare resident medical records transport to the appropriate receiving facilities.
2. Assist nursing to obtain charting from each nursing station and provide them to the transporting nurse.
3. In situations of planned evacuation to affiliated centers, centers follow a process to obtain/grant access to electronic medical records. Refer to the Planned Evacuation process on Central for details.

LL. RECEIVING CENTER: MEDICAL RECORDS

1. Place the Clinical Record at the appropriate nurse's station.
2. Make copies made of documentation from sending facilities, place the copies in a manila envelope marked "CONFIDENTIAL: Do Not Destroy". Place with the clinical record in the event of discharge of the resident. Send originals back to the sending center as soon as possible, and appropriate.
3. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices.
4. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures, and apply administrative, physical and technical safeguards of the HIPAA Security Rule to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy if possible, and disclosures are limited to the minimum necessary to accomplish the purpose.
5. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

VII. SURGE CAPACITY

A. EXTERNAL DISASTER EXPANSION GUIDELINES

1. In the event of an external disaster, this center may be used by local hospitals and other health care facilities to care for additional patients as space/staff permit. Unplanned admissions from an external disaster are completed in collaboration with external agencies and healthcare providers and the CED, CNE, Medical Director, Admissions Coordinator, Human Resources or Staffing Coordinator, and the CareLine.
   i. The center only accepts admissions within its scope of care unless directed by the local health authorities or a regulatory agency.
2. If the center team determines that it is experiencing a healthcare surge, the following guidelines are used to assess, prepare, and mobilize to meet the need for increased patient care capacity:
   i. Transfer patients to other institutions in the region, state, or other states.
   ii. Group like-patient types together to maximize efficient delivery of patient care.
   iii. Convert single rooms to double rooms or double rooms to triple rooms, if possible.
   iv. Designate units or areas of the facility for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients.
   v. Use cots, beds, or other sleeping surfaces in flat space areas (e.g., cafeterias, recreation areas, lounges, lobbies) for noncritical patient care.
      a. Beds should not be placed near windows, if possible and appropriate to the emergency, so as to avoid broken glass and protect patient privacy and security.
   vi. Determine whether additional staff, including State or Federally designated health care professionals and volunteers may be used to address surge needs.
3. The center identifies areas and spaces that could be opened and/or converted for use as patient treatment areas, such as activity rooms, dining rooms, rooms with unlicensed beds, or other unused center space. Areas are selected based on the intensity of the incident and the anticipated number of healthcare surge patients that the center may receive. The identified areas are cleared of excess furniture and equipment as needed.

Refer to Appendix 13: Surge Capacity

B. ROLES AND RESPONSIBILITIES

1. The Center Nurse Executive/Resident Care Director and Admissions Director determine bed availability and admission placement in collaboration with CareLine.
2. The Medical Director is notified and is responsible for emergency physician coverage, if necessary.
3. The CNE/Resident Care Director evaluates nurse staffing needs.
4. The CED/Designee and department heads are responsible for assuring adequate supplies and staff.
5. The CED/Designee contacts area leadership, the law department and regulatory agencies, as necessary, to obtain waivers for additional capacity.
6. The Social Worker is responsible for notifying the residents' responsible parties of admission.

7. Center staff coordinates admission, identification, assessment and care planning for new residents, following established operational, clinical and admissions policies and procedures, except when suspended or waived by management and/or in consideration of CMS, state agency and other regulatory guidance.
8. The center assumes responsibility for the care and services of residents admitted as the result of an emergency.

VIII. EMERGENCY PHYSICIAN COVERAGE

The Medical Director is notified of all center-related emergencies having the potential for or currently requiring medical intervention.

A. DEPENDING ON THE CIRMCUMSTANCES AND TYPE OF EMERGENCY, IT IS THE MEDICAL DIRECTOR'S RESPONSIBILITY TO:

1. Provide on-site and/or offsite assistance during an external or internal emergency;
2. Coordinate unplanned admissions resulting from external emergencies with the Center Nurse Executive;
3. Triage casualties; and
4. Obtain additional medical resources in collaboration with the Vice President/Senior Vice President of Medical Affairs.

IX. INTERRUPTION OF NORMAL OPERATIONS

A. The Incident Commander may suspend or relax policies and procedures during an emergency. These decisions and the associated potential consequences are considered carefully. In making these decisions, the Incident Commander prioritizes essential operations that must continue to prevent compromise of resident care. All significant departures from established policy and procedures and this EPP must be approved by the Incident Commander.

General Emergency Management Procedures during COVID-19

The center has identified separate areas of refuge locations for positive, negative, and Admission Quarantine Unit (AQU) residents. When the "All Clear" announcement is given, the areas of refuge will be immediately cleaned and disinfected following the infection control and HCSG COVID-19 policies.

The following guidance is followed where possible:

- Staff will attempt to remain within assigned units. Staff that work in both positive and negative refuge areas will start in the negative areas first.
- Staff move residents without crossing through any units of a different COVID status.
- During emergencies, residents should wear a standard face mask, when possible, when leaving rooms and social distance.
- Trash and laundry bins are made available for used PPE.
- EPA-approved, List N disinfectants are dedicated to the area, not accessible by residents.

COVID-19 Positive Residents

- Residents go directly to the refuge area and avoid touching surfaces or other individuals.
- Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
- Fans are not used unless absolutely necessary, based on temperatures in Center/refuge areas.
- Windows and doors to other areas of the Center are closed to prevent spread of virus throughout the Center.
- Staff use a dedicated medication cart, supplies, and equipment.
- Center identifies a dedicated bathroom for staff.

Admission Quarantine Unit Residents

- With the assistance of staff, residents go directly to the refuge area without touching surfaces or other individuals.
- Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
- Fans are not used unless absolutely necessary, based on temperatures in Center/refuge areas.
- Windows and doors to other areas of the Center are closed to prevent spread of virus throughout the Center.
- Staff use a dedicated medication cart, supplies, and equipment
- Center identifies a dedicated bathroom for staff.

Asymptomatic Residents on COVID-Naive Units

• Staff wear at a minimum face masks and eye protection; and wear appropriate PPE based on resident diagnosis and applicable transmission-based precautions.

Evacuation Procedures During COVID-19

• When possible, transport residents separately by COVID-19 status. Asymptomatic COVID-naive residents are transported first, followed by those on the AQU, and lastly COVID-19 positive residents.

• The Center will communicate COVID-status to receiving Centers.

• Van drivers will follow the CDC COVID-19 Cleaning and Disinfecting of non-Emergency Transport Vehicles policy regarding PPE usage and disinfecting.

• Receiving Centers:

Residents will be cohorted according to COVID status, where possible.

NHICS FORM 260 Resident Evacuation Tracking Form

• Resident COVID-19 status will be identified.

X. CAPACITY FOR DECEASED RESIDENTS

This center plans for the potential handling and holding of deceased individuals if support from local emergency responders or other community resources is not immediately available.

A. HUMAN REMAINS

This center considers the following information in handling, processing, and storing human remains onsite on a temporary basis:

1. The center's normal capacity, if any, to store deceased individuals; including refrigeration capacity available to store human remains safely and separated from emergency food supply;
2. Suitable areas on the center's periphery to store human remains without refrigeration;
3. Equipment (ice-making, etc.) or materials/supplies needed (storage bags for ice, deodorizers, body bags, heavy duty plastic wrap, personal protective equipment (PPE), tarps, pallets, etc.) to provide temporary storage of human remains; and
4. Ways to control and isolate temporary morgue provisions away from healthy center occupants (residents, staff, and visitors).

The Incident Commander makes decisions and provides direction regarding temporary storage of human remains, and contacts support services and the local EMS for assistance.

B. DOCUMENTATION

The center documents information about deceased individuals on **NHICS Form 259: Master Center Casualty Report.**

XI. RECOVERY AND RESTORATION

A. POST-EMERGENCY PROCEDURE

Immediately following the emergency, when it is safe to do so, the Incident Commander undertakes the following actions:

1. Coordinate recovery and restoration operations with area, division, region and corporate representatives, the Emergency Management Services (EMS), and other agencies with jurisdiction to restore normal operations.
2. Provide local authorities with a master list of displaced, injured, or dead and notify next of kin/responsible party. ***Refer to NHICS Form 259 Master Facility Casualty Fatality Report.***
3. Advise personnel to dispose of any food/supplies that are suspected to be or actually contaminated or spoiled.
4. INSPECTION TASK LIST

   When it is safe to do so, the Incident Commander and the Maintenance Director, with support services as necessary, perform an initial damage inspection. **NOTE: If there is concern of structural damage, center staff do not enter the building. The following precautions are taken to avoid injury and damage:**

   i. Open doors carefully.
   ii. Avoid the use of open flame in the event of fuel leakage, dampened electrical equipment, or flammable materials.
   iii. Watch for falling objects or downed electrical wires. Do not touch downed electrical wires or objects touched by downed wires.
   iv. Stay away from windows and/or glassed areas.
   v. Take pictures and document damage.
   vi. Arrange for cleaning services, including removal/clean up of spilled medications, drugs, and other potentially harmful materials following center policies and procedures. (Refer to: Safety and Health P&P SH800.)
5. When it is safe to do so, the Incident Commander and the Maintenance Director perform a utilities inspection. **The following precautions are taken to avoid injury and damage:**

   i. If a natural gas smell is noticed, open windows and doors, shut off main gas valve, and contact the Utility Provider **IMMEDIATELY.**
   ii. If damage to wiring is suspected, do not use any appliances and shut off electrical power. Contact the Utility Provider and the contracted Electrical Contractor.
   iii. If damage to plumbing is suspected, check water outlets and sewage lines. Shut off the main water valve if damage is observed. Contact the Utility Provider and contracted Plumbing Contractor.
6. The Incident Commander reports all building, equipment, or utility damage to the RVP.
7. Upon notification from the proper authorities, center support services and/or utility providers that the emergency has been terminated or de-escalated, the CED oversees the orderly return of residents and staff.
8. Before reoccupation of the building, a safety inspection of the center and surrounding areas, including the utilities delivery systems and HVAC units, is performed by the Incident Commander, the Maintenance Director, and regulatory agency(ies).

9. Recovery and restoration is managed in consideration of best practices for infection control, including:
   i. Frequent hand washing. If local water supply contaminated, use of bottled water. If hands not visibly soiled – use of alcohol-based hand rub.
   ii. In response to flooding or water damage and when possible, cleaning out damaged areas within 24 to 48 hours to prevent mold growth.
   iii. Cleaning, wearing rubber gloves, with a solution of approximately 1 cup bleach to each gallon of water, with open doors and windows for air circulation. (Bleach solution is not mixed with ammonia or other cleaners.)
   iv. Use of dust masks during activities that may stir up mold spores or excessive dust.
   v. If applicable, following local officials' instructions for use of bottled water. If instructed to boil water, boiling for at least a full minute before using it to cook, clean or bathe.
   vi. Discarding all perishable food items that may have become contaminated or into contact with flood water, including canned food.
   vii. Treating wounds in accordance with routine infection control practices.
   Note: Adapted from Becker's Infection Control and Clinical Quality, "APIC: 6 tips for infection prevention after a hurricane" written by Brian Zimmerman, 8/29/17.
10. After center reoccupation is considered safe, the Incident Commander and department leaders work to prepare the center to resume normal operations, and coordinate transportation and re-admission of residents.
11. After re-admission, the center re-establishes all essential services.
12. After re-admission, the Incident Commander coordinates provision of crisis counseling for residents/patients, families, and staff as needed.

XII. LOSS OF UTILITIES

Loss of Utilities Procedures During COVID-19

The Center may have to manage extreme temperatures during a loss of power. Fan use will follow normal Loss of Utilities EPP; within the temperature parameters of the EPP. Resident room doors and windows may need to be opened. If fans are used and resident doors and windows are open, all staff on the unit use PPE for contact and airborne precautions.

A. LOSS OF ELECTRICAL POWER

1. **Back-up Power/Generators:** Emergency lighting/power is provided in conformance with center policies and the state's Department of Health policies to maintain temperatures, provide emergency lighting, as well as for fire detection and extinguishing systems and sewage and waste disposal. The ability to obtain and maintain generator power is a factor in whether to evacuate or Shelter-in-Place. The center follows multiple policies and procedures regarding infection control, hazardous waste, food handling and life safety that guide the center's sewage and waste control practices. The center will seek additional resources as necessary to meet sewage and waste disposal needs in accordance with current standards.

   If this center has a generator, the emergency generator system will be inspected weekly by appropriate service location staff and annually by a qualified outside contractor, or more frequently if required by state regulation. If this center maintains an onsite fuel source to power the emergency generator(s), the center has contracted with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency.
2. **Service Delays**: In the event electrical service is disrupted, flashlights are distributed throughout the center, prioritized as needed.
3. **Extended Loss**: If power is lost and expected to be disrupted for an extended period of time, assistance is requested from local agencies.
4. **Center staff should consider the content of residents' personal refrigerators and advise residents accordingly.**
5. In the absence of power for the call bell/light system the center uses bells or other methods to alert staff to their needs.
6. Loss of Utilities Alert
   i. When appropriate and possible, the following announcement is made: **"Center Alert-We are activating Loss of Utilities protocols- (Describe loss of Power and Location). Please continue your duties and listen for further instructions."**
   ii. Provide instructions as necessary for the specific circumstances.

B. AIR CONDITIONING FAILURE: INCIDENT COMMANDER TASK LIST

1. Notify HVAC Company and report problem.
2. Monitor room temperatures. When the temperature of any resident/patient area reaches 81 degrees Fahrenheit for four (4) consecutive hours:
   i. Open doors;
   ii. Operate fans;
   iii. Notify the CED or designee and the Medical Director;

iv. Make arrangements for transfer of residents/patients to other areas of the Center, or other facilities if necessary;
v. Monitor residents'/patients' temperatures every four (4) hours;
vi. Encourage fluids, begin intake and output records as necessary;
vii. Relocate residents/patients who are at risk of hyperpyrexia/over-heated;
viii. Observe residents/patients for symptoms of hyperpyrexia. Document findings.

3. The center follow protocols for addressing significant changes in condition for residents with symptoms of hyperpyrexia.

C. HEATING FAILURE: INCIDENT COMMANDER TASK LIST:

1. Notify HVAC Company.
2. If the outside temperature goes below 30 degrees Fahrenheit, drain plumbing and put antifreeze in the toilets and sinks.
3. Monitor room temperatures. When the temperature inside the center remains at 65 degrees Fahrenheit, for four (4) consecutive hours:
   i. Obtain and distribute blankets, covering hands, feet, and heads;
   ii. Distribute warm soups, coffee, or tea to residents/patients;
   iii. Notify the CED, CNE, or designees;
   iv. Notify the Medical Director;
   v. Monitor and chart resident/patient temperatures every four (4) hours;
   vi. Relocate residents/patients at high risk of hypothermia;
   vii. Observe residents/patients for symptoms of hypothermia. Document findings.
4. The center follows protocols for addressing significant changes in condition for residents with symptoms of hypothermia.

D. INTERRUPTION OF TELEPHONE SERVICE: INCIDENT COMMANDER TASK LIST

1. Notify the telephone company and report disruption of service (use cellular or public telephone);
2. Evaluate all phones and fax lines in the Center to determine the extent of the disruption;
3. During the disruption, the Incident Commander uses a cellular phone for emergent communication; other available cell phones are used as needed with prioritization to avoid interruption to care and services.

E. LOSS OF WATER SUPPLY: INCIDENT COMMANDER TASK LIST

1. Notify the water division of the public utility department of the disruption of services.
2. If the water department advises services will be resumed promptly, all residents/patients and service areas will be informed and instructed to refrain from turning on water taps until supply is re-established. Nursing services are responsible for advising residents/patients of the situation.
   i. If necessary, a minimum of the supply in hot water tanks and the emergency supply of water may be used. Contact may be made with the potable water supplier for additional water.
3. In the event of a disaster in the immediate area creating prolonged and/or indefinite disruption of water supply to the center, the Incident Commander attempts to obtain water for residents/patients. If adequate water is not available, the Incident Commander proceeds with evacuation.

4. Prepare and handle disposal of human waste using supplies for containment and specific storage locations, and with use of PPE.

Refer to Appendix 14: Emergency Water Supply

XIII. UTILITY SHUTOFF: Refer to Appendix 15: Utility Shut-Off Procedures

XIV. UTILITY, ELEVATOR & GENERATOR SYSTEM FAILURE

Failure	Contact	Action
Sewer drains backing up	Maintenance	• Do not flush toilets or hoppers. • Do not use equipment that sends water to drain. • Be sure to turn off water except for drinking. • If long-term outage expected, consider: o Evacuation; o Bath in a Bag; o Accessible Portable Showers; and o Accessible Portable Toilets
Water-sinks and toilets inoperative.	Maintenance	• Use distilled or sterile water for drinking.
Fire sprinklers or alarm system inoperative.	Maintenance	• Begin fire watch. • Minimize fire hazards. • NOTIFY LOCAL FIRE DEPARTMENT by calling 911
Water non–potable (not drinkable)	Maintenance	• Water cannot be used for drinking, washing or cooking. • Place "Non-Potable Water-Do Not Drink" signs at all drinking fountains and sinks. If a water shut-off valve is in place, turn off the water to the sink/drinking fountain. Use emergency water supply for drinking and cooking.
Elevator(s) out of service	Maintenance	• Review fire and evacuation plans: modify plans if necessary. • If people are trapped inside elevator, notify them help is on the way and call fire department. • Notify elevator maintenance contractor.
Telephones	Maintenance	• Use pay phones, cell phones, and runners as needed. • Contact the phone company.
Electrical power (emergency generators working)	Maintenance	• Ensure life support systems are on emergency power (red outlets). • Distribute flashlights/glow sticks. • Never plug generator into wall outlet. • Keep generator dry. • Allow generator to cool completely before refueling. • Use only approved fuel containers. • Monitor the generator for overheating. • Always operate generators outdoors.
Generator and all electric systems failure	Maintenance Nursing	• Use battery powered lighting (flashlights, etc.). • Watch battery levels on all critical medical equipment. • Implement transfer agreements for residents on critical medical equipment. • Prepare center for evacuation
Nurse call system or resident alarms.	Maintenance Nursing	• Establish visual resident monitoring rounds or surveillance. • Call in additional staff if necessary.
Natural Gas outage or natural gas odor.	Maintenance	• Open windows/ventilate area. • Remove residents and employees from the area. • Turn off gas equipment. • Contact the gas company and the fire department.

XV. BOMB THREAT

A. CENTER BOMB THREAT GUIDELINES FOR STAFF

1. Do not panic or act in such a way that causes panic to residents, family members, or other employees.
   i. Do not hang up.
   ii. Notify other employees.
   iii. Have another employee contact 911 and alert authorities to threat.
   iv. The following announcement is made: "**Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions.**"
2. **Do not evacuate** the center until instructed to do so by the Incident Commander. This decision is generally based on advice from the police and/or fire department.
3. Restrict access to the center.
4. Close all doors.
5. Escort visitors and residents to resident rooms where they remain with doors closed until an all-clear is given.

IF THE BOMB'S LOCATION IS MENTIONED IN THE THREAT:

1. Immediately remove any residents, visitors and staff from the area.
2. If you find an object out of the ordinary or appearing to be an explosive device, do not touch it and inform authorities of the object's location.
3. Do not attempt to disarm, remove or disturb the potential explosive device.
4. Report all suspicious activities to investigating authorities.

B. POTENTIAL EXPLOSIVES

The center maintains a list of potential explosives to report to the fire/police departments. The potential explosives list:

1. Identifies oxygen storage locations;
2. Identifies fuel storage locations; and
3. Identifies locations of any other potential explosives in the center.

Refer to Appendix 16: Potential Explosives List

C. AFTER THE THREAT IS RECEIVED:

1. As soon as possible after receiving the call, the receiver of the call documents all information relating to it, including the:
   i. Possible location and type of bomb;
   ii. Time of detonation;
   iii. Background noises (e.g., music, voices, etc.),
   iv. Voice quality (male/female), accents, or any speech impediments.

D. IF A SUSPICIOUS/EXPLOSIVE OBJECT IS FOUND

1. Immediately contact the Incident Commander. The Incident Commander then contacts law enforcement to immediately report the object's location. In the absence of immediate notification, center staff calls 911.
2. Do not touch the object.
3. Follow the instructions of the bomb squad or local law enforcement officials who assume authority regarding object removal.
4. Law Enforcement and/or the Incident Commander initiates a partial or total evacuation as needed.

E. IF A SUSPICIOUS OBJECT IS FOUND WITHOUT PRIOR NOTIFICATION

1. Call 911.
2. Report the exact location and description of the object.
3. Follow any instructions given to you at this time by law enforcement officers.
4. Call CED, CNE, or Designees.

XVI. BIOTERRORISM

A. REPORTING REQUIREMENTS AND CONTACT INFORMATION

Any employee recognizing chemical or biological exposure symptoms immediately notifies the CED/Designee/Incident Commander.

1. The Incident Commander immediately contacts 911 and area leadership.
2. Restrict building entrance and exit until cleared by authorities.
3. The Incident Commander contacts the Centers for Disease Control Bioterrorism Emergency Response Office at (770) 488-7100.
4. Employees promptly evacuate all persons from the affected area as instructed by the Incident Commander.
    i. As instructed by regulatory authorities, all building occupants remain on the premises until cleared and approved to exit.

B. MAIL HANDLING

The center follows general mail handling guidelines, including:

1. Opening all mail with a letter opener or method least likely to disturb contents;
2. Opening letters and packages with a minimum amount of movement.
3. Center staff are advised not to blow into envelopes; or shake or pour out contents, and to keep hands away from nose and mouth while opening mail; and to wash hands after handling mail.
4. Observing for suspicious envelopes or packages, such as:
    i. Envelopes/packages with discoloration, strange odors or oily stains, powder or powder-like residue;
    ii. Protruding wires, aluminum foil, excessive tape or string;
    iii. Unusual weights for size, or lopsided or oddly shaped envelopes;
    iv. Poorly typed or written addresses, no return address, incorrect titles, misspelling of common words, a postmark not matching the return address, and restrictions such as "personal" or "confidential."
5. In Handling Suspicious Mail, staff should:
    i. Stay calm and do not shake or empty contents of any suspicious package or letter;
    ii. Keep hands away from mouth, nose, and eyes;
    iii. Isolate package or letter and not carry or show to others, and cover gently with clothing, paper, inverted trash can; and
    iv. Not try to clean up any spills or walk through any spilled material;
    v. Alert others in area and leave area, closing all doors;
    vi. Wash hands with soap and water;
    vii. Notify supervisor/designated responder who in turn calls 911, local FBI Field Office, area, division, region and corporate leadership;
    viii. Not allow anyone to enter the room until proper authorities arrive;
    ix. List all people who were in the room or area when the package or letter was recognized. Give the list to the health and law enforcement officials.

C. POTENTIAL AGENTS

Diseases with recognized bioterrorist potential and the agents responsible for them are described in Table 1. (Note: The Center for Disease Control does not prioritize these agents in any order of importance or likelihood of use.)

Table 1. Most Common Chemical and Biological Agent Used in Terrorist Attacks

Chemical Agents	Effects	Onset
Nerve Agents • Tabun • Sarin • Soman • GF, VX	• Contraction of the pupils of eyes • Watery discharge from nose • Labored or difficult breathing • Convulsions	• Seconds to minutes
Blister Agents (Vesicants) • Mustard • Lewisite • Phosgene • Oxime	• Skin redness • Blisters • Eye Irritation • Blindness • Labored or difficult breathing • Coughing	• Minutes to hours
Blood Agents • Hydrocyanic Acid • Cyanogen Chloride • Arsine • Methyl Isocyanate	• Panting • Convulsions • Loss of consciousness • Breathing stops - usually temporary in nature	• Minutes
Choking Agents • Phosgene • Chlorine • Ammonia	• Tightness in the chest • Coughing • Labored or difficult breathing	• Minutes to hours

Biological Agents	Effects Of Inhalation	Time From Exposure Until Symptoms Appear	Contagious?/Treatment
Anthrax	• Fever • Headache • Fatigue • Labored or difficult breathing • Death if untreated	1 to 5 days	• Not contagious, but spores can survive outside host for years. • Treat with IV antibiotics for 30 days. Can also use vaccination which is effective only if begun before symptoms appear.
Botulism	• Blurred vision • Eyes sensitive to light • Difficulty speaking • Progressive paralysis • Respiratory failure	1 to 5 days	• Not contagious. • Treat with supportive therapy. • Antitoxin available from CDC.
Hemorrhagic Fever	• High fever • Low blood pressure • Bleeding from mucous membranes • Organ failure • Death	4 to 21 days	• Contagious: spread through body fluids. • Treat with supportive therapy. • Ribavirin for some viruses.
Plague	• Fever • Chills • Headache • Nausea • Vomiting • Pneumonia • Septicemia/blood poisoning • Death	2 to 3 days	• Highly contagious by aerosol/droplet route. • Medications available - Should be given within 8 to 24 hours of time symptoms begin.
Smallpox	• Fever • Severe fatigue • Headache • Backache • Abdominal pain • Blister-like skin lesions • Death - 20 to 30% of those infected	7 to 17 days	• Highly contagious by aerosol route or contact with pox scabs. • Symptomatic treatment. • Vaccine available through CDC.

XVII. NUCLEAR, RADIATION, OR HAZARDOUS CHEMICAL FALLOUT: STAFF TASK LIST

A. IN THE EVENT OF A NUCLEAR, RADIATION, OR HAZARDOUS CHEMICAL FALLOUT:

1. Notify CED or designee.
2. Contact the local health department or police if there is the belief that exposure has occurred.
3. Tune radio to the local emergency broadcast station.
4. Alert center residents/patients, staff, and visitors and keep them informed of new developments. The following announcement is made: "**Center Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions.**" Provide instructions as needed.
5. Close all doors, windows, and drapes.
6. Move residents/patients to the hallways and close the fire doors.
7. In the event of hazardous chemical fallout, seal all openings to the outside air and block all outside air intakes.
8. Reassure residents/patients, visitors, and staff.
9. Evaluate the need to restrict entrance into the center in collaboration with Area leadership, division, region, state and local authorities.
10. Follow the direction of state and local authorities.
11. If directed by local authorities, evacuate residents/patients per location Evacuation Plan.

Note: Facilities located in a Nuclear Emergency Planning Zone should follow the plan developed for their location.

XVII. FIRE EMERGENCY GUIDELINES

Fire Emergencies Procedures During COVID-19
The purpose of this section is to plan for the safety of residents in case of a fire. Due to the profile of the COVID-19 residents, procedures may vary from routine Center policy.

If fire is on the COVID-19 Positive Unit:
- Staff move residents past fire doors to safe area, preferably not in AQU or COVID-naive areas.
- Staff close all doors to rooms.
- Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
- Staff remain with residents until all clear.

If fire is on the Admission Quarantine Unit (AQU):
- Staff move residents past fire doors to refuge area, preferably not in COVID-positive or the COVIDnaïve units • Staff close all doors to rooms.
- Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
- Staff remain with the AQU residents until all clear. In case of a fire in any other zone in the building (outside of the COVID-19 Positive Unit):
- Staff move residents past fire doors to safe area, preferably not in COVID-positive or AQU area.
- All COVID-19 positive residents who are not in bed will be kept together in a specific area.
- Staff close all doors in the unit and stay with COVID-19 residents.
- Any residents who are in bed will remain in bed with the room door closed until all clear.
- Staff wear at a minimum face masks and eye protection, and wear appropriate PPE based on resident diagnosis and applicable transmission-based precautions

Procedures for Non-COVID-19 Fire Plan

This center monitors potential fire risk. Any unsafe condition is reported to a supervisor immediately so corrective measures can be taken promptly.

A. IN THE EVENT OF A FIRE

1. **Extinguishers:** Fire extinguishers are used in accordance with instructions.
2. **Transport:** Residents are transported to a safe area.
3. **Staff Assignments:** One person is assigned to wait outside the building to direct the fire department personnel to the area of the fire.
4. **Evacuation:** Residents are evacuated as necessary and according to the Evacuation Plan.
5. **Staff ensure that the Fire Lane is clear for emergency personnel and vehicles**
6. **Staff use the census log, staff census/schedule, and visitor log to account for staff, residents and visitors.**
7. **Staff relocate wheeled equipment during fire or other emergency.**
8. **Report** fire incidents, death or serious bodily injury by phone to the state agency and others as required by state guidelines.

B. FIRE RESPONSE AND ANNOUNCEMENT

1. Upon discovering fire or smoke, center staff:
   i. Remove residents from immediate danger according to evacuation guidelines
   ii. Make the following announcement: "**Center Alert-We are activating Fire Emergency Protocols (Describe Situation and Location).**"
   iii. Implement the R.A.C.E. program:
      a. **Rescue** Remove residents to at least 20 ft. from the threatened area, preferably on the opposite side of the closest fire door.
      b. **Alarm** Activate the closest fire alarm. Even though automatic alarms may be activated, contact the fire department by calling 911.
      c. **Confine** After removing endangered residents, close the door(s) of the threatened room or area. Close smoke/fire doors behind you as you go.
      d. **Extinguish/Evacuate** Assess the fire threat to either attempt to extinguish the fire or evacuate residents from the affected station. If the area is evacuated, check that all smoke/fire doors are properly closed. Block the bottom of the doors with sheets or towels to slow smoke penetration into the unaffected areas.

C. FIGHTING THE FIRE

1. **Call 911 for all fires.**
2. If the fire is small, it may be extinguished by smothering (covering) with sheets or clothes, or by using a portable fire extinguisher.
   i. Fire extinguishers are used only if the fire is small and there is no threat of endangering the user or other individuals.
      a. When using a portable extinguisher, staff are instructed to follow the "PASS" protocol: Pull, Aim, Squeeze, and Sweep.
         - **Pull** the fire extinguisher pin.
         - **Aim** the nozzle at the base of the flame.
         - **Squeeze** the handle.
         - **Sweep** the fire extinguisher back and forth at the base of the flame. Staff are advised to make **one** attempt to extinguish a fire with a fire extinguisher. If that attempt is unsuccessful, staff should confine the fire area and evacuate the residents and staff.

D. SPECIAL CARE UNIT/RESIDENTS FIRE PROCEDURE:

1. Vent units, dialysis units, dementia units, bariatric patients, and hospice patients are subject to special consideration during a fire emergency due to a locked unit and acuity. Due to this consideration, this center has special procedures for addressing these specific patients' safety needs, as documented in Appendix 17.

Refer to Appendix 17: Special Care Unit Fire Procedure

E. AUTOMATIC SPRINKLER OR ALARM SHUT-OFF

1. When it becomes necessary to shut off the automatic sprinkler or fire alarm system in the building for any reason, it is the duty and responsibility of the CED/Designee to:
   i. Inform the Fire Department prior to the sprinkler or alarm system being shut off, the reasons for system shut off, and the approximate length of time the system will be off.

ii. Designate personnel to serve on fire watch for the period the sprinkler or alarm system is shut off.
   a. Fire watch personnel tour the center at least every 20 minutes to check for fire or conditions that could result in fire. (The center follows local fire regulations requiring more frequent rounds to the extent that such regulations exist.)

Refer to: **Appendix 18: Fire Sprinkler Shut-Off Procedures**
Appendix 19: Fire Alarm Reset Procedures

XIX. SECURITY PLAN

This center has established a security plan to help protect the safety of residents/patients, staff, and visitors.

A. EXTERIOR BUILDING SECURITY

1. This center has a schedule for locking/unlocking of exterior doors during nighttime hours, including persons responsible;
2. This center follows a schedule to inspect outdoor lighting adequacy.

B. INTERIOR BUILDING SECURITY

1. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection.
2. This center's security plan includes a schedule to inspect indoor lighting adequacy.
3. The center's plan also contemplates resident-specific security needs, including:
   i. Security measures for special units;
   ii. Risk for resident elopement;
   iii. Use of Electronic alarms systems; and
   iv. Communication call bells.

C. ADMINISTRATIVE CONTROLS FOR SECURITY

1. The center follows the communications protocols established in Section V of this plan as needed to address security issues.
2. The center's security plan describes the check-in procedures for visitors.

Refer to Appendix 20: Security Plan

XX. INTERNAL OR EXTERNAL DISTURBANCES: CENTER GUIDELINES FOR STAFF

A. INTERNAL DISTURBANCES

1. For disturbances within the center, staff are advised to:
   - i. Approach the individual causing the disturbance (subject) and attempt to calm them down.
   - ii. If the individual cannot be quieted, politely ask the subject to leave the center.
   - iii. Call the police department for assistance if the subject does not cooperate.
     - a. If the subject attempts to leave after the call is made, do not attempt to detain him/her. Call the police back and inform them of the current situation.

B. UNDER THE INFLUENCE

1. To protect the center, residents, visitors and personnel from being injured or offended by individuals under the influence of alcohol or narcotics, staff are advised to:
   - i. Inform the individual of your intention to call them a cab and have them leave the property.
   - ii. If the individual refuses to leave, call the police department.
   - iii. If the individual is an employee, immediately notify their supervisor and CED.

C. EXTERNAL DISTURBANCES

1. Anyone detecting a civil disturbance or potential civil disturbance during normal business hours reports the situation to the CED and/or, after normal business hours, to the Manager on Duty (Incident Commander) who:
   - i. Assesses the situation (location of the disturbance, what the disturbers are doing, how many are there, etc.).
   - ii. Reports the situation to the police department immediately by dialing 911 and requesting assistance.
   - iii. Instructs staff to lock all building doors and windows and close all blinds and curtains in resident rooms.
   - iv. Instructs staff to move residents into their rooms and away from exterior windows and close room doors.
   - v. Instructs visitors to stay in the resident room(s).
   - vi. Monitors building access at all entrances to identify non-authorized persons attempting to enter the center. Unauthorized access/attempts at access to the center are immediately reported to 911.
   - vii. Relinquishes control of the situation, if established, to the police department/EMS upon their arrival.
   - viii. When the disturbance has subsided or has been controlled, the Incident Commander surveys the affected areas and determine the need for additional assistance.

XXI. HOSTAGE SITUATION: CENTER GUIDELINES

A. If a hostage situation is identified, staff are advised to:

1. Immediately call 911* and explain the situation to the police and provide specifics such as the:
   - i. Subject's name or identifying information,
   - ii. Victim(s),
   - iii. Exact Location,
   - iv. Known or suspected weapon(s),
   - v. Injuries.

   *** Staff should remain on the phone during all calls to 911 for as long as is feasible and safe.**
2. Notify CED or designee as soon as possible and activate the Emergency Plan.
3. The following announcement is made: "**Security Alert-We are activating Hostage protocols- We have a Hostage situation (Location). Please listen for further instructions."** Provide further instructions as needed.
4. Evacuate the affected area per the location's Evacuation Plan, attempt to isolate the subject, and secure the perimeter.
5. Remain calm; follow the subject's directions.
6. If the subject is talking: listen; do not argue.
7. Avoid heroics: be aware not to make sudden movements; and don't crowd the subject.
8. Be prepared to respond to law enforcement personnel regarding your observations and any additional information you may have involving the subject or victim.

XXII. ELOPEMENT: MISSING RESIDENT/PATIENT

A. IF A RESIDENT/PATIENT IS DISCOVERED MISSING:

1. Communicate internal notification of missing resident/patient. The following announcement is made: **""Medical Alert: We are activating Missing Patient protocols. The resident was last seen (location)".** This alerts all staff that a formal search is underway.
2. Begin a coordinated search throughout the building; search every room in the Center;
3. Search immediate grounds, supply flashlights and associated supplies;
4. If the resident/patient is not found, the charge nurse/supervisor should:
   - i. Notify the CED and CNE or designees,
   - ii. Call 911 and report the missing resident/patient,
   - iii. Notify responsible family member,
   - iv. Notify the resident's/patient's physician,
   - v. Notify the appropriate state and local agencies;
   - vi. Supply resident's/patient's picture to police, etc.

Refer to Appendix 21: Elopement Drill Documentation Form

XXIII. SEVERE WEATHER/NATURAL DISASTER: GENERAL GUIDELINES AND INFORMATION

Severe Weather/Natural Disasters Procedures During COVID-19

During severe weather and other natural disasters, the Center will follow the EPP, with the following additions:

Tornadoes

- Staff will collect and assist residents with use of masks or other face coverings.
- During a tornado warning, residents will be assisted to designated areas of refuge following the procedures described above for general emergency management.

Hurricane Planning: During the approach of the hurricane (days out):

- Contact the identified evacuation locations to determine their COVID status, their surge capacity for both asymptomatic COVID-naive, COVID-19 positive, and AQU residents. Collaborate with local health authorities and destination centers on evacuation locations in consideration of COVID status.
- Planning and decision-making regarding evacuation will be initiated at least 48 hours prior to estimated hurricane landfall.

Earthquakes/Floods

Following an earthquake or flooding event, the shelter in place and the evacuation protocols are determined based on the condition of the Center. The NHICS Form 251, Center Systems Status Report to assess the Center after an earthquake.

Procedures During Non-COVID-19

A. TORNADOES

Tornadoes are violent local storms that extend to the ground with whirling winds reaching 300 mph. Spawned from powerful thunderstorms, tornadoes can uproot trees, damage buildings, and turn harmless objects into deadly missiles in a matter of seconds. Damage paths can be in excess of one mile wide and 50 miles long. Tornadoes can occur in any state but occur more frequently in the Midwest, Southeast, and Southwest, with little or no warning.

i. **Tornado Watch** – Atmospheric conditions are right for tornadoes to potentially develop. Be ready to take shelter. Stay tuned to radio and television stations for additional information. NOTE: Multi-floor centers consider relocating non-ambulatory and dependent residents from the higher floors to the lowest floor.

ii. **Tornado Warning** – A tornado has been sighted in the area or is indicated by radar. Take cover immediately.

B. BASED ON THE RESULTS OF THE HAZARD VULNERABIITY ANALYSIS, IF THIS CENTER IS AT RISK FOR TORNADO, THE CENTER:

1. Consults Emergency Management officials regarding the tornado warning system.
2. Monitors local media and alerts for tornado **watches** and **warnings.**
3. Has established procedures to inform personnel when **tornado warnings** are posted and considers the need for spotters to be responsible for looking out for approaching storms.

4. Educates staff on Areas of Refuge identified in Appendix 2.
    i. Considers the amount of space needed during a tornado, including consideration that adults each generally require about six square feet of space and that nursing home residents may require more space.
5. Identifies Areas of Refuge considering that the best protection in a tornado is usually an underground area. If an underground area is not available, consider:
    i. Small interior rooms on the lowest floor without windows.
    ii. Hallways on the lowest floor away from doors and windows.
    iii. Rooms constructed with reinforced concrete, brick, or block with no windows or heavy concrete floor or roof system overhead.
    iv. Protected areas away from doors and windows. **Note: Auditoriums, cafeterias, and gymnasiums that are covered with flat, wide-span roofs are not considered safe.**
6. Makes plans for evacuating personnel away from lightweight modular offices or mobile home buildings. These structures offer no protection from tornadoes.
7. Conducts periodic tornado drills.
8. Reviews the **Take Cover** Procedure (discussed above) and instructs affected individuals to **Take Cover** inside the center in a safe area if necessary.

C. EMERGENCY PROCEDURE: TORNADO WATCH GUIDELINES

1. The following announcement is made in the event of a Tornado Watch: "**Medical Alert. We are activating severe weather protocols. A tornado watch has been issued for this area** effective until _____ (*time watch ends*). A **tornado watch** means current weather conditions may produce a tornado. Close all draperies and blinds throughout the center and await further instructions. Please continue with your regular activities."
2. The above message is repeated several times after the first announcement, and then approximately hourly until the **watch** has terminated.
3. In accordance with this EPP, the CED and CNE are notified if not on the premises. Additional center personnel are notified as needed.
4. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover procedures (described above).
5. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position.
6. The Incident Commander monitors weather alerts on radio and television.
7. Staff closes all window drapes and blinds.
8. Staff distributes flashlights, towels, and blankets to staff and residents.
9. First aid and medical supplies are secured and taken to central area for refuge.
10. Staff secures outside furniture, trash cans, etc.
11. After the **Tornado Watch** has been cancelled and the Incident Commander has determined the dangerous situation has passed, an announcement is made: **"All Clear, Repeat, All Clear"**.
12. The Incident Commander/Designee then accounts for residents, staff, and visitors.

D. EMERGENCY PROCEDURE: TORNADO WARNING

1. The following announcement is made in the event of a Tornado Warning: "**Medical Alert. We are activating severe weather protocols. A tornado warning** has been issued for our area. Immediately implement Take Cover procedures. Repeating—a

tornado warning has been issued for our area. Immediately implement Take Cover procedures."

2. The above message is repeated several times after the first announcement and then hourly until the **warning** has terminated.
3. In accordance with this EPP, the CED and CNE are notified if not on the premises. Additional center personnel are notified as needed.
4. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover/Evacuation procedures (described above).
5. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position.
6. The Incident Commander monitors weather alerts on radio and television.
7. First aid and medical supplies are secured and taken to central area for refuge.
8. Upon hearing this announcement, all personnel follow the Shelter-in-Place/Take Cover procedures to provide for the safety of the residents, visitors, and themselves.
9. After the Tornado warning is over and the Incident Commander has determined the dangerous situation has passed, am **"All Clear, Repeat, All Clear"** announcement is made to inform affected parties that the **Take Cover** situation has ended.
10. Upon issuance of the All Clear announcement, residents are taken back to their rooms.
11. The Incident Commander/Designee then accounts for residents, staff, and visitors.

E. EMERGENCY PROCEDURE: EARTHQUAKES/NATURAL DISASTERS GENERAL GUIDELINES

Earthquake: An earthquake is a sudden, rapid shaking of the ground caused by the breaking and shifting of rock beneath the Earth's surface. This shaking can cause buildings and bridges to collapse; disrupt gas, electric, and phone service; and sometimes trigger landslides, avalanches, flash floods, fires, and huge, destructive ocean waves (tsunamis). Buildings with foundations resting on unconsolidated landfill, old waterways, or other unstable soil are most at risk. Buildings or trailers and manufactured homes not tied to a reinforced foundation anchored to the ground are also at risk since they can be shaken off their mountings during an earthquake. Earthquakes can occur at any time of the year.

Hazards Associated with Earthquakes: When an earthquake occurs in a populated area, it may cause deaths, injuries and extensive property damage. Ground movement during an earthquake is seldom the direct cause of death or injury. Most earthquake-related injuries result initially from collapsing walls, flying glass, and falling objects, or from people trying to move more than a few feet during the shaking. Some of the damage in earthquakes is predictable and preventable.

Aftershocks: Aftershocks are smaller earthquakes that follow the main shock and can cause further damage to weakened buildings. Aftershocks can occur in the first hours, days, weeks, or even months after the quake. Some earthquakes are actually foreshocks, and a larger earthquake might occur.

HAZARDS ASSOCIATED WITH STRUCTURAL COLLAPSE: The following hazards ARE considered if an earthquake may have caused structural damage to the center:

1. Water system breaks: may flood basement areas
2. Exposure to pathogens from sanitary sewer system breaks
3. Exposed and energized electrical wiring

4. Exposures to airborne smoke and dust (asbestos, silica, etc.)
5. Exposure to blood borne pathogens
6. Exposure to hazardous materials (ammonia, battery acid, leaking fuel, etc.)
7. Natural gas leaks creating flammable and toxic environment
8. Structural instability
9. Insufficient oxygen
10. Confined spaces
11. Slip, trip or fall hazards from holes, protruding rebar, etc.
12. Falling objects
13. Fire
14. Sharp objects such as glass and debris
15. Secondary collapse from aftershock, vibration and explosions
16. Unfamiliar surroundings
17. Adverse weather conditions; and/or
18. Noise from equipment (generators/heavy machines)

F. IN PLANNING CONSIDERATIONS FOR EARTHQUAKES, THE CENTER:

1. Completes the HVA and determines the probability of an earthquake.
2. Consults with Emergency Management officials regarding earthquake preparedness and response expectations.
3. Identifies safe areas in the center; for example, under a sturdy tables or desks, against interior walls away from windows, bookcases, or tall furniture, considering that the shorter distance the center's occupants need to move to safety, the less likely occupants will be injured.
4. Secures furniture, appliances and other large items in accordance with applicable requirements to help comply with safety compliance and reduce potential damage and injury.
5. Uses NHICS Form 251, Center Systems Status Report, to assess the center following an earthquake.
    i. The findings from NHICS Form 251 assist the Incident Commander in determining if the center needs to be evacuated or if occupants can shelter-in-place following the initial earthquake.
6. Trains staff, residents, and families on immediate response procedures to an earthquake including the steps to evacuate or shelter-in-place.
7. Conducts drills to prepare staff and residents for earthquakes.
8. Tracks costs associated with the earthquake's damage.
9. Identifies primary and secondary communications systems.
10. Prepares to address the psychological impact an earthquake can have on residents and staff.
11. If an immediate peril is identified like a gas leak, uncontrolled fire, or threat of building collapse, the center may immediately evacuate in accordance with the **evacuation procedures described above.**

G. FLOOD/FLASH FLOOD/DAM FAILURE

1. **Flood Watch:** An announced Flood Watch indicates that local flooding is possible. To the extent practicable, the center team listens to the local radio and television stations for information and prepares to evacuate.
2. **Flood Warning:** An announced Flood Warning indicates that flooding is already occurring or will occur soon. The center team takes precautions immediately after being

made aware of this warning. Center teams prepare to move to higher ground and evacuate.

H. PLANNING CONSIDERATIONS FOR FLOODS: SPECIAL CONSIDERATIONS

1. The risk of flood is assessed in the Appendix 1: Hazard Vulnerability Assessment. If flood is a probable risk, the center:
   i. Considers purchasing a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup, and staff listens for flood watches and warnings.
   ii. Reviews the local community's emergency plans and becomes familiar with the planned evacuation routes and areas of higher ground.
   iii. Inspects onsite areas potentially subject to flooding and onsite areas to which records and equipment could be moved, and makes plans to move records and equipment as needed.
   iv. Reviews the center insurance coverage for flooding.
   v. Undertakes flood proofing measures, as necessary. These measures include:
      a. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings.
      b. Installing watertight doors.
      c. Constructing movable floodwalls.
      d. Installing pumps to remove flood waters.

Note: The center may undertake other emergency flood proofing measures that are generally less expensive than those listed above, but require substantial advance warning. They include:

- Building walls with sandbags;
- Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil; and/or
- Constructing a single wall by stacking small beams or planks on top of each other.

The center evaluates the need for backup systems, such as:

- Portable pumps to remove flood water.
- Alternate power sources such as generators or gasoline-powered pumps.
- Battery-powered emergency lighting.

I. EMERGENCY PROCEDURE: FLOODING GENERAL PROCEDURES

1. In the event of an expected flood, the following announcement is made: "**Medical Alert-We are activating severe weather protocols. A flood/flash flood watch or warning has been issued for this area effective until _____ (*time watch ends*).** A **flood watch** means that current weather conditions may produce flooding. A **flood warning** indicates flooding is occurring in the area. Please await further instructions." The center provides additional instructions as known and necessary.
2. CED and CNE are notified if not on the premises.
3. Center staff accounts for all residents and staff members.
4. Center management staff convene together for a briefing and instruction.
5. The Incident Commander activates this plan to manage the incident. (The most qualified staff member on duty at the time assumes the Incident Commander position.)
6. The Incident Commander decides whether to flood proof (see above) or evacuate based on geographical location and history of flooding of the center, as well as the results of

the evacuation analysis discussed above. If evacuation is necessary, the evacuation processes described above are followed.

7. The situation is only deemed "under control" after the local authorities have concluded emergency operations and the Incident Commander has declared the situation "safe."

J. EMERGENCY JOB TASKS: FLOODING

1. CED/Incident Commander:
   i. Determine to flood proof the center or evacuate.
   ii. If decision is to evacuate, use the evacuation procedures described above.
   iii. Account for residents, staff, and visitors.
2. All Staff/Management:
   i. Assist with flood proofing the center if necessary.

K. HURRICANES, TROPICAL STORMS AND FLOODING: PLANNING CONSIDERATIONS BASED ON THE HVA:

1. This center consults with Emergency Management Office to determine flood zone and hurricane evacuation zones, and monitors flood watches and warnings. (Note: Wind damage from a hurricane can necessitate evacuation even if there is no threat of flooding from the storm surge.)
2. If hurricane or tropical storm warnings are issued for the area, the center team makes plans to protect outside equipment and structures, and follows guidance from the EMS regarding evacuation and other precautions. The center also makes and implements plans to protect windows, such as by use of permanent storm shutters or installation of window covers.
3. The center also considers and implements backup systems as needed, such as portable pumps to remove flood water and alternate power sources, such as generators or gasoline-powered pumps.

L. EMERGENCY PROCEDURE: HURRICANE AND TROPICAL STORM THREAT AND WATCH CENTER PROCEDURES

1. Local authorities issue a ***"Watch"*** when a hurricane or tropical storm is expected to hit within 36 hours. The center then makes the following announcement is made: **"Medical Alert: We are activating severe weather protocols. A hurricane/tropical storm watch has been issued for this area effective until _____ (*time watch ends*)."**
2. After the announcement, each department leaders contacts their staff and creates a schedule of employees to work during the emergency. Staff is scheduled to work:
   i. Before the storm strikes.
   ii. During the storm.
   iii. After the storm.
3. The Incident Commander alerts alternate care facilities and transportation providers of the potential evacuation.
4. The Incident Commander and center team considers resident acuity/status, infection control precautions in determining transportation needs. (Refer to the procedures above regarding Shelter-in-Place or Evacuation.)

XXIV. PANDEMIC INFLUENZA

EPIDEMIC GENERAL STATEMENT

The leadership team (CED, CNE/Resident Care Director, and Center Medical Director) complete the **Epidemic Preparedness Checklist.** If there is an outbreak in the center, the leadership team directs activities.

EPIDEMIC GUIDELINES

1. When an epidemic is declared, follow instructions from clinical leadership to implement the following:
   i. If a severe staffing shortage is apparent, deploy alternative staffing and implement altered standards of care.
   ii. Implement use of the **Daily Symptom Screening Form** for all new admissions, re-admissions, staff, visitors, and vendors.
   iii. Make provisions to accommodate overcrowding.
2. **Refer to:**
   i. Epidemic Preparedness Checklist
   ii. Influenza Preparedness Plan PowerPoint (on Central)
   iii. Altered Standards of Care
   iv. Daily Symptom Screening Form
   v. Outbreak Intervention Tiers for Influenza and Gastroenteritis (on Central)

A. GENERAL GUIDELINES

1. Residents with symptoms of or confirmed with targeted epidemic illness should remain in their rooms. Limit transport to medically necessary purposes.
2. Place a sign stating "Stop-See Nurse Before Entering/For Instructions" on the door.
3. If there is a widespread outbreak of residents with targeted epidemic illness, or symptoms of influenza, use existing partitions (smoke doors, separate floors) to establish restricted entrance areas in the building furthest away from common areas used by residents and staff.
4. Label the area as "Stop-See Nurse Before Entering/For Instructions" on the entrances to the area.
5. Allow serial use of N95 disposable respirators and BioMasks within this area to conserve respirators/masks if the respirator/mask supply is in question.
6. Place a surgical mask on residents with influenza or other respiratory illness symptoms who are required to be moved out of the restricted area or their rooms.
7. Instruct visitors:
   i. To limit movements within the building;
   ii. On limiting hand contact with surfaces in the center; perform hand hygiene after surface contact.
   iii. On respiratory hygiene/cough etiquette; and
   iv. On hand hygiene before entering and when leaving the resident room and with any resident contact.
8. Treat all excretions, secretions and body fluids as potentially infectious.
9. Perform hand hygiene immediately after removing mask or respirator or any PPE.
   i. Wash hands with soap and water if hands visibly soiled or caring for resident with C.diff or any gastrointestinal infection or use an alcohol-based hand gel.

XXV. EMERGING INFECTIOUS DISEASES

Definition: Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

1. General Preparedness for Emergent Infectious Diseases (EID)
   a. Center leadership will be vigilant and stay informed about Emerging Infectious Diseases (EID) with the assistance of Corporate and Divisional Clinical leaders. They will keep Divisional administrative and clinical leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
2. Local Threat
   a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the center's community, the center activates specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.
   b. The center's Infection Preventionist (IP), with assistance from the National Infection Prevention and Control Team as needed, researches the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.
   c. Based on the specific disease threat, the center reviews and revises internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated.
   d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.
   e. If EID is spreading through an airborne route, then the center activates its respiratory protection plan (refer to SH408 Respiratory Protection Program) to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.
   f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information.
   g. Brief contractors and other relevant stakeholders on the center's policies and procedures related to minimizing exposure risks to residents.
   h. Post signs regarding hand hygiene and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the center along with the instruction that anyone who is sick must not enter the building.
   i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the center, screening for exposure risk and signs and symptoms may be done, if possible, prior to admission of a new resident and/or allowing new staff persons to report to work.

j. Self-screening: Staff will be educated on the center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
   i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
   ii. Precautionary removal of employees who report an actual or suspected exposure to the EID.
   iii. Self-screening for symptoms prior to reporting to work.
   iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

k. Self-isolation: In the event there are confirmed cases of the EID in the local community, the center may consider closing the center to new admissions, and limiting visitors based on the advice of local public health authorities.

l. Environmental cleaning: The center follows current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.

m. Engineering controls: The center uses appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

3. Instructions to manage suspected case(s) in the care center:
   a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation/precaution room and notify local public health authorities.
   b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible. Resident to wear mask during the transfer.
   c. If the suspected infectious person requires care while awaiting transfer, follow center policies for isolation/precaution procedures, including all recommended PPE for staff at risk of exposure.
   d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.
   e. If feasible, ask the isolated resident to wear a mask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated resident unless it advised otherwise by public health authorities.
   f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation/precaution room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
   g. Implement isolation/transmission-based precautions (TBP) procedures in the center (isolation/TBP rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities.
   h. Activate quarantine (separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the

disease) interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

XXVI. ARMED INTRUDER GENERAL GUIDELINES

A. In situations in which there is lead-in time to a potential armed intruder violence threat against the center, the center management team discusses actions to be taken by the center and questions to ask the intruder.

B. During an armed intruder event, the center follows steps, when possible, staff will determine which of the "Four Outs" will be the best for their survival::

1. "Get Out": Identifying current residents, visitors and staff for potential exit from the center. Individuals will proceed to exit the building until they find a safe place. (This is the best choice if staff can safely do so.)
2. "Lock Out": Identifying if residents, visitors and staff could be protected by potentially locking them in the center, preventing entry by the intruder. Individuals will get behind a locked or barricaded door. This action is the next best choice and if it is safe to do so, the best way to protect residents from becoming a victims.
3. "Hide Out": Identifying current residents, visitors, staff and locations for potential concealment within the center. Staff will hide in inconspicuous places in the center. Staff can help residents by hiding them in plain sight (e.g. Put extra linens on a resident's bed when the resident is bed-ridden.
4. "Take Out": Establishing a plan to stop the armed intruder's activities. Staff will use diversions and weapons of opportunity to take out the Armed Intruder. When considering a take out plan, if there are several people, use diversions and make a plan to gang up on the Armed Intruder.

   In addition, a staff member calls 911 when safe to do so. Gives the 911 operator specific details to aid in law enforcement's response to the event. Uses a center phone even if just to leave an open line to the 911 operator.

   The fire alarm is not pulled/activated.

C. Refer to the Armed Intruder Training and associated Armed Intruder Table Top Exercise for more information on the center's plan and practices used to manage these emergencies.

XXVII. WINTER STORMS

Background

Winter storms are often an underestimated threat. For the frail elderly, the single greatest threat posed by winter is the loss of body heat. Normal aging is accompanied by a decline in the ability to thermo-regulate. Chronic ailments and acute injuries exasperate the ability to self-regulate body temperature. In fact, fifty percent of cold-related injuries happen to individuals over the age of 60.

Preparing for the Storm

A. Before the snow begins:

1. All departments must inventory existing supplies and order low supplies prior to snowfall.
2. Generator fuel must be checked and generator test run. If your generator uses diesel or propane, the tank should never fall below ½ tank fill level at any time.
3. Snow blower fuel must be checked and test run.

B. After snow has started to fall:

1. Parking lot entrance, fire lane and all facility exits must be kept clear.
2. Fire hydrants are to be kept accessible at all times.
3. Areas for ambulances and supply vehicles take priority over parking areas.

Winter Hazard Communication

The National Weather Service issues outlooks, watches, warnings, and advisories regarding potentially hazardous winter weather.

- Outlook: this is essentially a forecast, informing the public that winter storm conditions are possible in a 2 to5 day timeframe. Actions at this time are to monitor local media for weather condition updates.
- Advisory: winter weather conditions are expected and should cause significant inconvenience and could potentially create hazardous conditions. However, if one is prepared and cautious, advisory conditions should not be life threatening.
- Watch: winter storm conditions are possible within a 36 to 48 hour window. Begin preparations.
- Warning: potentially hazardous winter weather is occurring or will occur in 24 hours.

Wind Chill

Wind chill can be a significant problem. Exposure to cold can lead to frostbite or hypothermia. The elderly are highly susceptible. Regardless of whether the temperature is 32F or -32F, cold has the same effect. Wind chill is not the actual air temperature, but is the impact of the combination of wind and cold upon exposed skin. Moving air conducts heat away from the body faster.

Wind Chill Chart

Adapted from the National Weather Service, Originally Published 11/01/01.

Temperature across top, wind speed down left side.

Calm	40	35	30	25	20	15	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	36	31	25	19	13	7	1	-5	-11	-16	-22	-28	-34	-40	-46	-52		
10	34	27	21	15	9	3	-4	-10	-16	-22	-28	-35	-41					
15	32	25	19	13	6	0	-7	-13	-19	-26	-32	-39						
20	30	24	17	11	4	-2	-9	-15	-22	-29	-35							
25	29	23	16	9	3	-4	-11	-17	-24	-31								
30	28	22	15	8	1	-5	-12	-19	-26	-33								
35	28	21	14	7	0	-7	-14	-21	-27									
40	27	20	13	6	-1	-8	-15	-22	-29									
45	26	19	12	5	-2	-9	-16	-23	-30									
50	26	19	12	4	-3	-10	-17	-24	-31									
55	25	18	11	4	-3	-11	-18	-25										
60	25	17	10	3	-4	-11	-19	-26										

Frostbite Times
30 Minutes
10 Minutes
5 Minutes

Response

To ensure residents do not suffer from exposure to cold, consider the following:

- Providing extra attention to residents who wander or are at risk for elopement.
- Clothing in loose-fitting layers and an insulated head covering, even indoors.
- Attempt to ensure that residents remain dry.
- Should a person succumb to cold, warming the person slowly, starting with the body core. Do not start warming with the arms and legs, as this will drive cold blood toward the heart which can trigger heart failure. Change the resident into warm, dry clothing and then cover them with a blanket. Avoiding providing alcohol, coffee, or any other hot beverage or food. Discuss administration of medications with the attending provider.
- Providing high calorie foods and snacks for staff and residents.
  Providing extra blankets. (If possible, hypo-allergenic blankets should be used. Residents who wish to use their own wool blankets or quilts with other natural fibers should be allowed to do so, but they should not be allowed to share these items as other residents may be allergic to the natural fibers.)
- Monitoring residents and increasing hydration activities; increased clothing and use of blankets may increase sweating. Dry air associated with extremely cold weather may also lead to residents dehydrating faster.

If the heating system suffers a significant mechanical failure during cold weather, consider evacuation.

Residents on medical oxygen should be given alternate safe means of staying warm and should be kept away from any potential source of ignition.

Evacuation under icing conditions is not a good idea. Be prepared to shelter in place in winter.

Note: Follow XII. Loss of Utilities C. Heating Failure if center heat is compromised.

XXVIII. 1135 WAIVERS

F. In the event that a major disaster or public health emergency is declared by the Secretary, the facility reserves the right to request a waiver in accordance with section 1135 of the Social Security Act, and by which certain statutory requirements and or services may be modified or waived during the duration of the emergency.

G. Under the waiver the role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials is such that sufficient services and healthcare items will be provided to the maximum extent feasible and in part, modifies requirements that physicians and other healthcare professional hold licenses in the State in which they provide services if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area).

XXIX. VOLUNTEERS

F. The Center may use volunteers in an emergency or other emergency staffing strategies as necessary to provide for the care and treatment of patients. The Center collaborates with the local Emergency Management Services and state or federally designated health care professionals to address surge needs during an emergency. Involvement of volunteers in management of emergencies is addressed in this EPP.

2. The CED/Designee determines involvement, appropriate tasks and roles of volunteers.
3. In advance of a crisis or disaster situation, the center works to ensure that staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand that the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations.
4. Staff are monitored through use of the staffing schedules (updated as needed), and volunteers, visitors and others are monitored using the visitor log (typically kept in the reception area).
5. The center maintains current information all center personnel and volunteers with addresses and phone numbers for contact purposes;
6. The Incident Commander/designee coordinates with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event that staff is needed in alternate locations. Trained volunteers are permitted to transport, move and assist residents if necessary.

Refer to Exhibit 8. NHICS Form 523, Volunteer Staff Registration.

XXX. ANNUAL REVIEW AND SIGN-OFF

A. The Safety Committee and the CED reviews and approves this manual and associated appendices and supporting documentation:

1. Prior to implementation;
2. After regulatory updates;
3. If new hazards are identified or existing hazards change;
4. After tests, drills, or exercises, if issues requiring corrective action have been identified;
5. After actual disasters/emergency responses;
6. After infrastructure changes;
7. At each update or revision; and
8. At least annually.

B. Staff Training

All staff are trained and demonstrate competency during orientation and annually with materials based on this Emergency Preparedness Plan and corresponding policies and procedures. The center maintains electronic and/or written documentation of training. CEDs must ensure that training is completed as required.

C. Staff Testing: Exercises, Drills and Simulations

1. This center conducts internal and external training exercises, drills, and simulations **at least annually and in accordance with applicable local, state, and federal guidelines**. This training is discussed further in the center's Emergency Preparedness Compliance Guide.
   i. This center participates in full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. (Note: If this center has experienced an actual natural or man-made emergency that required activation of the emergency plan, the center will not in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of that event.); and
   ii. This center conducts an additional exercise that may include, but is not limited to the following: a second full-scale exercise that is community-based or individual, facility-based, or a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.
   iii. The center documents completion of these activities. This documentation includes an analysis of the center's response to the exercise and emergency events, and revises this Emergency Preparedness Plan as needed.
2. Exercises, drills, and simulations are used to practice emergency procedures and to identify concerns prior to a crisis or disaster situation.
   i. Drill evaluation are be conducted on different levels of management within the center.
   ii. Drill evaluations are not confined to routine fire or evacuation drills.
   iii. Drill evaluations are used to verify planning, response, and recovery programs are in place for the center.
3. Outside resources, including local emergency responders/support services, are invited to periodically participate in, observe, and evaluate internal exercises, drills, and simulations.
4. Exercises, drills, and simulations are documented to include:

i. Who participated;
ii. Concerns identified;
iii. Corrective actions taken to correct deficient areas; and
    a. Reports of such activities are retained within the center per state and federal regulations.

Refer to: <u>Appendix 24: Annual Review and Sign-off</u>

XXXI. STATE AND LOCAL REQUIREMENTS

F. The center may be required to follow more stringent state and local regulations than guided within this manual. As such, additional regulations are analyzed and complied with as necessary.

Refer to: Appendix 25: State and Local Requirements

XXXII. POLICIES AND PROCEDURES LINKS

Corporate Policies and Procedures

1.22 Emergency Preparedness (Summaries general emergency preparedness compliance.)
1.29 Emergency Preparedness: Evacuation and Waivers
1.30 Emergency Preparedness: Medical Records
1.31 Emergency Preparedness: Shelter in Place
1.32 Emergency Preparedness: Supplies
1.21 Significant Events Reporting

Food and Nutrition Services Procedures

6.3 Food Service Emergency Plan
6.4 Food Service Emergency Procedures

Omnicare LTC Pharmacy Services

1.0 LTC Facilities Receiving Pharmacy Products and Services from Pharmacy
7.5 Relocation of Residents or Pharmacy Services During an Emergency or Disaster

Center Operations

OPS100 Accidents/Incidents (Includes requirement to self-report.)
OPS142 Transfer Agreements
OPS161 Facility Assessment
OPS164 Utilization of Outside Resources during an Emergency

Preventative Maintenance Policies and Procedures

2.0 Emergency Generators

Safety and Health Policies and Procedures

SH100 Safety Management Program

XXXIII. FEDERAL DEFICIENCIES (ETAG) CROSSWALK

Provided as reference. **Users are strongly encouraged to refer to Genesis Central for up to date policies and procedures and to search for key words within this document and on Central for additional information.**

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0001	Establishment of the Emergency Program	Corporate P & P 1.22, Emergency Preparedness	Completed EPP (Full Plan) Completed EP Compliance Guide Appendices
E-0004	Development Maintain EP Program	Same as above	Same as above
E-0006	Maintain and Annual EP Updates	Same as above	Same as above
E-0007	EP Program Population	Center Operations P & P OPS 161 Facility Assessment	EPP Appendix 23. Description of Center Patient/Resident Population
E-0009	Process for EP Collaboration	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	References to collaboration throughout EPP
E-0013	Development of EP Policies and Procedures	Refer to Links Above	Refer to Links Above
E-0015	Subsistence Needs for Staff and Patients	Refer to Links Above	References throughout EPP
E-0018	Procedures for Tracking of Staff and Patients	Corporate P & P 1.22, Emergency Preparedness	Refer to Exhibit 3 and Exhibit 7 NHICS Forms 255 and 252 and references to these forms in the EPP
E-0020	Policies and Procedures including evacuation	Refer to Links Above	References to Evacuation throughout EPP
E-0022	Policies and Procedures for Sheltering	Corporate P & P 1.31, Emergency Preparedness: Sheltering in Place	References to Sheltering in Place in EPP
E-0023	Policies and Procedures for Medical Documents	Corporate P & P 1.30, Emergency	Refer to Section LL, Receiving Center: Medical Records

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
		Preparedness: Medical Records	
E-0024	Policies and Procedures for Volunteers	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Refer to Section XXIX. Volunteers and Exhibit 8, N HICS Form 523, Volunteer Staff Registration
E-0025	Arrangement with Other Facilities	Center Operations P & P OPS142 Transfer Agreements and OPS 164 Utilization of Outside Resources During an Emergency	Refer to Section VI.D. D. CED (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0026	Roles under a Waiver Declared by the Secretary	Center Operations P & P OPS163 Utilization of Outside Resources during an Emergency	Refer to Section XXVIII. 1135 WAIVERS
E-0029	Development of Communication Plan	Corporate P & P 1.22, Emergency Preparedness	Refer to section V. COMMUNICATION PLAN and associated exhibits
E-0030	Names and Contact Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Appendix 3: Center Administrative/Staff Contact List
E-0031	Emergency Contact Information	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Appendix 7: Emergency Resources and Contacts
E-0032	Primary/Alternate Means of Communication	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN
E-0033	Methods of Sharing Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN and Appendix 7: Emergency Resources and Contacts as well as references to evacuation and

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
			medical records throughout the EPP
E-0034	Sharing Information on Occupancy/Needs	Corporate P & P 1.22, Emergency Preparedness, Center Operations P & P OPS 142 Transfer Agreements	Refer to Section VII, SURGE CAPACITY and Appendix 13, Surge Capacity, and Refer to Section VI.D. D. CED (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0035	LTC and ICF/IID Family Notifications	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. Communication Plan and Section III. General Guidelines, D. Notification of Plan
E-0036	Emergency Prep Training and Testing	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0037	Emergency Prep Training Program	Corporate P & P 1.22, Emergency Preparedness	Vital Learn Reports and Completed Attestations; refer to Emergency Preparedness Compliance Guide
E-0039	Emergency Prep Testing Requirements	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0041	LTC Emergency Power	Preventative Maintenance P & P 2.0, Emergency Generators	Refer to Section XII, Loss of Utilities, Appendix 2, Building Construction and Safety, and Appendix 15, Utility Shut Off Procedures
E-0042	Integrated Health Systems	Not Applicable	Not Applicable

XXXIV. EMERGENCY NOTIFICATION ANNOUNCEMENTS

TAKE COVER

"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."

"All Clear, Take Cover is over" is then paged to signal the Take Cover situation has ended.

LOSS OF UTILITIES

"Facility Alert-We are activating Loss of Utilities protocols- (Describe loss of Power and Location). Please continue your duties and listen for further instructions."

BOMB THREAT

"Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions."

NUCLEAR, CHEMICAL, OR RADIATION FALLOUT

"Facility Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."

FIRE

"Facility Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."

INTERNAL OR EXTERNAL DISTURBANCE

"Security Alert- We have a disturbance (Location). Please listen for further instructions."

HOSTAGE/ARMED INTRUDER SITUATION

"Security Alert-We are activating Hostage/Armed Intruder protocols- We have a Hostage/Armed Intruder situation (Location). Please listen for further instructions."

ELOPEMENT

"Medical Alert-We are activating Missing Resident protocols- The Resident was last seen (location)."

TORNADO WATCH

"Medical Alert-We are activating severe weather protocols-A tornado watch has been issued for this area effective until _____ (time watch ends)." (Repeated after five (5) minutes and then hourly until the watch has terminated.)

TORNADO WARNING

"Medical Alert-We are activating severe weather protocols-A tornado warning has been issued for our area. Immediately implement Take Cover procedures. Repeating—a tornado warning has been issued for our area. Immediately implement Take Cover procedures." (Repeated after five (5) minutes and then hourly until the warning has terminated)

FLOOD WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols-A flood/flash flood watch or warning has been issued for this area effective until _____ (time watch ends)."

HURRICANE WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- a hurricane/tropical storm watch has been issued for this area effective until _____ (time watch ends)."

GENERAL ALL CLEAR ANNOUNCEMENT

"All Clear, Repeat, All Clear"

Emergency Preparedness Plan (EPP) List of Appendices

- Appendix 1: Hazard Vulnerability Analysis (HVA)
- Appendix 2: Building Construction and Life Safety
- Appendix 3: Center Administrative/Staff Contact List
- Appendix 4: Emergency Operation Center Designation
- Appendix 5: Area Administrative Staff Contact List
- Appendix 6: Company Contacts
- Appendix 7: Emergency Resources and Contacts
- Appendix 8: Additional Resources
- Appendix 9: Transfer Agreements
- Appendix 10: Short-term Evacuation Plan
- Appendix 11: Triage of Casualties
- Appendix 12: Emergency Supplies and Location of Critical Equipment
- Appendix 13: Surge Capacity
- Appendix 14: Emergency Water Supply
- Appendix 15: Utility Shut-off Procedures
- Appendix 16: Potential Explosives List
- Appendix 17: Special Care Unit Fire Procedure
- Appendix 18: Fire Sprinkler Shut-Down Procedures
- Appendix 19: Fire Alarm Reset Procedures
- Appendix 20: Security Plan
- Appendix 21: Elopement Drill Documentation Form
- Appendix 22: Succession Plan
- Appendix 23: Description of Center Patient/Resident Population
- Appendix 24: Annual Review and Sign-Off
- Appendix 25: State and Local Requirements
- Appendix 26: Insertions from Compliance Guide Completed Tasks

Appendix 1: Hazard Vulnerability Analysis (HVA)

Instructions
Evaluate each event type using the hazard specific scale, using an all-hazards approach that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address a wide spectrum of emergencies/disasters.

Event Type
This column includes the event, risk or disaster you are assessing. Additional events may be added and evaluated in the Assessment; use the blank lines for these items.

Probability
Rate the probability of the risk occurring on a scale of zero (event will not occur) to 3 (event is very likely to occur). To rate the probability of an event occurring, at a minimum consider the known risk of the event occurring based on historical data and manufacturer/vendor statistics.

- Scale: How often has the event occurred within the last year to 10 years?
  - There is no likelihood of this event occurring in this setting/area (i.e., volcano). = score of 0 (no additional entries are required for this event type)
  - Event has not occurred in the past 10 years = score of 1
  - Event occurs every 3 to 10 years = score of 2
  - Event occurs approximately every 1 to 3 years = score of 3

Note: The Probability of human events (i.e., workplace violence, mass casualties) can never be assessed with a probability score of 0. These types of events have the score of 0 identified as N/A in the HVA.

Risk
Rate the associated risk of each event to patients and staff, property, finances (such as the cost to replace, cost of repair, time to recover and the potential interruption or inability to provide services). Input the highest associated score.

- Scale: If the event occurs will it result in:
  - A threat to human health, safety or life? Could the event result in significant injury or death? Score = 5
  - Property Damage? Score = 4
  - Economic Loss or Legal Ramifications? Will employees be able to report to work? Will patients be able to get to the center? Would the center be at risk for fines, penalties, or other legal interventions? Score = 3
  - Systems Failure? Score = 2
  - Loss of Community Trust or Goodwill? Score = 1

Preparedness
Rate the center's level of preparedness for the event.

- Scale: If the event occurs the center is:
  - Well prepared: the center has a current plan, the staff is aware of the plan and has participated in drills, back-up systems are available = score of 1
  - Partially prepared: the center has a plan, with current documents and contracts. Staff may require additional training or drills, center may need back-up systems = score of 2

- Not Prepared: the center does not have a plan at all, or only has a plan, and has not trained the staff or collected associated documents and contracts, and does not have back-up systems = Score of 3

Using the HVA

For each row, Multiply the Probability score by the sum of the Risk and Preparedness scores from all columns, enter score Review and highlight the events types with highest Hazard Vulnerability (HV) scores. These events pose the greatest risks to the center, and are carefully considered and prepared for as the center completes the rest of the appendices in the EPP, and associated training and drills.

Hazard Vulnerability Assessment

Center Name Westwood Center Keene NH Business Unit #: 57042 Date: 1/20/2019

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			HV SCORE
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	←Multiply probability score by sum of risk and preparedness scores from all columns, enter score
HURRICANE	X						X					X	7
TORNADO		X			X							X	8
SEVERE THUNDERSTORM	X								X			X	5
SNOWFALL	X								X			X	5
BLIZZARD	X								X			X	5
ICE STORM	X								X			X	5
EARTHQUAKE			X				X					X	5
TIDAL WAVE				X					X	X			4
EXTREME TEMPERATURES	X								X	X			5
DROUGHT	X								X			X	5
FLOOD, EXTERNAL	X								X			X	5
WILD FIRE	X								X			X	5
LANDSLIDE	X								X			X	5
VOLCANO				X	X					X			4
PANDEMIC			X						X			X	3
ELECTRICAL FAILURE	X								X			X	5
GENERATOR FAILURE	X								X			X	5
TRANSPORTATION FAILURE			X						X			X	3
FUEL SHORTAGE		X							X			X	4
NATURAL GAS FAILURE		X							X			X	4
SEWER FAILURE		X							X			X	4
STEAM FAILURE				X					X	X			4
FIRE ALARM FAILURE		X							X			X	4
COMMUNICATION FAILURE	X								X		X		6

Revised 4/1/23

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			TOTAL
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	← *Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
MEDICAL VACUUM FAILURE				X					X			X	**2**
HVAC FAILURE		X							X			X	**4**
INFORMATION SYSTEM		X							X			X	**4**
FIRE, INTERNAL	X							X				X	**6**
FLOOD, INTERNAL	X							X				X	**6**
HAZMAT, INTERNAL	X							X				X	**6**
MASS CASUALTY – TRAUMA				N/A									**0**
MASS CASUALTY – MEDICAL				N/A									**0**
MASS CASUALTY – HAZMAT				N/A									**0**
HAZMAT EXPOSURE				N/A									**0**
TERRORISM – BIOLOGICAL				N/A									**0**
TERRORISM – CHEMICAL				N/A									**0**
HOSTAGE SITUATION				N/A									**0**
CIVIL DISTURBANCE (RIOT)				N/A									**0**
LABOR ACTION				N/A									**0**
BOMB THREAT				N/A									**0**
WORKPLACE VIOLENCE				N/A									**0**
DOMESTIC VIOLENCE				N/A									**0**
BUILDING BREAK-IN				N/A									**0**
AUTO BREAK-IN				N/A									**0**
MEDICATION THEFT				N/A									**0**
ASSAULTS (OUTSIDE)				N/A									**0**
ELOPEMENT				N/A									**0**
KIDNAPPING				N/A									**0**

Appendix 2: Building Construction and Life Safety

Instructions: Enter information as prompted.

A. Building Construction Type/Year Built (refer to Life Safety Survey for details): 1965 - Concrete Construction

B. Have additions been constructed? □ Yes X □ No

1. If additions have been constructed, in what year(s)?

C. Number of Stories:	2
D. Number of Buildings:	1
E. Number of Beds:	85
F. Approximate Number of Staff per Shift:	20, 12, 8 1st, 2nd , 3rd
G. Fire Alarm System – Name of Monitoring Service:	Fire Impact
H. Generator Vendor Name:	Power Up Generator
Generator Vendor Phone Number:	866-420-4906
1. Type, phase and voltage of generator:	Cat 3 Phase 75 Volts
2. Areas of the building supplied by emergency power:	All except walk in fridge and dryers
3. Fuel Type:	Diesel
4. Fuel Capacity:	275 Gallons
5. Fuel Duration:	3 days of running
6. Fuel Tank above or below ground level?:	Above
7. How/When is generator tested?:	Every week no load test/every month under load for 30 minutes
8. Is generator above projected flood level?:	Yes
9. How/When is generator tested?:	Annually by Power Up Generator

I. Is the building constructed to withstand hurricanes or high winds? □ YesYES

If Yes:

1. What is the highest category of hurricane or wind speed that the building can withstand? Category 4 miles per hour
2. What is the highest category of hurricane or wind speed that the center roof can withstand Category 2 miles per hour
3. Is the center in a flood plain? NO □ No
4. If the center is in a hurricane zone, is a storm surge expected? NO

J. General description of resident/patient population:Elderly or have medical needs or rehab.

Guide for Areas of Refuge Identification

For the safety of building occupants, the Emergency Preparedness Leadership Team identifies the best available refuge areas in the center. Many buildings contain rooms or areas designed to offer some degree of protection from all but the most extreme tornadoes and winds. In buildings without specific rooms designed and constructed to serve as safe rooms, the goal should be to select the **best available refuge areas** - the areas that will provide the greatest degree of protection.

In general, the **best available refuge areas** meet the following criteria:

- **Interior rooms.** Rooms without an exterior wall or window are less likely to be penetrated by windborne debris. Examples include resident bathrooms, small office areas without windows, janitor closets, clean and soiled utility rooms, pantry storage rooms, medication rooms, basement rooms and corridors, central supply rooms, center restrooms, staff locker rooms, and closets.
- **Location below ground or at ground level.** Upper floors are more vulnerable to wind damage.
- **No glass in the room.** Typically, windows and glass doors are extremely vulnerable to high wind pressures and the impact of windborne debris.
- **Reinforced concrete or reinforced masonry walls.** Reinforced walls are much more resistant to wind pressures and debris impact, but can fail if the roof deck is blown away.
- **Strong connections between walls and roof and walls and foundation.** Walls and roofs are better able to resist wind forces when they are securely anchored to the building foundation.
- **Short roof spans.** Roofs with spans of less than 25 feet are less likely to be lifted up and torn off by high winds.
- **Long central corridors** often qualify as the best available refuge areas. In addition to having desirable structural characteristics (e.g., short roof spans, minimal glass area, and interior locations), corridors usually are long enough to provide the required amount of refuge area space and can be quickly reached by building occupants. **If a corridor is chosen, marking the high wind area of refuge boundaries at least 30 feet from a glass door or window is advisable,** as well as educating staff to keep occupants within the boundaries and to close all doors leading to the corridor during a high wind event.

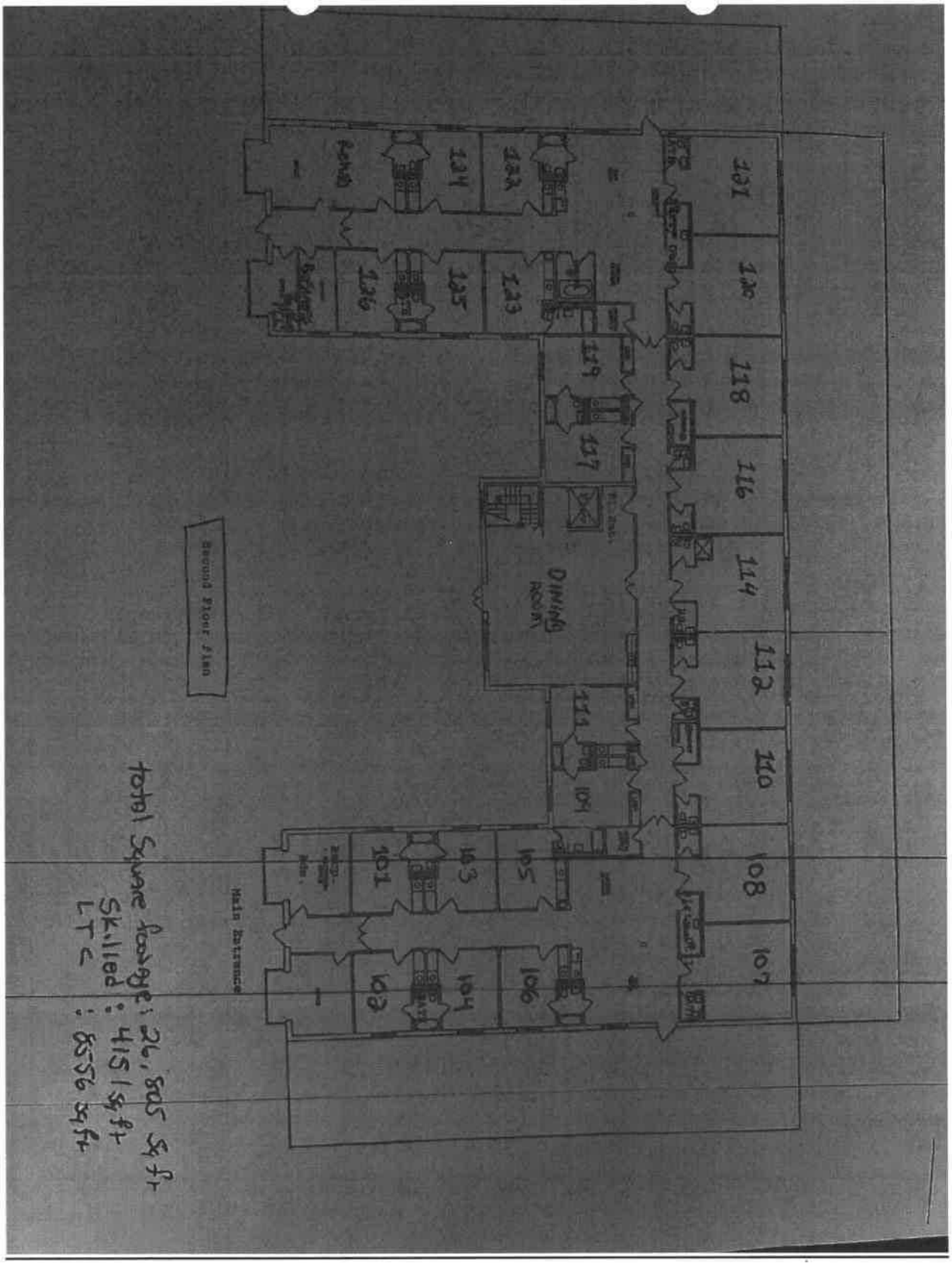
*Note: The best available refuge areas do **not** ensure the safety or survival of their occupants. They are simply the areas of a building in which survival is most likely.*

If the center is unsure whether a particular location is appropriate to use as a high wind area of refuge, the Team refers to Federal Emergency Management Agency FEMA's Best Available Refuge Area Checklist to evaluate appropriate areas of refuge

Part B: Refuge Areas

List all areas of refuge according to the guidelines above and mark these areas on the center floor plan:

1. Main Dining Room- Concern: Large wall of windows
2. Main Hallways No windows
3. Downstairs Dining Room- Limited Window, Under Ground from Front of Building
4. Downstairs Main Hallway- No windows, inside building
5. Downstairs Resident Bathrooms- No Windows
6. Employee Breakroom- Small Limited Window, Underground from front of building
7. Laundry- No Windows, Under Ground from Front of Building, Within Center of Building
8. Resident Bathrooms- No Windows, Inside Building Space
9. Shower Rooms- No Windows, Inside Building Space
10. Maintenance/MDS/Recreation Office- No Windows, Inside Building Space
11. Kitchen- No Windows, Inside Building Space
12. Employee Enterance- No Windows
13. Main Stairwell


Second Floor Plan
DINING ROOM
Main Entrance
131
130
118
116
114
112
110
108
107
134
132
126
125
123
119
117
111
101
103
105
102
104
106
Total Square footage: 26,805 Sq ft
Skilled : 4151 Sq ft
LTC : 8556 Sq ft

Demolish unit: 4340 sq. ft.
Unit 3
Kitchen
Office
Laundry
Crawl space
= BEDS

Enhanced Fujita (EF) Scale for Tornadoes

EF-Scale:	Typical Damage:
EF-0 (65-85 mph)	Light damage. Peels surface off some roofs; some damage to gutters or siding; branches broken off trees; shallow-rooted trees pushed over.
EF-1 (86-110 mph)	Moderate damage. Roofs severely stripped; mobile homes overturned or badly damaged; loss of exterior doors; windows and other glass broken.
EF-2(111-135 mph)	Considerable damage. Roofs torn off well-constructed houses; foundations of frame homes shifted; mobile homes completely destroyed; large trees snapped or uprooted; light-object missiles generated; cars lifted off ground.
EF-3 (136-165 mph)	Severe damage. Entire stories of well-constructed houses destroyed; severe damage to large buildings such as shopping malls; trains overturned; trees debarked; heavy cars lifted off the ground and thrown; structures with weak foundations blown away some distance.
EF-4 (166-200 mph)	Devastating damage. Whole frame houses Well-constructed houses and whole frame houses completely leveled; cars thrown and small missiles generated.
EF-5 (>200 mph)	Incredible damage. Strong frame houses leveled off foundations and swept away; automobile-sized missiles fly through the air in excess of 100 m (109 yd); high-rise buildings have significant structural deformation; incredible phenomena will occur.
EF No rating	Inconceivable damage. Should a tornado with the maximum wind speed in excess of EF-5 occur, the extent and types of damage may not be conceived. A number of missiles such as iceboxes, water heaters, storage tanks, automobiles, etc.will create serious secondary damage on structures.

Hurricane Categories

Category	Sustained Winds	Types of Damage Due to Hurricane Winds
1	74-95 mph 64-82 kt 119-153 km/h	**Very dangerous winds will produce some damage:** Well-constructed frame homes could have damage to roof, shingles, vinyl siding and gutters. Large branches of trees will snap and shallowly rooted trees may be toppled. Extensive damage to power lines and poles likely will result in power outages that could last a few to several days.
2	96-110 mph 83-95 kt 154-177 km/h	**Extremely dangerous winds will cause extensive damage:** Well-constructed frame homes could sustain major roof and siding damage. Many shallowly rooted trees will be snapped or uprooted and block numerous roads. Near-total power loss is expected with outages that could last from several days to weeks.
3 (major)	111-129 mph 96-112 kt 178-208 km/h	**Devastating damage will occur:** Well-built framed homes may incur major damage or removal of roof decking and gable ends. Many trees will be snapped or uprooted, blocking numerous roads. Electricity and water will be unavailable for several days to weeks after the storm passes.
4 (major)	130-156 mph 113-136 kt 209-251 km/h	**Catastrophic damage will occur:** Well-built framed homes can sustain severe damage with loss of most of the roof structure and/or some exterior walls. Most trees will be snapped or uprooted and power poles downed. Fallen trees and power poles will isolate residential areas. Power outages will last weeks to possibly months. Most of the area will be uninhabitable for weeks or months.
5 (major)	157 mph or higher 137 kt or higher 252 km/h or higher	**Catastrophic damage will occur:** A high percentage of framed homes will be destroyed, with total roof failure and wall collapse. Fallen trees and power poles will isolate residential areas. Power outages will last for weeks to possibly months. Most of the area will be uninhabitable for weeks or months.

Contact/Title:	US Department of Homeland Security
Address:	500 C Street SW
City, State Zip	Washington, DC 20472
Phone Number:	202-646-2500

COMMUNITY RESOURCES CONTACTS:

Agency:	**Name:**	**Phone:**
County Health Department	Health Department	603-352-5440
LTC Ombudsman	LTC Ombudsman Office	800-442-5640
State Licensing and Certification Agency	Heatlh Facilities	603-271-9499
County DHHR Office	Elder Care	800-624-9700
Poison Control Center	NH Poison Control	800-222-1222

Appendix 8: Additional Resources

Use this form to maintain contact information for emergency support services.

NHICS FORM 258 | CENTER RESOURCE DIRECTORY

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Agency for Toxic Substances and Disease Registry (ATSDR)	ATSDR	1-800-232-4636	1-770-488-7100		www.ATSDR.cdc.gov/
Ambulance/EMS	Diluzio Ambulance Service	603-357-0341	1-888-345-8946		
American Red Cross	American Red Cross NH	603-225-6697	1-800-464-6692	NHinfo@redcross.org	www.redcross.org/local/New-Hamsphire-Vertmont/about-us/contact
Biohazard Waste Company	Stericycle	1-866-783-7422			www.stericycle.com
Buses	Delano Company	603-399-4371			
Cab, City	Adventure Limousine	603-357-2933			www.advlimo.com
Emergency Management Agency	Cheshire County EMA	603-354-5454 ext3030			
CDC	CDC and prevention	(770) 455-0546			www.cdc.gov/contact/index.htm
Clinics	Cheshire Medical Center	603-354-5400			www.**cheshire-med**.com
Coroner/Medical Examiner	Medical Examiner	(603) 271-1235			www.doj.nh.gov/medical-examiner
Dispatcher - 911	911 call Center	911			
Emergency Operations Center (EOC), Local	Keene Dispatch Center	603-357-9861			
Emergency Operations Center (EOC), State	New Hampshire Dept. of Safety	603-271-2231			
Engineers:					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
HVAC	Granite state plumbing and heating	603-529-3322			
Mechanical	Holmes construction	603-231-3242			
Structural					
Environmental Protection Agency (EPA)	NH Dept of Enviornmental services	603-271-3500			www.epa.gov/NH
Epidemiologist	NH Dept of Health	603-624-6466			www.manchesternh.gov/dept/health
Family	*SEE FAMILY CONTACT LIST*				
Fire Department	Keene Fire Department	603-209-1742			https://ci.keene.nh.us/fire
Food Service	US Foods				
Fuel	Liberty Utilities	(800)833-4200			www.libertyutilities.com
Funeral Homes/Mortuary Services	Foley Funeral	(603) 352-0341			www.foleyfuneralhome.com/
Generators	Power up Generator	866-420-4906	603-657-9080		powerupgeneratorservice.com
HazMat Team	Keene Fire Dept.	911			
Health Department, Local	Keene Health Dept.	603-357-9836			
Heavy Equipment (e.g., Backhoes, etc.)	Holmes Construction	603-231-3242			
Home Repair/Construction Supplies:	Home Depot	603-355-2113			
Hospitals:	Cheshire Medical Center	603-354-5400			www.**cheshire-med**.com

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Hotel	Best Western				bestwestern.com/Official
Housing, Temporary					
Ice, Commercial	US foods				
Laboratory Response Network	US Labs				
Laundry/Linen Service	People's Linen	(603) 352-2038			peopleslinen.com
Law Enforcement:	Keene Police Dept.	603-352-2222			www.keenepd.org
City Police	Keene Police Dept.	603-352-2222			www.keenepd.org
County Sherriff					
Highway Patrol	NH state police	603-271-1162			
Licensing & Certification District Office	Michael Fleming	(603) 271-9499			https://www.dhhs.nh.gov/contactus/index.htm
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:	Keene Center	603-357-3800			
Media:	WMUR channel 9				
Print	Keene Sentinel	603-352-1234			
Radio					
Radio					
TV					
TV					
TV					
Medical Gases	Airgas	603-357-1288			
Medical Supply	Twinmed				

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Medication, Distributor:	Pharmscript				
Moving Company:					
Pharmacy, Commercial:	Pharmscript				
Poison Control Center	Northern NE Poison Center				https://www.nnepc.org/
Portable Toilets					
Radios:	Keene Center/Langdon Place	357-3800			
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds	Joerns	1-800-826-0270			**joerns**.com
Biomedical Devices					
Medical Devices					
Oxygen Devices	All Purpose Llc	877-595-8317			
Radios					
Restoration Services (e.g., Service Master)					
Road Conditions					
Salvation Army					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Shelter Sites					
Staff	*SEE STAFF CONTACT LIST*				
Surge Facilities	Listed with CED				
Trucks:					
Refrigeration	GKS	603-622-7300			
Towing					
Utilities:					
Gas	Liberty Utilities	603-209-2586			
Power	Eversource	1-800-662-7764			www.eversource.com
Sewage	Keene water dept.	(603) 352-6550			https://keenetx.com/departments/utilities
Telephone	Sentenia systems	978-536-4499			
Water					
Ventilators					
Water Vendor - Potable	US foods	See above			
Other:					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE

Appendix 9: Transfer Agreemen

Use this form to document every transfer agreement for transportation and reception of residents (eg. other Long-Term Care Centers, Hospitals, and Ambulance Companies). **Reminder: Execute at least one agreement with a Long Term Care Center more than 50 miles away.**

Resident COVID-19 status will be identified

Type of Service:	Hospital
Name:	Cheshire Medical
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 354-5400

Type of Service:	Ambulance/Transport
Name:	Diluzio
Address:	
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 357-0341

Type of Service:	Long Term Care
Name:	Landgon Place of Keene
Address:	Arch Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-3902 Kathleen Nichols Administrator

Type of Service:	Long Term Care
Name:	Applewood
Address:	8 Snow Road
City, State, Zip	Winchester, NH 03470
Phone Number:	(603) 239-6355 Gail Cushing, Administrator

Type of Service:	Long Term Care
Name:	Jaffry Rehabiliation and Nursing Center
Address:	20 Plantation Drive
City, State, Zip	Jaffrey, NH 03452
Phone Number:	(603) 532-8762 Patrick Lyons, Administator [redacted]

Type of Service:	Long Term Care
Name:	Keene Center
Address:	677 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 357-3800 Michale Johnson, Admin [redacted]

App. dix 10: Short-Term Evacuatio. 'lan

Enter the information requested below. Describe the center's plan for short-term evacuation procedures. Consider custody issues for patients in specialty care units, accountability process for visitors and vendors, maintaining clear approach areas for emergency equipment and personnel, and a communication plan when developing these procedures.

Short-term evacuation will be used if immediate evacuation of the center is needed for safety considerations (e.g. the structural integrity of the building is compromised or there is an active fire in the center). Employees, staff, and residents will gather at established meeting spaces outside the center. Choose gathering points away from where emergency personnel will be responding to the center. Plan to use cell phones to communicate the short-term evacuation activation to the RVP, transportation services, short-term evacuation site, and the long-term evacuation sites to indicate a long-term evacuation is possible. Plan for no re-entry to the building until it is determined it is safe to do so.

(Note: While areas such as school gymnasiums and churches are not good evacuation sites for a long-term evacuation, they may be used if the structural integrity of the center is compromised. If it is determined a long-term evacuation is necessary, follow the center's plan for evacuation using the short-term evacuation area as the sending center.)

PLAN

Meeting Place 1:Main Dining Room 2nd Floor,

Meeting Place 2: Dining Room 1st Floor Unit #3

Transportation Services: Diluzio Ambulance . The back up is Thomas Transporation

Potential Locations – Stop Over: Alumni Center at Keene State. – Contact Security to activate the plan and they can unlock the center after hours. Telephone # 603-358-2228

Appendix : Triage of Casualties (update 1/15/2017)

Instructions:

In the event of an internal or external disaster resulting in injuries, all casualties will be triaged using the priority Mass Casualty criteria and tags identified below. The Center Nurse Executive and Medical Director or designees will coordinate the process in collaboration with emergency personnel. Where appropriate, victims from external disasters will be triaged at the ambulance entrance.

Priority 1 Immediate (Red): Serious, but salvageable life threatening injury/illness

Victims with life-threatening injuries or illness (such as head injuries, severe burns, severe bleeding, heart-attack, breathing-impaired, internal injuries) are assigned a priority 1 or "Red" Triage tag code (meaning first priority for treatment and transportation).

Priority 2 Secondary (Yellow): Moderate to serious injury/illness (not immediately life-threatening)

Victims with potentially serious (but not immediately life-threatening) injuries (such as fractures) are assigned a priority 2 or "Yellow" (meaning second priority for treatment and transportation) Triage tag code.

Priority 3 Delayed (Green): 2 types

- Victims who are not seriously injured, are quickly triaged and tagged as "walking wounded", and a priority 3 or "green" classification (meaning delayed treatment/transportation). Generally, the walking wounded are escorted to a staging area out of the "hot zone" to await delayed evaluation and transportation.
- Delayed also includes those victims with critical and potentially fatal injuries or illness, indicating no immediate treatment or transportation.

Priority 4 Deceased (Black):

Victims who are found to be clearly deceased at the scene with no vital signs and/or obviously fatal injuries are classified as deceased or priority 4 (Black) in the triage coding system.

Planned Triage Locations

After triage, casualties will be moved to the following locations for treatment, evaluation, and transportation, as appropriate:

Priority 1: Front Conference Room
Priority 2: Upstairs Dining Room
Priority 3: Front Lobby
Priority 4: Evergreen Courtyard

Appendix 12: Em. gency Supplies and Location of :itical Equipment

Instructions: *Enter the location of emergency supplies; add additional items as necessary.*

ITEM	LOCATION
Radio (transistor) weather / radio alert	Garage/Maintenace backroom
Flashlight / Glow Sticks (extra batteries and bulbs)	Crash carts at each nursing unit
Self-stick tags for identification purposes	All nursing stations
Basic tool kit (hammer, pliers, screwdriver(s), knife, etc.)	***All 3 nursing stations***
Shovel(s)	Maintenance Garage
Drinking water supply per contract	Sand Cellar downstairs
Disposable eating equipment	Kitchen
Food, emergency supply	Kitchen
Waterless hand cleaner	Central Supply
Gloves and masks	Central Supply
Linens, blankets, adequate in case of power failure	Laundry Room
Emergency first-aid kit	Nursing Units
Trash Bags	Kitchen and Laundry
Log or tablet to list residents/patients/employees leaving the Center	Visitor log books
Incontinent supplies (briefs), disposable wash cloths	Central Supply
Room thermometers	Nursing Units
Blood pressure cuffs	Central Supply or Nursing Units
Stethoscopes	Central supply or Nursing Units
Mass Casualty Tags (red, yellow, green, blue, black)	Unit One Crash Cart
Policy and procedure manuals	Nursing Units On line
Personal protective equipment	Janitor Closets Kitchen Laundry Rooms
MSDS	Nursing Units, Activities Housekeeping Dietary Reception
Master keys	Reception Lock Box

FIRE EXTINGUISHERS	LOCATION
10# ABC	Medical Records Room
5 # ABC	Break Room
Class K	Kitchen near entrance door
10 # ABC	Kitchen by phone
20 # ABC	Boiler Room inside door
10 #ABC	Exit Door by Salon

10 #ABC	Central Supply
10 #ABC	Elevator Room
10 #ABC	Laundry Room
10 #ABC	By Room 2
10 #ABC	By Room 7
10 #ABC	By room 106
10 #ABC	By Main Dining Room
10 #ABC	Inside main dining room double doors
10 #ABC	By room 122
10 #ABC	In training office
10 #ABC	At timeclock
10 #ABC	Outside main dining room door at gazeebo
10 #ABC	Inside of garage roll-up door

Appendix 13: Surge Capacity

Instructions: Enter information into the table as prompted below.

This analysis assists the center in determining the maximum number of patients that may be accommodated if the center is asked to expand services through the local EMS or to meet the terms of a Memorandum of Understanding (MOU) with another provider.

Location	Number of Possible Additional Beds (Based on 70 Sq. Ft./Bed)	Priority Level of the Area (from least desirable to most (Scale: 1 – 10)	Comments (Ex: Possible Isolation Area or Specialty Area)
Private Rooms Which Can Accept Additional Beds	0	0	
Semi-Private Rooms Which Can Accept Additional Beds	0	0	
Additional Bed Space Downstairs Dining Rooms	8	5	Specialty Area
Additional Bed Space Upstairs Dining Room	8	5	Specialty Area
Additional Bed Space Beauty Shop	2	10	
Additional Bed Space Rehab Gym	3	2	Specialty Area
Additional Bed Space Unit 1 & 2 Lounges	6	1	Open area
Additional Bed Space Employee Lounge	4	10	Has Bathroom Attached
Additional Bed Space Offices	3	8	CNE, SSD, CED
Additional Bed Space Temp Therapy Gym	4	10	Room 114
Additional Bed Space Offices	4	10	Room 101 & 102
Total Additional Beds (Surge Capacity)	8		

[redacted] HEALTHCARE ~ WESTWOOD — SQUARE FOOTAGE SURVEY

#	DESCRIPTION	SQFT
40	ADMINISTRATOR	219.66
41	BUSINESS OFFICE	219.66
42	SOCIAL SERVICE	121.60
43	DNS OFFICE	103.07
44	W2 OFFICE	19.80
29	LOUNGE OFFICE	346.50
45	W2 STAFF BATH	20.64
46	W1 STAFF BATH	20.64
30	W3 STAFF BATH	23.02
	ADMINISTRATIVE & GENERAL	1095.22

#	DESCRIPTION	
13	BOILER ROOM	599.74
19	ELEVATOR ROOM	123.84
20	ELEVATOR	25.01
	PLANT OPERATIONS	748.59

#	DESCRIPTION	
47	W2 DIRTY UTILITY	65.00
48	W2 CLEAN LINEN CLOSET	17.50
49	W2 CLEAN LINEN CLOSET	17.50
50	W1 CLEAN LINEN CLOSET	17.50
51	W1 CLEAN LINEN CLOSET	17.50
52	W1 DIRTY UTILITY	65.00
16	PERSONAL CLOTHES	80.36
17	CLEAN LAUNDRY AREA	230.56
18	DIRTY LAUNDRY AREA	345.60
	LAUNDRY & LINEN	649.52

53	W2 JANITORS CLOSET	13.72
14	W3 JANITORS CLOSET	22.96
	HOUSEKEEPING	36.68

P.2

#	DESCRIPTION	SQ. FT.
54	UPSTAIRS DINING	1004.80
22	DOWNSTAIRS DINING	942.00
23	KITCHEN	945.10
24	KITCHEN OFFICE	68.88
25	KITCHEN FOOD STORAGE	173.76
26	KITCHEN JANITORS CLOSET	11.22
27	STAFF LOUNGE	501.54
	DIETARY	3647.30

#	DESCRIPTION	
201	RESIDENT ROOM	199.18
202	RESIDENT ROOM	199.18
203	RESIDENT ROOM	199.18
204	RESIDENT ROOM	199.18
205	RESIDENT ROOM	254.30
206	RESIDENT ROOM	243.04
207	RESIDENT ROOM	199.18
209	RESIDENT ROOM	199.18
210	RESIDENT ROOM	442.00
212	RESIDENT ROOM	442.00
214	RESIDENT ROOM	442.00
216	RESIDENT ROOM	442.00
218	RESIDENT ROOM	442.00
55	W2 NURSES STATION	176.00
56	W2 SHOWER ROOM	37.65
101	RESIDENT ROOM	199.18
102	RESIDENT ROOM	199.18
103	RESIDENT ROOM	199.18
104	RESIDENT ROOM	199.18
105	RESIDENT ROOM	254.30
106	RESIDENT ROOM	243.04
107	RESIDENT ROOM	199.18
109	RESIDENT ROOM	199.18
110	RESIDENT ROOM	442.00
112	RESIDENT ROOM	442.00
114	RESIDENT ROOM	442.00
116	RESIDENT ROOM	442.00
57	W1 NURSES STATION	76.44
58	W1 SHOWER ROOM	37.65
59	WHIRLPOOL ROOM	72.88

P.3

#	DESCRIPTION	
1	RESIDENT ROOM	309.16
2	RESIDENT ROOM	309.16
3	RESIDENT ROOM	423.19
4	RESIDENT ROOM	309.16
5	RESIDENT ROOM	309.16
6	RESIDENT ROOM	309.16
7	RESIDENT ROOM	309.16
8	RESIDENT ROOM	309.16
9	RESIDENT ROOM	309.16
10	W3 SHOWER ROOM	20.80
11	W3 NURSES STATION	62.09
	ROOMS	10878.86

#	DESCRIPTION	
60	OXYGEN STORAGE	13.72

#	DESCRIPTION	
15	CENTRAL SUPPLY	234.16

#	DESCRIPTION	
62	W1 MED ROOM	48.00
61	W2 MED ROOM	48.00
	MEDICAL SUPPLY	96.00

#	DESCRIPTION	
12	BEAUTY SHOP	167.44

#	DESCRIPTION	
63	W1 SITTING AREA	391.00
64	W2 SITTING AREA	391.00
	SITTING AREAS	782.00

P.4

#	DESCRIPTION	
31	LOUNGE SAND CELLAR	758.10
32	LAUNDRY SAND CELLAR	2340.56
65	STAIRWELL	126.50
		3225.13

#	DESCRIPTION	
66	W2 SHORT HALL	406.00
67	W2 SITTING HALL	280.00
68	UPSTAIRS LONG HALL	700.00
69	W1 SHORT HALL	406.00
70	W1 SITTING HALL	280.00
71	UPSTAIRS ELEVATOR ENTRANCE	64.86
21	DOWNSTAIRS ELEVATOR ENTRANCE	62.98
33	W3 SHORT HALL	196.80
34	W3 LONG HALL	1120.00
35	LOUNGE HALL	141.24
	HALLWAY	3657.88

#	DESCRIPTION	
72	ACTIVITY ROOM	219.66
73	ACTIVITY CLOSET	29.55

#	DESCRIPTION	
74	PUBLIC BATH	34.50
28	LOUNGE BATH	23.02
75	201-203 RESIDENT BATH	43.86
76	202-204 RESIDENT BATH	43.86
77	207-209 RESIDENT BATH	43.86
78	101-103 RESIDENT BATH	43.86
79	102-104 RESIDENT BATH	43.86
36	1-2 RESIDENT BATH	39.87
37	4-5 RESIDENT BATH	39.87
38	6-7 RESIDENT BATH	39.87
39	8-9 RESIDENT BATH	39.87
	BATH	436.30

TOTAL FACILITY SQFT: 25,917.71

Instructions: Enter information into the table as prompted below

1. Potable Water Contract Information

Company:	Garelick Farms
Address:	Farm Road
City:	Boston
State:	MA
Zip:	02010
Contact Person:	Brenda Cahill

2. Emergency Water Supply

The center may prioritize use of water for activities as follows:

i. Drinking
ii. Medicating
iii. Dietary use
iv. Personal hygiene
v. Waste water (mopping)

The Red Cross, FEMA and USGS recommend an emergency supply of one gallon of water per person, per day. The center has calculated this need as follows:

- Total bed capacity = 85__ + Total approximate expected staff per day 25 = 110 Total people
- Total people X 3 days = 330 gallons of water

The center's water source amounts and locations are as follows (enter applicable amounts and sites:

a. Primary

i. 200 gallons bottled water. Location(s): Sand cellar Staff lounge
ii. 0 gallons water in barrels. Location(s): _____
iii. 30 gallons in ice machine(s) Location(s): Kitchen
iv. TOTAL: 230 gallons*

(*Note: should meet or exceed gallons calculated in # 2, Above)

b. Secondary

i. 238 gallons in water heaters. Location: Boiler Room
ii. 41 gallons in toilet tanks.
iii. 10 gallons in other _____. Location: Staff lounge
iv. _____gallons in other _____. Location:

_____

Appendix 15: Utility Shut-Of rocedures

In the event of utility disruption, call the Center Executive Director and Maintenance Director immediately. The Center Executive Director or designee will be responsible for notifying the appropriate state agencies, as required. Enter the information required below.

Utility Shut-Off Locations

1. Water: Boiler Room near Sprinkler system
2. Electricity: Boiler Room near generator panel
3. Gas: Boiler Room as marked next to generator panel
4. Heat: Boiler Room first boilers when walking into the room, Turn off switches on boilers
5. Fire Sprinkler System:in boiler room far left corner, follow directions on system but should be qualified personnel all explained during orientation
6. Oxygen Room: NONE
7. Oxygen Manifold Shutoff: NONE

Generator/Battery System

The generator may be used in emergency situations.

Generator Location: Outside but panel is in boiler room

Extra Fuel Storage Location: Undernearth Generator

Location of generator Start Up Procedures: On back of panel in boiler room

In an emergency situation, the following individuals have the authority to "shut off" the utilities: Melissa Castor, Scott Meade, Daniel Birmingham and Andrew Mackey

Use diagrams and instructions on the shut off values, utility controls to explain and use each utility shut-off.

For centers that maintains an onsite fuel source to power the emergency generator(s), insert the contract with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency. (INSERT CONTRACT FOLLOWING THIS PAGE.)

Appendix 16: Potential Explosives List

Instructions: Enter all potential explosives and current location.

ITEM	LOCATION
Oxygen Storage	Outside against the building near employee entrance
Generator Fuel	Under generator on side of building near the boiler room
Garage heat	Propane tank beside Maintenance garage

Appen ɾ 17: Special Care Unit Fire Pı edure

The purpose of this section is to plan for the safety of Specialty Care Unit (SCU) residents in case of a fire or fire drill. Insert the required information below. *Due to the profile of the SCU residents, procedures may vary from routine center policy.*

In case of a fire or fire drill in any other zone in the building (outside of the SCU):

- All SCU residents who are not in bed will be kept together in a specific area.
- SCU staff close all doors in the unit and stay with SCU residents.
- Any residents who are in bed will remain in bed with the room door closed until all clear.

If fire or fire drill is in the SCU:

- SCU staff close all doors to rooms.
- SCU staff move residents past fire doors to safe area.
- SCU staff remain with the SCU residents until all clear.
- If residents are in bed, staff move residents potentially in immediate danger to safe area.

Fire Emergency During COVID-19 In Special Care Unit-

The purpose of this section is to plan for the safety of residents in case of a fire. Due to the profile of the COVID-19 residents, procedures may vary from routine Center policy.

If fire is on the COVID-19 Positive Unit:

• Staff move residents past fire doors to safe area, preferably not in AQU or COVID-naive areas.
• Staff close all doors to rooms.
• Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
• Staff remain with residents until all clear.

If fire is on the Admission Quarantine Unit (AQU):

• Staff move residents past fire doors to refuge area, preferably not in COVID-positive or the COVIDnaïve units
• Staff close all doors to rooms.
• Staff wear appropriate PPE including N95/approved KN95 respirator and face shield during transport and in refuge areas.
• Staff remain with the AQU residents until all clear

In case of a fire in any other zone in the building (outside of the COVID-19 Positive Unit):

• Staff move residents past fire doors to safe area, preferably not in COVID-positive or AQU area.
• All COVID-19 positive residents who are not in bed will be kept together in a specific area.
• Staff close all doors in the unit and stay with COVID-19 residents.
• Any residents who are in bed will remain in bed with the room door closed until all clear.
• Staff wear at a minimum face masks and eye protection, and wear appropriate PPE based on resident diagnosis and applicable transmission-based precautions

-Communicate with Fire Dept. before you do anything
-Located in the boiler room in the corner on the left.
-2 Valves or handles that are black.
-They will be turned to the right to turn off.
-Inform CED and maintenance of Shut Off

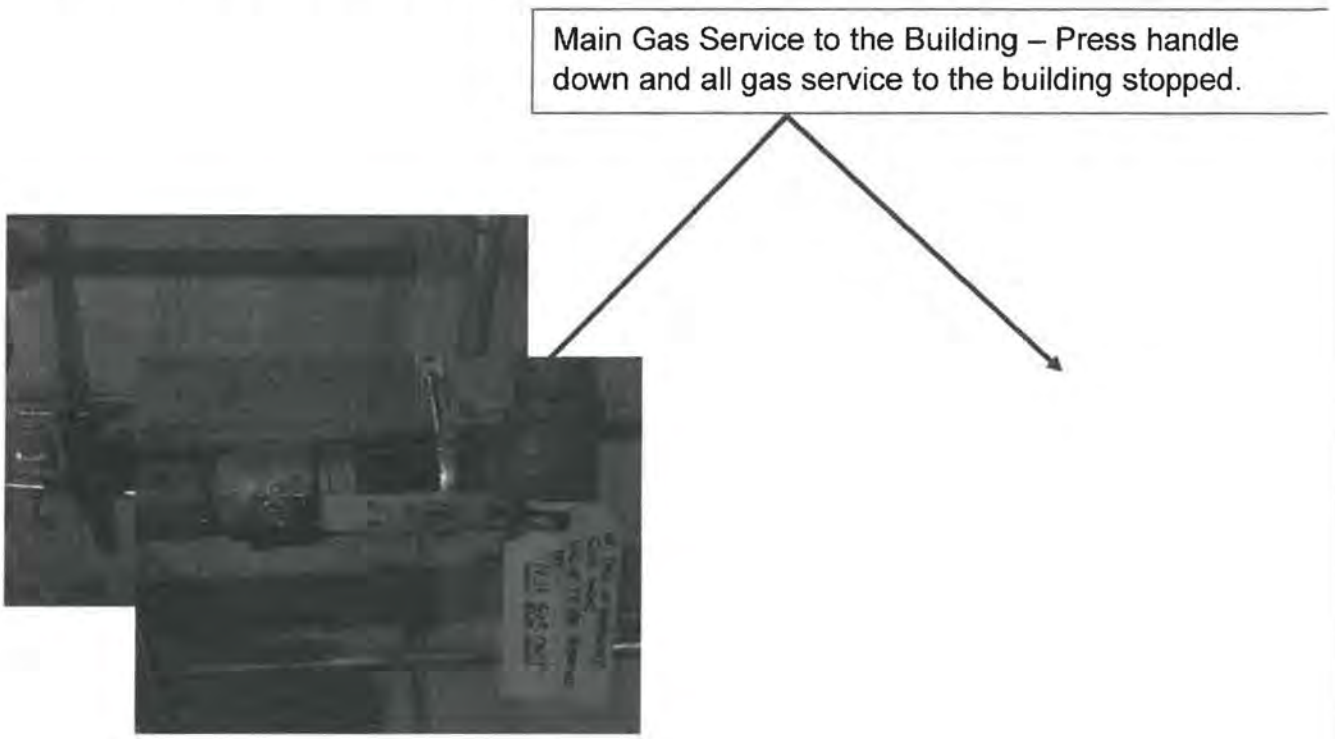
Appendix 19: Fire Alarm Reset Procedures

Insert the center's fire alarm shut-off procedures. Use pictures and/or diagrams to help provide a detailed explanation.

Step 1: Turn Key to program mode, which is to the left and up.
Step 2: Push the reset button and wait for assistance
Step 3: Push code 1111 if needed
Note: Panel takes about 1 minute to go through checks and resets.

Mechanical Room Gas, Electric, and Water Services to Alpine

Gas Service - Main Propane to the Building - January 2019
Yellow placards at the Gas Main guide you -



Mechanical Room Water Services to Alpine

Water Service – Water Main - January 2019

Yellow placards at the Water Main guide you

Primary Main Water Valve shutting off water to the building… Pull upward perpendicular to the flow.

Sprinkler System Riser

Two control valves manage the sprinkler riser that are turned clockwise **to turn off the water flow** .. The fire department and maintenance must be involved in turning these risers on or off based upon the situation. This water is a separate water feed outside of the primary water main shown above. ONLY FIRE DEPT. CAN TURN BACK ON.

Appendix 20: Security Plan

This form is used to describe the center's plan for access and perimeter security. Instructions: Enter the location of entrances and exits and the security plan for each in the table below.

Entrance/ Exit Location	Used by/ Purpose	Restricted access (Keypad/ lock)		Frequency of entry code change	Type of alarm system	Current signs on door?	Locked/ Open Days/Times		Lighting Evaluation *	Comments and/or Corrective Action
		YES	NO							
Example: Kitchen Backdoor (by ramp)	*Employees to take out trash; supply vendors.*	*Y*		*Monthly, Qtrly*	*Wander-guard, Watch Mate, IBI, or Catchall.*	*Marked as exit, no sign on outside of door*	*Daily*	*5:00 a.m. – 8:00 p.m.*	*Adequate*	
Front Entrance- Lobby side of building	All visitors, staff, vendors	Y		Semi annually	Wanderguard	Main Entrance	Daily	5am until 10:30 pm Daily- Locked During COVID-19	Adequate	
Front Entry- Therapy Gym Side of Building	Emergency Only	Y					Locked	Locked		
Unit 1 Resident Solarium	Emergency Only	Y					Locked	Locked		
Main Dining Room	Emergency Only	Y					Locked	Locked		
Unit 2 Resident Solarium	Emergency Only	Y					Locked	Locked		
Unit 3 Courtyard	Emergency Only	Y					Locked	Locked		

Downstairs Employee Breakroom Enterance	Emergency Only	Y					Locked	Locked		

Appendix 20: Security Plan

*Lighting Evaluation: When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting and remove brush or debris to eliminate shadowed areas.

B. Interior Building Security

1. Describe what the center has in place for stairwell protection (if applicable). Included in the description may be door security alarms/keypads, persons responsible for updating/changing entry codes, CCTV cameras and how the system is monitored, or other systems used for stairwell protection.

One Stairwell located next to the main dining rooms on both floors both have coded doors so only personnel with the code will use unless an emergency

Lighting Adequacy- When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting to eliminate shadowed or dark areas.

Adequate Lighting in Stairwell

2. Describe the check-in procedures for visitors and how identification badges for employees and/or visitors being used.

Visitors check in at the front desk and sign the guest book. Employee badges worn in the building and around the property. Time clock on side of the building that is coded to enter and at the elevator main floor.

Appendix 20: Security Plan

4. Describe how the following are used for Resident-Specific Security:

- Security measures for special units.

  Residents that are high risk for leaving the building have wanderguards on ankles. Alarms will be set off and the panel will light up as to what door is being breached.

- Resident Elopement Wander Guards.

Wanderguards are worn by residents that are a safety risk

- Electronic alarms systems such as door alarms.

  All exits are alarmed and have wanderguard security.

- Communication call bells.
- There are call bells in each room and bathroos in the center
- Visitor Log Protocol.

All visitors sign in at the front desk.

Appendix 21: Elopement Drill Documentation Form

Drill Date and Time:_____ **Unit:**_____

Check (✓) all that apply:

____ Nurse alerts all staff of missing patient with an announcement, for example, "Medical Alert – We are activating Missing Patient protocols. The Resident was last seen (location)". This alerts all staff that a formal search is underway.

____ Each unit sends a person to the unit that announced the code to learn the name and description of the missing patient.

____ Each unit charge nurse directs in-house staff to search room to room and all areas of the Center: patient rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen (including walk-in refrigerators and freezers), bathrooms, dayrooms/lounges, courtyards, and employee lounges.

____ Search outside building perimeter and grounds.

____ Report all unit, kitchen, and grounds search findings to the person in charge of the Center immediately.

____ Staff are able to verbalize what to do if patient is not located by the end of the search.

____ Staff are able to verbalize documentation and follow-up requirements.

Comments:

_____

_____

_____

_____

Plan of Correction (if indicated):

_____

_____

_____

_____

_____

_____

_____

Signature of Person Conducting Drill:_____

Printed Name: _____

Appendix 22: Succession Pla

During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Center Executive Director (CED)/Designee arrives. This person immediately contacts the CED/Designee.

When on-site, the CED/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. In the absence of the CED, The Center Nurse Executive (CNE) acts as the Incident Commander. In the absence of the CED and CNE, the following team members act as the Incident Commanders, in priority order.

CED Name: Melissa Castor

CNE Name: Laurie Madden

Incident Commanders in absence of CED and CNE:

Name and Title: Scott Meade, Maintenance Director and Safety Director

Name and Title: Daniel Birmingham, Maintenance Director Keene Center

Name and Title:

Appendix 23 Description of Center Patient/Resident Population
(Insert from or Refer to Center Facility Assessment. See OPS 161, Facility Assessment for details.)

Appendix 24: Annual Review and Sign-Off

This EPP has been reviewed, with changes noted, and approved by the Safety Committee and Center Executive Director:

Safety Committee Chairman Name: Scott Meade, Supervisor Mainteance

Safety Committee Chairman Signature and Date: April, 2023

Center Executive Director Name: Melissa Castor, CED

Center Executive Director Signature and Date: April, 2023

Appendix 25: State and Local Requirements

If your state/county/city/municipality has more stringent requirements, enter those requirements below, or insert reference materials. Contact your local EMS for information.

There are no local code requirements that we conduct a disaster drill semi-annually

Appendix 26. Insertions fro[illegible]ompliance Guide Completed Tasks

Instructions: After this page, insert the following completed documents from the Emergency Preparedness Compliance Guide:

1. **Resident Council Minutes indicating dates/times of presentations of the EPP.**
2. **Contact with Local Emergency Management Services (EMS) Form.**
3. **Community-Based Drill After Action Report**
4. **Training Acknowledgement Forms (Staff)**
5. **Tabletop Exercise**

Exhibit 1: Food and [illegible]rition Services – Sample Emergenc[illegible]lenu, Level 1: No Power

Meal	Portion	Regular/Liver/Renal	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	3/4 cup	Cold Cereal	Cold Cereal, Moistened	Cream of Wheat or Rice 1/2 cup	Cream of Rice 1/2 cup
	1/4 cup	Cottage Cheese	Cottage Cheese	Puree Cottage Cheese 1/2 #10 scoop	Cottage Cheese
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1-1/2 cup	Beef Stew, Cnd	Beef Stew, Cnd, Ground	Puree Beef Stew, Cnd	GF Peanut Butter & Jelly Sandwich 1 each
	1/2 cup	Seasoned Green Beans	Seasoned Green Beans	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Tuna Salad Sandwich	Plain Tuna Salad on Wheat	Puree Tuna Salad,Puree Bread 1 serving	GF Tuna Salad Sandwich
	1/2 cup	Seasoned Beets	Seasoned Beets	Puree Seasoned Beets 1 #8 scoop	Seasoned Beets
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Level 2, Limited Power

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1/4 cup	Scrambled Egg	Scrambled Egg	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1 each	Roasted Chicken	Roasted Chicken,Grd, Moistened 1 #12 scoop	Puree Roasted Chicken 1 #12 scoop	Roasted Chicken
	1/2 cup	Mashed Potatoes	Mashed Potatoes	Mashed Potatoes	Fresh Mashed Potatoes
	1/2 cup	Scalloped Tomatoes	Scalloped Tomatoes	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Ice Cream/Pudding	Smooth Ice Cream/Pudding	Smooth Ice Cream/Pudding	GF Pudding
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	3/4 cup	Soup, Cnd	Puree Soup, Cnd	Puree Soup, Cnd	
	2 packet	Saltines			
	1 each	Grilled Cheese Sandwich	Grilled Cheese Sandwich,No Crust	Puree Grilled Cheese Sandwich 1 serving	GF Grilled Cheese Sandwich
	1/2 cup	Three Bean Salad	Plain Three Bean Salad	Puree Three Bean Salad 1 #8 scoop	Fresh Three Bean Salad
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Level 3, Limited Power

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1 each	Hard Cooked Egg	Scrambled Egg 1/2 cup	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg 1/2 cup
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	2 ounce	Baked Ham	Baked Ham,Grd,Moistened	Puree Baked Ham 1 #12 scoop	Baked Ham
	1/2 cup	Sweet Potatoes	Sweet Potatoes	*Puree Sweet Potatoes 1 #10 scoop	Sweet Potatoes
	1/2 cup	Wax Beans	Chopped Wax Beans	Puree Wax Beans 1 #10 scoop	Wax Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Sliced Meat Sandwich	Sliced Meat Sandwich, Ground, Moistened	Puree Sliced Meat Sandwich	GF Sliced Meat Sandwich
	1 packet	Mustard	Mustard	Mustard	Mustard
	1/2 cup	Baked Beans	Mashed Baked Beans	Puree Baked Beans 1 #10 scoop	Seasoned Green Beans
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered

Exhibit 2. Sample Emergency Snack M. 1

Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
2 each	*Assorted Cookies	*Puree Sugar Cookies 1 #16 scoop	*Puree Sugar Cookies 1 #16 scoop	GF Cookies
1 each	Chocolate Cream Cookie (S)	Choc. Cream Cookies (S)	Puree Choc. Cream Cookies 1 #16 scoop	GF Cookies
1 each	Oatmeal Crème Cookie (S)	Oatmeal Crème Cookie (S)	Puree Oatmeal Crème Cookie 1 #16 scoop	GF Cookies
1 packet	*Graham Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
4 each	Vanilla Wafers	Puree Vanilla Wafers 1 #24 scoop	Puree Vanilla Wafers 1 #24 scoop	GF Cookies
1 ounce	Cheese Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
1 ounce	Cheese Puffs	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1 ounce	Pretzels (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
4 packet	Saltines (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1/2 cup	Applesauce	Applesauce	Applesauce	Applesauce
1/2 cup	Mandarin Oranges	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Mandarin Oranges
1/2 cup	Peaches	Peaches	Puree Peaches 1 #10 scoop	Peaches
1/2 cup	Pears	Pears	Puree Pears 1 #10 scoop	Pears
1/2 cup	Pineapple Tidbits	Crushed Pineapple	Puree Pineapple 1 #10 scoop	Pineapple Tidbits
1 each	Fresh Apple	Applesauce 1/2 cup	Applesauce 1/2 cup	Fresh Apple
1 each	Banana	Chopped Banana 1/2 cup	Mashed Banana 1/2 cup	Banana
1/2 cup	Cantaloupe	Soft Chopped Cantaloupe 1/2 cup	Puree Cantaloupe 1 #10 scoop	Cantaloupe
1/2 cup	Grapes	Applesauce	Applesauce	Grapes
1 each	Fresh Orange	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Fresh Orange
1/2 cup	Watermelon	Chopped Watermelon 1/2 cup	Puree Watermelon 1 #10 scoop	Watermelon
1/2 cup	Apple Juice	Apple Juice	Apple Juice	Apple Juice
1/2 cup	Orange Juice	Orange Juice	Orange Juice	Orange Juice
1/2 cup	Cranberry Juice	Cranberry Juice	Cranberry Juice	Cranberry Juice
1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
1/2 cup	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt
1/2 cup	Smooth Pudding	Smooth Pudding	Smooth Pudding	GF Pudding

NHICS

NHICS FORM 255 | MASTER RESIDENT EVACUATION TRACKING FORM

1. INCIDENT NAME:		2. FACILITY NAME:	
3. DATE PREPARED:		4. RESIDENT TRACKING MANAGER:	

5. RESIDENT EVACUATION INFORMATION

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

6. CERTIFYING OFFICER:		7. DATE/TIME SUBMITTED:	

PURPOSE: RECORD INFORMATION CONCERNING **RESIDENT DISPOSITION** DURING A FACILITY EVACUATION
ORIGINATION: OPERATIONS BRANCH
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT **LEADER LEADER**

NHICS 255
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REV. 1/11

Exhibit 3
Revised 4/1/23

Exhibit 4

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

IAL RESIDENT EVACUATION TRACKING FORM

		2. DATE:	
		5. AGE:	
	7. SIGNIFICANT MEDICAL HISTORY:		
☐ YES ☐ NO	CONTACT INFORMATION:	____	

IENT (CHECK THOSE THAT APPLY)		
☐ IV PUMPS ☐ OXYGEN ☐ VENTILATOR ☐ BLOOD GLUCOSE MONITOR ☐ RESPIRATORY EQUIPMENT	☐ SERVICE ANIMAL ☐ G TUBE PUMP ☐ MONITOR ☐ OTHER ☐ OTHER	☐ FOLEY CATHETER ☐ OTHER ☐ OTHER ☐ OTHER ☐ OTHER
☐ YES ☐ NO	TYPE:	____

		12. ARRIVING LOCATION	
TIME:		ROOM#:	TIME:
☐ YES ☐ NO		ID BAND CONFIRMED:	☐ YES ☐ NO
		ID BAND CONFIRMED BY:	
☐ YES ☐ NO		MEDICAL RECORD RECEIVED:	☐ YES ☐ NO
☐ YES ☐ NO		FACE SHEET/TRANSFER TAG RECEIVED:	☐ YES ☐ NO
☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		BELONGINGS RECEIVED:	☐ YES ☐ NO
☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		VALUABLES RECEIVED:	☐ YES ☐ NO
☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		MEDICATIONS RECEIVED:	☐ YES ☐ NO

LS		
	TIME DEPARTING TO RECEIVING FACILITY:	
	ARRIVAL TIME:	
☐ AMBULANCE UNIT ☐ HELICOPTER ☐ BUS ☐ OTHER: ____		
☐ YES ☐ NO	ID BAND CONFIRMED BY:	

) ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
N – ADMIT/TRANSFER & DISCHARGE UNIT

NHICS 260
PAGE __ of __
REV. 1/11

Exhibit 5: **NHICS FORM 251: CENTER STATUS REPORT**

1. INCIDENT NAME:		2. CENTER NAME:	
3. DATE PREPARED:		4. TIME PREPARED :		5. OPERATIONAL PERIOD:	

COMMUNICATION SYSTEM	OPERATIONAL STATUS	COMMENTS (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
FAX	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/PATIENT RECORDS/TIME CARD SYSTEM/INTRANET, ETC.)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NURSE CALL SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PAGING – PUBLIC ADDRESS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RADIO EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SATELLITE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM – CELL	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
VIDEO-TELEVISION-INTERNET-CABLE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
CAMPUS ROADWAYS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
FIRE DETECTION/SUPPRESSION SYSTEM	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
FOOD PREPARATION EQUIPMENT	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
ICE MACHINES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
LAUNDRY/LINEN SERVICE EQUIPMENT	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
RESIDENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
PHARMACY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
DIETARY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
DOOR LOCKDOWN SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SURVEILLANCE CAMERAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELECTRICAL POWER-PRIMARY SERVICE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SANITATION SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NATURAL GAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
AIR COMPRESSOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ELECTRICAL POWER, BACKUP GENERATOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS
ELEVATORS/ESCALATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HAZARDOUS WASTE CONTAINMENT SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OXYGEN	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PNEUMATIC TUBE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STEAM BOILER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SUMP PUMP	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WELL WATER SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER HEATER AND CIRCULATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

1. INCIDENT NAME:		2. CENTER NAME:	
3. DATE/TIME PREPARED:		4. OPERATIONAL PERIOD DATE/TIME:	
5. REPORTED CASUALTY/FATALITY			

RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

Exhibit 6: NHICS FORM 259 | MASTER CENTER CASUALTY/FATALITY REPORT

Exhibit 7: NHICS FORM 252 | SECTION PERSONNEL TIME SHEET (STAFF TRACKING SHEET)

6. FACILITY NAME:			
7. FROM DATE/TIME:		8. TO DATE/TIME:	
9. SECTION:		10. TEAM LEADER:	

11. TIME RECORD

#	EMPLOYEE (E)/VOLUNTEER (V) NAME (PLEASE PRINT)	E/V	EMPLOYEE NUMBER	NHICS ASSIGNMENT/ RESPONSE FUNCTION	DATE/TIME IN	DATE/TIME OUT	SIGNATURE	TOTAL HOURS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

1. CERTIFYING OFFICER:		2. DATE/TIME SUBMITTED:	

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY, INCLUDING VOLUNTEERS

NHICS 252

Exhibit 8: NHICS FORM 253 | VOLUNTEER STAFF REGISTRATION

12. FACILITY NAME:						
13. FROM DATE/TIME:			14. TO DATE/TIME:			
15. REGISTRATION						
NAME (LAST NAME, FIRST NAME)	ADDRESS (INCLUDE CITY, STATE, ZIP)	SOCIAL SECURITY NUMBER	TELEPHONE	CERTIFICATION/ LICENSURE & NUMBER	REFERENCE CHECK	SECTION ASSIGNMENT
16. CERTIFYING OFFICER:			17. DATE/TIME SUBMITTED:			

Exhibit 9. [illegible] IDEMIC PREPAREDNESS C[illegible]CKLIST

	Person Responsible	Date Completed
Planning and Decision Making		
CED/Executive Director is responsible for preparedness planning		
Create a multidisciplinary planning committee to include administration, medical director, nursing, reception, environmental, and others as needed; meet a minimum of monthly to evaluate your plan		
Incorporate epidemic preparedness into your Emergency Preparedness plan		
Develop plan to ensure that patient identification is on all patients/residents		
Complete the Emergency Numbers and Contacts List (refer to *Emergency Preparedness Plan: Attachment C*) ➢ **Include local, regional, or state emergency preparedness groups**		
Prepare updated employee contact list		
Ensure Test Kit is available, as indicated (i.e., Influenza)		
Communications		
Designate a person who will be responsible for **daily monitoring of updates (i.e., GHC Flu page)** and internal communications to staff, patients, and responsible parties		
Establish a system for communication with patients and families		
Maintain a list or database for patients' regular clinic, physician, or dialysis appointments in order to cancel non-essential appointments		
Education		
The Nurse Practice Educator/Practice Development Specialist or designee is responsible for coordinating education		
In-service all staff on Emergency Preparedness *(*may also refer to *Influenza Preparedness PowerPoint, if applicable)*		
In-service staff on infection control procedures and precautions, respiratory hygiene/cough etiquette		
Infection Control		
Post signage (Respiratory Hygiene/Cough Etiquette, Hand Hygiene, visitor sign in reception area)		
Implement respiratory hygiene/cough etiquette throughout the facility, as necessary		
Develop a plan for cohorting patients ➢ Discuss with VPMA and CQS if facility will confine all affected patients to one area, close off wings that are affected, or just confine sick patients and their roommates to their rooms		
Implement surveillance of targeted epidemic illness cases in the facility per Infection Control policies		
Collect information on: ➢ Incoming patients – confirmed or suspected targeted epidemic cases ➢ Number of new cases of targeted epidemic illness within the facility		
Report confirmed or suspected cases of targeted epidemic illness to the VPMA		
General Staff Management		
Develop plan for 100% vaccination of staff, if applicable; CED/ED and/or CNE/RCD will have a personal conversation with staff who decline vaccination		
In collaboration with Area leadership, develop plan for 30% absenteeism; submit plan to RVP		

	Person Responsible	Date Completed
➢ Number and categories of personnel needed to keep facility open or take patient overload ➢ Conduct a daily assessment of staffing status (refer to *Daily Review Form*) ➢ Develop plan for work/rest schedule as needed (i.e., place to sleep when extended work hours are necessary)		
Avoid floating staff if possible		
Educate staff to self-assess and report symptoms that they may be having before reporting to work		
Educate staff to develop a child care plan for school closings		
Review guidelines for Altered Standards of Care		
Discuss with staff the possibility of helping with essential patient care at times of severe staffing shortages		
Sick Staff		
Follow protocols for sick staff: ➢ Employees who develop symptoms during work hours should be sent home ➢ Employees who have been ill but are recovered may provide care to patients		
Alternative Staff		
If needed discuss use of alternative staff with SVP, VPMA and VPCO. Develop plan for use of employees not usually involved in patient care to perform basic patient care with supervision (Refer to *Alternative Staff Guidelines*)		
Influx of Infectious Patients		
Develop plan for patients requiring hospitalization ➢ Patient transport ➢ Lists of hospitals with contact information		
Develop plan to accommodate overcrowding and to ensure that an inflow of infectious patients does not overstretch the facility's resources ➢ Capacity of facility ➢ Number of empty beds/cots ➢ Patient care equipment ➢ Availability of treatment options ➢ Availability of vaccine and antiviral drugs ➢ Staffing resources		
Develop strategies to aid hospitals by admitting non-influenza patients not affected		
Environment		
Address whether adequate storage is available for additional supplies, e.g., water, food, medical supplies		
Make arrangements for additional storage, if needed		
Store adequate supplies/equipment (located in appropriate areas of building)		
For droplet precautions, position beds are at least three feet apart if setting up alternate bed areas		
Food Service		
Provide emergency food and disposable supplies are maintained		
Maintain hard copy of resident roster from Tray Trakker		
Develop staffing plans for full-day shifts (12 to 16 hours)		

Exhibit 10. DAILY SYMPTOM SCREENING FORM

INSTRUCTIONS: Use this form during an outbreak to screen **all** new admissions, re-admissions, staff, visitors, and vendors for symptoms of the illness before reporting to duty. Fill in specific symptoms monitored in the associated columns below. If staff report with symptoms meeting the clinical criteria, recommend follow-up treatment and send them home.

Name of Screener

Title

Date	Name	Time	Symptoms				Status		
			Temperature	______	______	______	OK to work/visit	Exclude from duty/visit	Screener initials
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Temperature <100°F, OK to work/visit.

Temperature >100°F with any of above symptoms, exclude from duty/visit.

Exhibit 11. ALTERED STANDARDS OF CARE (ASC) FOR EPIDEMIC

In most cases, the order to use ASC will be initiated by State authorities. Following a declaration by the Governor that there is an emergency which is detrimental to the public health, the DPH/HHSD may order adherence to ASC priorities and protocols.

Principles for Allocation of Limited Resources and ASC Protocols

Priority for limited medical resources and ASC protocols will be based upon the allocation of scarce resources to maximize the number of lives saved. This allocation will be:

1. Determined on the basis of the best available medical information, clinical knowledge, and clinical judgment;
2. Implemented in a manner that provides equitable treatment of any individual or group of individuals based on the best available medical information, clinical knowledge, and clinical judgment;
3. Implemented without discrimination or regard to sex, sexual orientation, race, religion, ethnicity, disability, age, income, or insurance status.

ASC protocols will recognize:

- Any changes in practices necessary to provide care under conditions of scarce resources or overwhelming demand for care
- An expanded scope of practice for health care providers
- The use of alternate care sites, at facilities other than health care facilities
- Reasonable, practical standards for documentation of delivery of care

Individual Rights

Civil liberties and patients' rights will be protected to the greatest extent possible; however, it is recognized that the protection of the public health may require limitations on these liberties and rights during an epidemic.

Provider Liability

Health care providers who provide care in accordance with the priorities and ASC protocols, including care provided outside of their scope of practice or scope of license, will be considered to have provided care at the level at which the average, prudent provider in a given community would practice.

Priority Activities for ASC

The term "altered standards" has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation. It could also mean changing who provides various kinds of care or changing privacy and confidentially protections temporarily.

Because there are no nationally defined altered standards of care, Genesis HealthCare has established the priorities listed below. However, state/federal authorities are in the process of developing altered standards of care which may supersede Genesis priorities.

Nursing:

- Basic personal hygiene
- Use of hospital gowns for residents as opposed to personal clothing to reduce laundry
- Turning
- Toileting
- Feeding
- Critical documentation only – fever, change in condition, incidents

Housekeeping:

- Focus on high-touch surfaces such as tabletops, side rails, door knobs, telephones, time clocks, faucets, etc.

Dietary:

- Minimum nutritional requirements for three meals a day
- Therapeutic diets will be evaluated on an individual basis
- Essential documentation only

Social Services:

- Limit activities to current pandemic issues
- Essential documentation only

Laundry:

- Additional shifts may be needed to handled increased demands

Maintenance:

- Suspend preventive maintenance activities to reallocate resources

Recreation Services:

- Suspend activities to reallocate resources

Admissions:

- Limited to only those associated with the epidemic
- Consider ECCs & marketing personnel reallocation to local centers

Business Office, Human Resources, Central Supply, Medical Records, Clerical Functions:

- Limit to essential functions only to reallocate resources

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
			Tasks
			• **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			• **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).
			• **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: * - Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc. - Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified. - Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place. - Sufficient resources are in supply for sheltering-in-place for at least 7 days, including: - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel - An adequate supply of potable water (recommended amounts vary by population and location) - A description of the amounts and types of food in supply - Maintaining extra pharmacy stocks of common medications - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment) - Identifying and assigning staff who are responsible for each task - Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days - Contract established with multiple vendors for supplies and transportation - Develop a plan for addressing emergency financial needs and providing security
			• **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: * - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees. - Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established - Adequate food supply and logistical support for transporting food is described.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
			Tasks
			- The amounts of water to be transported and logistical support is described. - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation. - Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff. - Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation. - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - It is described whether staff family can shelter at the facility and evacuate.
			• **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *
			• **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			• **Facility Reentry Plan:** Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			• **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
			Tasks
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			• **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			• **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: - Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. - Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.
			• **Needed Provisions:** Check if provisions need to be delivered to the facility/residents – power, flashlights, food, water, ice, oxygen, medications – and if urgent action is needed to obtain the necessary resources and assistance.
			• **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			• **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
			Tasks
			- Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - Encourage family participation
			• **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes
			• **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			• **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: - Exercises or drills must be conducted at least semi-annually - Corrective actions should be taken on any deficiency identified
			• **Loss of Resident's Personal Effects**: Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

Building and Site Maintenance

DIRECT SUPPLY TELS

MENU

Tasks in Use

Print List

Search for tasks

All task types

Weekly

Category	Title	Assigned To
Doors, Locks & Alarms	**Test operation of doors and locks.**	Regulatory Logs Maintenance
Dryer Vent	**Complete In-House System Cleaning**	Regulatory Maintenance
Emergency Power Generators	**Exercise generator (with no load), perform routine checks, create entry in logbook.**	Regulatory Requires Doc Logs Maintenance
Resident Monitoring Systems	**Check operation of door monitors and patient wandering system.**	Regulatory Logs Maintenance
Water Systems	**Inspect eyewash stations.**	Regulatory Maintenance
Water Temps	**Test and log the hot water temperatures.**	Regulatory Logs Maintenance
Laundry	**Check dryer**	Maintenance
Laundry	**Check washers**	Maintenance
Oxygen Concentrators	**In-House Maintenance**	Maintenance

Monthly

Category	Title	Assigned To
Ansul Systems	**Clean hood filters (use dishwasher if appropriate)**	Regulatory Maintenance
Boiler Water Heaters	**Flush to remove impurities, test pressure relief valve**	Regulatory Maintenance
Emergency Lighting	**Check illumination of exit**	Regulatory Maintenance

Support

	lighting a exit signs.				
Emergency Lighting	Conduct a 30 second functional test.	Regulatory	Logs	Maintenance	
Emergency Power Generators	Test generator under load, perform routine checks, create entry in logbook - Diesel	Regulatory	Requires Doc	Logs	Maintenance
Fire Alarm Test	Conduct routine test of fire alarm system	Regulatory	Maintenance		
Fire Extinguishers	Check and initial fire extinguishers	Regulatory	Maintenance		
Fire Sprinkler System	Fire Department Connections	Regulatory	Maintenance		
Fire Sprinkler System	In-house inspection.	Regulatory	Logs	Maintenance	
Nurse Call System Test	Conduct a test of the nurse call system.	Regulatory	Maintenance		
Resident Lifts	Inspect mobile lifts.	Regulatory	Maintenance		
Bathing Tubs	Inspect bathing tub(s)	Maintenance			
Dishwashers	In-house Inspection	Maintenance			
Exhaust Fans	Inspect exhaust fans for proper operation and clean if necessary	Maintenance			
Facility Inspection	Inspect kitchen small appliances	Maintenance			
Grease Traps	Have grease trap pumped out by contractor	Maintenance			
HVAC (Condensing Units)	Inspect condenser coils; clean as necessary	Maintenance			
HVAC (PTAC)	Clean air filters	Maintenance			
HVAC (PTAC)	Inspect condenser	Maintenance			

	coils, clean as required	
HVAC (RTU)	Clean / change air filter and verify unit operation	Maintenance
HVAC (RTU)	Inspect condenser coils; clean as necessary	Maintenance
HVAC - Air Handlers	Inspect air filter, verify operation	Maintenance
Mobility Aids	Conduct wheelchair inspection	Maintenance
Refrigerator/Freezer Combos	Inspect condenser coils, clean as required	Maintenance
Resident Scales	Check calibration of resident scales	Maintenance
Roof	Regular maintenance and safety inspection.	Maintenance

Every 3 Months

Category	Title	Assigned To				
Elevators	**Firefighters' Emergency Operation Testing** Next due: April 2023		Regulatory	Maintenance		
Fire Drills	**Perform a fire drill during 1st shift- (Upload copy of drill with signature sheet to TELS when complete)** Next due: April 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 2nd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: May 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 3rd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: June 2023		Regulatory	Requires Doc	Logs	Maintenance

Fire Sprinkler System	**Have fire sprinkler system certified/inspected.** Next due: April 2023	Regulatory, Requires Doc	Maintenance
Facility Inspection	**Smoke Barriers and Fire Walls.** Next due: June 2023		Maintenance
Ice Machines	**Check filters (if present), clean coils, sanitize interior, delime as necessary** Next due: June 2023		Maintenance

Every 6 Months

Category	Title	Assigned To			
Ansul Systems	**Have Fire Suppression System inspected by outside contractor** Next due: April 2023		Regulatory	Requires Doc	Maintenance
Ansul Systems	**Have hood cleaned by a certified contractor** Next due: June 2023		Regulatory	Requires Doc	Maintenance
Emergency Power Generators	**Have generator serviced by contractor** Next due: August 2023		Regulatory	Requires Doc	Maintenance
Emergency Preparedness Drills	**Conduct elopement drill (Missing Resident Drill)** Next due: August 2023		Regulatory	Requires Doc	Logs Maintenance
Emergency Preparedness Drills and Exercises	**Conduct a Facility-based exercise (Disaster Drill)** Next due: May 2023		Regulatory	Requires Doc	Maintenance
Fire Alarm Test	**Have fire alarm system inspected by a contractor** Next due: July 2023		Regulatory	Requires Doc	Maintenance

Every 12 Months

Category	Title	Assigned To			
Beds - Electric	**Rail Safety Audit.** Next due: January 2024		Regulatory		Maintenance
Electrical	**Test and Document the Electrical Receptacle Inspections** Next due: March 2024		Regulatory	Requires Doc	Maintenance
Elevators	**Schedule certification and ensure certificate in unit is up-to-date** Next due: January 2024		Regulatory	Requires Doc	Maintenance
Emergency Lighting	**Conduct a 90 minute operational test** Next due: September 2023		Regulatory		Maintenance

Emergency Power Generators	**Conduct a 90 mi[illegible]e load bank test** Next due: November 2023	Regulatory	Maintenance	
Facility Safety	**Complete and review the annual NFPA 99 Risk Assessment** Next due: February 2024	Regulatory	Requires Doc	Maintenance
Fire Extinguishers	**Have fire extinguishers certified.** Next due: March 2024	Regulatory	Requires Doc	Maintenance
Fire Sprinkler System	**5-Year Contractor Testing and Maintenance** Next due: February 2024	Regulatory	Requires Doc	Maintenance
Fire Sprinkler System	**Backflow Prevention Test.** Next due: August 2023	Regulatory	Requires Doc	Maintenance
Water Systems	**Legionella Water Management Plan Review - Upload your plan to TELS** Next due: November 2023	Regulatory	Requires Doc	Maintenance
TELS Masters Training	**TELS Offers Free Trainings - See instructions for further assistance** Next due: November 2023	Maintenance		

Every 24 Months

Category	Title	Assigned To		
Boiler Water Heaters	**Confirm that the state inspection for insurance purposes has occurred.** Next due: September 2024	Regulatory	Requires Doc	Maintenance
Detectors	**Smoke detectors sensitivity test** Next due: July 2023	Regulatory	Requires Doc	Maintenance

Every 36 Months

Category	Title	Assigned To		
Emergency Generators	**Conduct a 4 hour Load test** Next due: November 2025	Regulatory	Requires Doc	Maintenance

Staff Training and Procedures

STAFF ORIENTATION - GENERAL

Employee Name: _____ **Department:** _____

TASKS/TRAINING CONTENT	Completion Date
Introduction to the Facility	
Introduce all administrative and supervisory staff and review their roles. Introduce new employees.	
Welcome: Orientation schedule, bathroom location, snacks, etc.	
Discuss the facility's mission, vision, and values.	
Discuss the facility's organizational chart.	
Describe the facility's resident population.	
Tour facility. Meet and greet staff.	
Review employee rights and responsibilities, paycheck distribution, work hours, dress code, grievances, problem solving.	
Review employee handbook and/or personnel policies.	
Complete required paperwork for HR.	
Provide each employee a copy of job description and have them sign a copy for records.	
Review benefits handbook. Return date for benefit forms: _____.	
Employee health screening. Return for: _____. Return date: _____. Obtain consent/declination forms as indicated.	
Training Content	
Abuse, Neglect, Exploitation, Misappropriation: signs and symptoms, reporting protocols, prevention	
Dementia Management/Cognitive Impairment	
Effective Communication	
Elements and Goals of the QAPI Program	
Requirements of Compliance and Ethics Program. Obtain receipt notice/attestation statement regarding Code of Conduct.	

TASKS/TRAINING CONTENT	Completion Date
TASKS/TRAINING CONTENT	Completion Date
Fire Safety and Emergency Procedures	
Person Centered Care	
HIPAA Privacy and Security. Obtain confidentiality statement.	
Cultural Competency/Non-discrimination	
General Infection Control Principles: hand hygiene, standard and transmission based precautions, infection reporting. (Job specific training to be received during departmental orientation.)	
Resident Rights. Provide copy to employee, and retain a signed copy from the employee.	
OSHA/ Workplace Safety	
Introduction to Department	
Tour department. Meet and greet staff.	
Location, access, and review of policies and procedures.	
Provide competency form for role. Return date: _____.	
Classroom education for department (in accordance with competency form).	
Set orientation schedule. Assign preceptor.	

COMMENTS:

_____

_____

_____

_____

_____

_____

PERSON COMPLETING FORM: _____ **DATE:** _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

GENERAL ORIENTATION PLAN

This document establishes the facility's plan for orientation for all employees. The plan describes the required tasks and content of general orientation, including responsibilities for each task or content area.

TASK/CONTENT OF TRAINING
Scheduling of Orientation
1. Routine dates for general orientation: _____
2. Location of general orientation: _____
3. Primary responsibility for general orientation: Staff Development Coordinator (SDC)
4. Back up responsibility for general orientation: Director of Nursing, Human Resources Director
Introduction to the Facility
1. Introductions: Staff Development Coordinator to introduce all administrative and supervisory staff (all should be present, unless on vacation, etc.)
2. Welcome: Staff Development Coordinator
3. Facility Philosophy and Resident Population: Administrator or Staff Development Coordinator
4. Facility Tour: Staff Development Coordinator
5. Employee Rights/Responsibilities and Personnel Policies: Human Resources Director, or SDC
6. Employee Health: Infection Preventionist or Staff Development Coordinator
Training Content
1. Abuse, etc.: Social Services Director or Staff Development Coordinator
2. Dementia Management/Cognitive Impairment: Staff Development Coordinator
3. Effective Communication: Staff Development Coordinator
4. Elements and Goals of the QAPI Program: Administrator, Director of Nursing, or SDC
5. Requirements of Compliance and Ethics Program: Compliance liaison/officer, Administrator, Director of Nursing, or SDC
6. Fire Safety and Emergency Preparedness: Maintenance Director, Director of Nursing, and SDC
7. Person Centered Care: Director of Nursing, Assistant Director of Nursing, or SDC
8. HIPAA Privacy and Security: HIPAA Privacy/Security Officer or Staff Development Coordinator

TASK/CONTENT OF TRAINING
9. Cultural Competency/Non-Discrimination: Social Services Director, Human Resources Director, or Staff Development Coordinator
10. Infection Control Principles: Infection Preventionist, Director of Nursing, or SDC
11. Resident Rights: Social Services Director, Activities Director, Director of Nursing, or SDC
12. OSHA/Workplace Safety: Maintenance Director, Human Resources Director, Infection Preventionist, and/or SDC
Introduction to Department
1. Department Tour: Department head, unit/neighborhood manager
2. Policies and Procedures: Department head or preceptor
3. Competencies: Preceptor or mentor is responsible for verifying competency. Employee is responsible for keeping track of the competency form and seeking opportunities to perform tasks
Completion of Orientation Process
1. Competency Form: Preceptor to review form at least weekly
2. Employee turns competency form in to Staff Development Coordinator upon completion
3. Staff Development Coordinator verifies completion of form and discusses employee's competency with preceptor
4. Once competency has been determined, Staff Development Coordinator forwards completed form to Human Resources Director to place in employee's personnel file

New Hire Employee Infection Control Paperwork

Name: _____

Date of Hire: _____

_____Hand Washing Competency

_____Donning/Doffing PPE Competency

_____Employee Health Questionnaire

_____Tuberculosis (Mantoux) Screening

_____Hepatitis B Consent/ Declination Form

_____History of Infectious Disease/ Immunization

_____Reportable Conditions for Employees

_____Flu Consent/ Declination Form

_____Copy of Covid Card

NURSE AIDE COMPETENCY

Employee Name: _____ **Hire Date:** _____

Competency Type: ☐ **Initial** ☐ **Annual** ☐ **Other:** _____

Training on the following topics was provided. (* Indicates competence)

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
General			
Abuse, Neglect, Exploitation, Misappropriation ☐ Signs and symptoms ☐ Reporting protocols	☐ Lecture/video, post test ☐ Policy review, post test		
Dementia Management and Abuse Prevention	☐ Video series with active participation ☐ Lecture/video, post test		
Effective Communication	☐ Lecture/video with role play ☐ Lecture/video, post test		
Elements and Goals of QAPI Program	☐ Lecture with post test		
Resident Rights and Facility Responsibilities	☐ Lecture with post test ☐ Signed receipt of information		
Requirements of Compliance and Ethics Program	☐ Lecture with post test ☐ Signed receipt of Code of Conduct		
Safety and Emergency Procedures ☐ Active Shooter ☐ Blood Borne Pathogens/Needlestick Injury ☐ Emergency Codes ☐ Evacuation/Shelter In Place ☐ Fire Safety ☐ Hazard Communication/Safety Data Sheets ☐ Lockout/Tagout ☐ Missing Resident ☐ Natural Hazards (tornado, hurricane, ice storm) ☐ Oxygen Safety	☐ Lecture with post test ☐ See Oxygen Safety Education form ☐ Disaster/fire drill participation ☐ Table top exercise, active participation ☐ Full scale exercise, active participation ☐ Policy review, post test ☐ Facility tour, demonstration		
Person Centered Care	☐ Lecture/video, post test		
Cultural Competency (i.e. LGBT, religious affiliation, other characteristics of resident population)	☐ Lecture/video, post test		
HIPAA Privacy and Security	☐ Policy review, post test ☐ Lecture/video, post test		
Infection Control			
Hand Hygiene	☐ Lecture/video with return demonstration ☐ See Hand Washing Validation Checklist		
Standard and Transmission Based Precautions/PPE	☐ Policy review, post test ☐ Lecture with return demonstration ☐ See Removing PPE Validation Checklist ☐ See Handling Soiled Linen Checklist		
Isolation	☐ Policy review, post test		
Infection Reporting ☐ Residents with s/s infection ☐ Employee with s/s infection/work restrictions	☐ Policy review, post test		

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
Behavioral Health			
Trauma-Informed Care	☐ Lecture/video, post test		
Mood Disorders (ie. depression, anxiety)	☐ Lecture/video, post test		
Psychiatric Disorders (ie. schizophrenia, personality)	☐ Lecture/video, post test		
Substance Abuse Disorders	☐ Lecture/video, post test		
Implementing Non-Pharmacological Interventions	☐ Lecture/video, post test		
Suicide Precautions	☐ Lecture/video, post test		
Nurse Aide Skills			
Notify Nurse: Changes in Condition, Report of Pain	☐ Lecture, post test		
In-house Communication ☐ Care plan ☐ Nurse aide to nurse ☐ Nurse aide to manager	☐ Lecture, post test		
Basic Nurse Aide Skills ☐ Aspiration precautions/thickened liquids ☐ Bathing a resident (bed bath, shower) ☐ Capillary blood glucose ☐ Cardiac precautions ☐ Care of dentures, eye glasses, hearing aids ☐ Drain/tube management ☐ Dressing a resident ☐ Emptying catheter/ostomy bags ☐ Foot care Grooming a resident ☐ Making a bed (occupied, not occupied) ☐ Normal/"alert" vital signs ☐ Oral care ☐ Orthopedic precautions Oxygen therapy Peri care/incontinence care ☐ Seizure precautions ☐ Toileting assistance ☐ Washing a resident's hair	☐ Skills fair ☐ Lecture, post test ☐ Policy review, post test ☐ Lecture, return demonstration ☐ Product demonstration, return demonstration ☐ Direct observation		
Basic Restorative Skills ☐ Falls prevention program ☐ Bowel/bladder management program ☐ Bed mobility ☐ Transfers ☐ Ambulation with/without devices ☐ Wheelchair locomotion ☐ Range of motion exercises ☐ Splint management ☐ Eating and/or swallowing ☐ Amputation/prosthesis care ☐ Use of lifts (EZ Stand, hoyer)	☐ Program review, post test ☐ Lecture, post test ☐ Lecture, return demonstration ☐ Product demonstration, return demonstration ☐ Direct observation		
Skin and Wound Care Pressure ulcer/injury prevention and management Skin tear prevention and management Report to nurse: changes in skin condition; loose, missing, or soiled dressings	☐ See Pressure Ulcer/Injury Nurse Aide Education Form ☐ Policy review, post test ☐ Lecture/video, post test		

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
Nutrition/Hydration Management ☐ Feeding a resident ☐ Dietary orders ☐ Ice pass ☐ Meal pass ☐ Therapeutic diets ☐ Snack/supplement administration ☐ Intake monitoring ☐ I&O forms ☐ Calorie counts ☐ Weight monitoring	☐ Policy review, post test ☐ Medical record review (intake documentation) ☐ Equipment demo, return demonstration		
Disease Specific Knowledge ☐ Bariatric considerations ☐ COPD ☐ Diabetes ☐ Dialysis ☐ End of life considerations/Hospice ☐ Hypertension ☐ Musculoskeletal (arthritis, joint replacement, amputations, fractures) ☐ Parkinson's disease ☐ Stroke	☐ Lecture, post test ☐ Independent study, certificate of completion ☐ Video, post test ☐ Case study, active participation		
Alarms and Restraints	☐ Policy review, post test ☐ Product demonstration, return demonstration		

Notes:

Initials/Signature/Title: _____

Initials/Signature/Title: _____

Initials/Signature/Title: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

LICENSED NURSE COMPETENCY

Employee Name: _____ **Hire Date:** _____

Competency Type: ☐ **Initial** ☐ **Annual** ☐ **Other:** _____

Training on the following topics was provided. (* Indicates competence)

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
General			
Abuse, Neglect, Exploitation, Misappropriation ☐ Signs and symptoms ☐ Reporting protocols	☐ Lecture/video, post test ☐ Policy review, post test		
Dementia Management and Abuse Prevention	☐ Video series with active participation ☐ Lecture/video, post test		
Effective Communication	☐ Lecture/video with role play ☐ Lecture/video, post test		
Elements and Goals of QAPI Program	☐ Lecture with post test		
Resident Rights and Facility Responsibilities	☐ Lecture with post test ☐ Signed receipt of information		
Requirements of Compliance and Ethics Program	☐ Lecture with post test ☐ Signed receipt of Code of Conduct		
Safety and Emergency Procedures ☐ Active Shooter ☐ Blood Borne Pathogens/Needlestick Injury ☐ Emergency Codes ☐ Evacuation/Shelter In Place ☐ Fire Safety ☐ Hazard Communication/ Safety Data Sheets ☐ Lockout/Tagout ☐ Missing Resident ☐ Natural Hazards (tornado, hurricane, ice storm)	☐ Lecture with post test ☐ Disaster/fire drill participation ☐ Table top exercise, active participation ☐ Full scale exercise, active participation ☐ Policy review, post test ☐ Facility tour, demonstration		
Person Centered Care	☐ Lecture/video, post test		
Cultural Competency (i.e. LGBT, religious affiliation, other characteristics of resident population)	☐ Lecture/video, post test		
HIPAA Privacy and Security	☐ Policy review, post test ☐ Lecture/video, post test		
Infection Control			
Hand Hygiene	☐ Lecture/video with return demonstration ☐ See Hand Washing Validation Checklist		
Standard and Transmission Based Precautions/PPE	☐ Policy review, post test ☐ Lecture with return demonstration ☐ See Removing PPE Validation Checklist ☐ See Handling Soiled Linen Validation Checklist		
Isolation	☐ Policy review, post test		
Infection Reporting ☐ Residents with s/s infection ☐ Employee with s/s infection/work restrictions	☐ Policy review, post test		

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
Behavioral Health			
Trauma-Informed Care	☐ Lecture/video, post test		
Mood Disorders (ie. depression, anxiety)	☐ Lecture/video, post test		
Psychiatric Disorders (ie. schizophrenia, personality)	☐ Lecture/video, post test		
Substance Abuse Disorders	☐ Lecture/video, post test		
Implementing Non-Pharmacological Interventions	☐ Lecture/video, post test		
Suicide Precautions	☐ Lecture/video, post test		
Nursing Skills			
Identification of Changes in Condition ☐ Physical assessment ☐ Lab values ☐ Physician notification ☐ Family notification	☐ Observation, review of documentation ☐ Education lab, return demonstration ☐ Lecture, post test ☐ Medical record review		
In-house Communication ☐ Care plan ☐ Nurse to dietary department ☐ Nurse to therapy department ☐ Nurse to nurse aide ☐ Nurse to manager	☐ Lecture, post test ☐ Medical record review		
Documentation ☐ Documentation system (paper/electronic) Back up documentation system (if applicable) ☐ Content ☐ Frequency	☐ Lecture, post test ☐ Practice mode, review of documentation ☐ Medical record review		
Basic Nursing Skills ☐ Aspiration precautions/thickened liquids ☐ Blood draw ☐ Capillary blood glucose ☐ Cardiac precautions ☐ CPR ☐ Crash cart overview ☐ Drain/tube management ☐ DVT prevention ☐ Nail care ☐ Normal/"alert" vital signs ☐ Orthopedic precautions ☐ Ostomy care ☐ Oxygen therapy ☐ Physical assessment ☐ Seizure precautions ☐ Tracheostomy care Urinary catheterization Urinary/bowel specimen collection ☐ Wound cultures	☐ Skills fair ☐ See Oxygen Safety Education Form ☐ See Catheterization Validation Checklists ☐ Lecture, post test ☐ Policy review, post test ☐ Lecture, return demonstration ☐ Product demonstration, return demonstration ☐ CPR class, proof of completion (i.e. card) ☐ Direct observation		
Basic Restorative Skills ☐ Falls prevention program ☐ Bowel/bladder management program ☐ Bed mobility Transfers ☐ Ambulation with/without devices Wheelchair locomotion Range of motion exercises ☐ Splint management ☐ Eating and/or swallowing	☐ Program review, post test ☐ Lecture, post test ☐ Lecture, return demonstration ☐ Product demonstration, return demonstration ☐ Direct observation		

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
☐ Amputation/prosthesis care ☐ Use of lifts (EZ Stand, hoyer)			
Skin and Wound Care ☐ Arterial, diabetic, venous wounds ☐ Incontinence care ☐ Pressure ulcer/injury prevention and management ☐ Skin tear prevention and management ☐ Surgical site care	☐ See Pressure Ulcer/Injury Nurse Education Form ☐ Policy review, post test ☐ Lecture/video, post test ☐ Dressing change, return demonstration ☐ Product review, return demonstration		
Medication Management ☐ Administration via feeding tube ☐ Clean technique ☐ Controlled substances ☐ Dosages and solutions Ear, nose, eye drops Enemas, medications per rectum Indications for use/side effects Inhalers ☐ Injections ☐ IV therapy ☐ MAR ☐ Medication errors ☐ Medication storage ☐ Medication times ☐ Pharmacy procedures (ordering, receipt, Stat box, E-kit, irregularity reports) ☐ PO medications ☐ Rights of administration ☐ TPN administration	☐ See Medication Pass Observation Form ☐ Policy review, post test ☐ Pharmacology test ☐ Dosages and solutions calculation test ☐ Equipment demonstration, return demonstration ☐ Direct observation ☐ Case study, active participation		
Pain Management ☐ Pain assessment ☐ Non-pharmacological management ☐ Pharmacological management	☐ Lecture, post test ☐ Policy review, post test ☐ Medical record review		
Disease Specific Knowledge ☐ Bariatric considerations ☐ Cardiac (hypertension, coronary artery disease, MI, CHF) ☐ Diabetes ☐ End of life considerations/Hospice ☐ GI/GU (renal failure, hemodialysis, GERD, colon cancer, constipation, diarrhea) ☐ Musculoskeletal (arthritis, joint replacement, amputations, fractures) ☐ Neurology (stroke, multiple sclerosis, coma, spinal cord injury, traumatic brain injury, Parkinson's disease) ☐ Pulmonary (asthma, COPD, pulmonary hypertension, lung cancer)	☐ Lecture, post test ☐ Independent study, certificate of completion ☐ Video, post test ☐ Case study, active participation		
Alarms and Restraints	☐ Policy review, post test ☐ Product demonstration, return demonstration		
Nutrition/Hydration Management ☐ Dietary orders/therapeutic diets ☐ Snack/supplement administration ☐ Intake monitoring; I&O forms; calorie counts ☐ Weight monitoring	☐ Policy review, post test ☐ Medical record review ☐ Equipment demo, return demonstration		
Advance Directives	☐ Policy review, post test		

Notes:

Initials/Signature/Title: _____

Initials/Signature/Title: _____

Initials/Signature/Title: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Medication Administration Competency

Name: _____

Action	Met	Unmet	Comments
1. Performs hand hygiene.			
2. Checks each label with order on MAR.			
3. Checks expiration date on the medication.			
4. Checks medical record for medication allergy.			
5. Punches medication into dispensing cups using proper infection control technique.			
6. Follows manufacturer guidelines and regarding crushing of medications, as ordered by physician.			
7. Measures liquid medication at eye level.			
8. Shakes bottles properly (if applicable).			
9. Provides for adequate food or fluids, as needed per manufacturer recommendations.			
10. Locks medication cart when away from cart.			
11. Maintains confidentiality of resident information, and resident privacy/dignity.			
12. Identifies resident by picture or name band.			
13. Explains to resident the name and purpose of each medication/what to do if experiences signs or symptoms of an adverse reaction.			
14. Obtains vital signs prior to administration of medications with "parameters of use".			
15. Observes resident swallow medications.			
16. Documents initials after administration of medication.			
17. Administers eye drops using proper technique. Waits 3 to 5 minutes between eye drops			
18. Properly administers inhalers. Administers bronchodilators first, if applicable. Rinses mouth and cleans inhalers as indicated.			
19. Administers medications via feeding tube using proper technique.			
20. Administers injections using proper technique.			
21. Administers medications in a way that does not interrupt the dining experience.			
22. Medication error rate during observed medication observation is less than 5%.			
23. No significant medication errors were made during observed medication observation.			

Nurse Signature _____ Date: _____

Nurse Observer _____ Date: _____

ALPINE
HEALTHCARE CENTER

Nursing Agency Orientation

Please initial each item to validate orientation to each topic.

Orientation Item	Agency Staff Initials	Center Staff Initials
Fire, Disaster Plan, Emergency Contacts, Facility Phone Number with Extensions		
Abuse and Neglect Policies		
Resident Rights		
Center Tour including Code Card and AED Locations		
Wander management System		
Point Click Care/Point of Care System Review		
Medication Rooms, Narcotic Count, E-Kit, and Pharmacy		
Risk Watch Event Reporting System Review		
Communication and Supervision		
Shift to Shift Report		
Shift Routine		
Attendance, Lunch and Breaks		
Smoking Areas		
Center Specific Items		
Center Specific Items		
Center Specific Items		
Center Specific Items		

I have received an orientation to Alpine Healthcare Center.

The information listed above was reviewed and I have had the opportunity to ask questions to assure understanding.

_____ _____

Signature and Title of Agency Employee Date

_____ _____

Signature and Title of Alpine Employee Conducting Orientation Date

CONTRACTED LICENSED NURSE COMPETENCY

Nurse's Name: _____ **Contract Start Date:** _____

Competency Type: ☐ Initial

Training on the following topics was provided. (* Indicates competence)

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
General			
Abuse, Neglect, Exploitation, Misappropriation ☐ Signs and symptoms ☐ Reporting protocols	☐ Lecture/video, post test ☐ Policy review, post test		
Dementia Management and Abuse Prevention	☐ Lecture/video, post test		
	☐		
	☐		
Resident Rights and Facility Responsibilities	☐ Lecture with post test ☐ Signed receipt of information		
	☐		
Safety and Emergency Procedures ☐ Active Shooter ☐ Blood Borne Pathogens/Needlestick Injury ☐ Emergency Codes ☐ Evacuation/Shelter in Place ☐ Fire Safety ☐ Hazard Communication/Safety Data Sheets ☐ Lockout/Tagout ☐ Missing Resident ☐ Natural Hazards (tornado, hurricane, ice storm)	☐ Lecture with post test ☐ Policy review, post test ☐ Facility tour, demonstration		
	☐		
	☐		
HIPAA Privacy and Security	☐ Policy review, post test ☐ Lecture/video, post test		
Infection Control			
Hand Hygiene	☐ Lecture with return demonstration ☐ See Hand Washing Validation Checklist		
Standard and Transmission Based Precautions/PPE	☐ Policy review, post test ☐ Lecture with return demonstration ☐ See Removing PPE Validation Checklist ☐ See Handling Soiled Linen Validation Checklist		
Isolation	☐ Policy review, post test		
Infection Reporting ☐ Residents with s/s infection ☐ Employee with s/s infection/work restrictions	☐ Policy review, post test		
Behavioral Health			
	☐		
	☐		
	☐		
	☐		
Implementing Non-Pharmacological Interventions	☐ Lecture, post test		
Suicide Precautions	☐ Lecture, post test		

COMPETENCY	ASSESSMENT METHOD*	DATE	EDUCATOR INITIALS
Nursing Skills			
Identification of Changes in Condition	☐ Observation, review of documentation ☐ Lecture, post test ☐ Medical record review		
In-house Communication ☐ Care plan ☐ Nurse to dietary department ☐ Nurse to therapy department ☐ Nurse to nurse aide ☐ Nurse to manager	☐ Lecture ☐ Medical record review		
Documentation ☐ Documentation system (paper/electronic) ☐ Back up documentation system (if applicable) ☐ Content ☐ Frequency	☐ Lecture, post test ☐ Practice mode, review of documentation ☐ Medical record review		
Basic Nursing Skills ☐	☐ Lecture, post test ☐ Policy review, post test ☐ Lecture, return demonstration ☐ Product demonstration, return demonstration ☐ CPR class, proof of completion (i.e. card) ☐ Direct observation		
Basic Restorative Skills ☐ Use of lifts (EZ Stand, hoyer)	☐ Product demonstration, return demonstration ☐ Direct observation		
Skin and Wound Care ☐ Arterial, diabetic, venous wounds ☐ Incontinence care ☐ Pressure ulcer/injury prevention and management ☐ Skin tear prevention and management ☐ Surgical site care	☐ Policy review, post test ☐ Lecture, post test ☐ Dressing change, return demonstration ☐ Product review, return demonstration		
Medication Management ☐ Controlled substances ☐ MAR ☐ Medication errors ☐ Medication storage ☐ Medication times ☐ Pharmacy procedures (ordering, receipt, Stat box, E-kit, irregularity reports) ☐	☐ See Medication Pass Observation Form ☐ Policy review, post test ☐ Equipment demonstration, return demonstration ☐ Direct observation		
Pain Management ☐ Pain assessment ☐ Non-pharmacological management ☐ Pharmacological management	☐ Lecture, post test ☐ Policy review, post test ☐ Medical record review		
Disease Specific Knowledge, as indicated	☐ Lecture		
Alarms and Restraints	☐ Policy review, post test ☐ Product demonstration, return demonstration		
Nutrition/Hydration Management ☐ Dietary orders/therapeutic diets ☐ Snack/supplement administration ☐ Intake monitoring; I&O forms; calorie counts ☐ Weight monitoring	☐ Policy review, post test ☐ Medical record review ☐ Equipment demo, return demonstration		
Advance Directives	☐ Policy review, post test		

Notes:

Initials/Signature/Title: _____

Initials/Signature/Title: _____

Initials/Signature/Title: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Health and Safety

Infection Prevention and Control Program

Date Implemented:	8/15/2022	*Date Reviewed/ Revised:*	8/15/2022	*Reviewed/ Revised By:*	Nicole Drew RN

Policy:

This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.

Definitions:

"Staff" includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions.

Policy Explanation and Compliance Guidelines:

1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.
2. All staff are responsible for following all policies and procedures related to the program.
3. Surveillance:
    a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards.
    b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.
    c. The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.
4. Standard Precautions:
    a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.
    b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.
    c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.
    d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies.
    e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility, and are to report problems outside of their scope to the appropriate department.
5. Isolation Protocol (Transmission-Based Precautions):

a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.
b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances.
c. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines.
d. Residents with tuberculosis are placed on airborne precautions and placed in a special room that is equipped with special air handling and ventilation capacity. If no such room is available, the resident(s) will be discharged to a facility with such capabilities.
e. Immunocompromised and myelosuppressed residents shall be placed in a private room if possible and shall not be placed with any resident having an infection or communicable disease.

6. Antibiotic Stewardship:
   a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program.
   b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.
   c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program.
   d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program.

7. Influenza and Pneumococcal Immunization:
   a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time.
   b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.
   c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines.
   d. Residents will have the opportunity to refuse the immunizations.
   e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.

8. COVID-19 Immunization:
   a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.
   b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions and contraindications to determine candidacy for the vaccination.
   c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.
   d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance.
   e. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy.
   f. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine.

9. Equipment Protocol:

a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.
b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident.
c. Reusable items potentially contaminated with infectious materials shall be placed in a impervious clear plastic bag. Label bag as "CONTAMINATED" and place in the soiled utility room for pickup and processing.
d. The central supply clerk will decontaminate equipment with a germicidal detergent prior to storing for reuse.

10. Supplies Protocol:
    a. Sterile supplies shall be appropriately packaged and sterilized or purchased prepackaged and sterile from the manufacturer.
    b. Sterile supplies are routinely checked for expiration dates and are replaced as necessary.
    c. Prepackaged sterile items are considered sterile until opened or damaged. Packaging shall be inspected prior to use.
    d. Non-sterile supplies are stored and maintained as clean prior to use.

11. Linens:
    a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection.
    b. Clean linen shall be separated from soiled linen at all times.
    c. Clean linen shall be delivered to resident care units on covered linen carts with covers down.
    d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.
    e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom.
    f. Environmental services staff shall not handle soiled linen unless it is properly bagged.

12. Resident/Family/Visitor Education and Screening:
    a. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff.
    b. Information on various infectious diseases is available from our Infection Preventionist.
    c. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions.
    d. Passive screening, such as signs, are posted in the facility to alert family members and visitors to adhere to handwashing, respiratory etiquette, and other infection control principles to limit spread of infection from family members and visitors.
    e. More active screening, such as the completion of screening tools or questionnaires that elicits information related to recent exposures or current symptoms may be used as per facility policy.

13. Staff Communicable Disease Screening and Immunization:
    a. Direct care staff shall comply with physical examinations and immunization screening requirements upon employment, and annually.
    b. Direct care staff shall be tested for TB upon hire and at least annually.
    c. Influenza vaccine shall be offered annually.
    d. Tetanus, Diphtheria, and Pertussis (Tdap) vaccine shall be offered to those employees who have not previously received this vaccine. Tetanus-Diphtheria vaccine shall be offered as a booster dose as needed (i.e. every ten years).
    e. Hepatitis B vaccine shall be offered to all staff that have the potential for contact with blood/body fluids, or other potentially infectious materials.

f. Varicella vaccine shall be offered to all staff that are serologically non-immune to varicella.

14. Staff Referral to Treatment Centers/Services:
    a. Our staff shall be referred to the appropriate medical treatment center/service when he/she:
        i. Is feverish and appears to be in the infectious stages of an illness.
        ii. Experiences an occupational exposure to blood/body fluids.
        iii. Has been exposed to a communicable disease.
        iv. Exhibits infected skin lesions.
    b. Based on the specific circumstances, employees with a communicable disease or infected skin lesion will be prohibited from direct contact with residents or their food, if direct contact will transmit the disease.
    c. Our Infection Preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease.

15. Staff Education:
    a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function.
    b. All staff shall demonstrate competence in relevant infection control practices.
    c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.

16. Water Management:
    a. A water management program has been established as part of the overall infection prevention and control program.
    b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems.
    c. The Maintenance Director serves as the leader of the water management program.

17. Annual Review:
    a. The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk.
    b. Following review, the infection and prevention control program will be updated as necessary.

References:

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities.* (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities.* (May 2021) F887 – COVID-19 Immunization. 42 C.F.R. §483.80 (d)(3)(i-vii).

City of Keene

FIRE DEPARTMENT

Office of the Fire Marshal

Office: 31 Vernon Street Keene, NH 03431

Telephone: (603) 357-9861 • **Fax:** 603-283-5668

KFDlifesafety@keenenh.gov

NOTICE OF VIOLATION AND ORDER TO CORRECT

Date of Inspection:	12/19/2023
Date of Notice:	01/03/2024
Occupancy:	Apline Healthcare Center 298 Main Street, Keene, NH 03431
Owner:	KEENE SNF REALTY LLC C/O THE PORTOPICCOLO GROUP 2420 KNAPP ST. BROOKLYN, NY 11235

This Notice details the findings of the inspection conducted on 12/19/2023. Present at this inspection was Lt. Meghan Manke. The buildings were inspected for compliance with the minimum standard for existing buildings as required by the State Fire Code and State Building Code. The building was inspected for fire and life safety concerns. Other problems with the building may need to be addressed that are outside the scope of this inspection. This Notice reflects the violations that were observed at the time of the inspection. Other violations may exist that were not observed at the time of the inspection. In summary, the building is classified as Health Care. Below is a breakdown of the observed Fire Code Violations. Pursuant to RSA 154:2, II(a), RSA 47:17, XVI, and City Code Section 42-1, you are hereby ordered to correct the below violations within 45 days of receipt of this Notice.

VIOLATIONS OF STATE FIRE CODE

NFPA 1: 4.4.3.1. Unobstructed Egress. In every occupied building or structure, means of egress from all parts of the building shall be maintained free and unobstructed.

-Rear hallway on lower level near lockers - keep all loose items contained inside storage cabinets/lockers so as not to impede egress

NFPA 13:8.6.6.1 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.

-Reduce height of storage in kitchen storage/food closet
-Remove storage on top of lockers in rear egress corridor

NFPA 73 : 2.2.1 Equipment Access Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. (36 in)

Storage in front of panels in kitchen storage closet

CORRECTION OF VIOLATIONS OF STATE CODES

Due to the severity of these violations, you are hereby ordered to correct these violations within 45 days of receipt of this Notice; a reinspection will be conducted on 45 days from this Notice. City Code Sec. 42-1(a).

If a violation is unable to be correct within the timeframe provided, within 45 days of receipt of this Notice, you must provide an action plan to correct those violations. A corrective action plan may be sent to: KFDlifesafety@keenenh.gov.

APPEALS

If you disagree with Notice, you may appeal to the Keene Fire Chief, or his designee, **within 10 days of the date of your receipt of this Notice**. City Code Sec. 42-32; RSA 31:39-c, I. Your appeal must be sent to: KFDlifesafety@keenenh.gov.

If, following the Keene Fire Chief's or his designee's review, you disagree with the decision of the Keene Fire Chief or his designee, you may appeal the Keene Fire Chief's decision to the City of Keene's Board of Appeals **within 15 days of your receipt of the Fire Chief's decision**. RSA 674:34, I; City Code Sec. 2-741 - 2-743.

A request for a variance from or exception to the State Fire Code may be made to the State Fire Marshal. RSA 153:4-a, I; N.H. Admin. R. Saf-C 6005.04. Such a request may be made via: https://www.nh.gov/safety/divisions/firesafety/documents/variance-request-form.pdf. A copy of any request for a variance or exception made to the State Fire Marshal shall be mailed to the City of Keene Fire Department, 31 Vernon Street, Keene, NH 03431.

FURTHER INFORMATION

If you have any additional questions or concerns, do not hesitate to contact me at the contact information below.

MEGHAN MANKE
mmanke@keenenh.gov
FIRE PREVENTION OFFICER

CERTIFICATION OF DELIVERY

I, MEGHAN MANKE, certify that I delivered this Notice to the Owner listed above on via:

- ☐ Certified Mail
- ☐ In-Hand Delivery

Signature:

ATTACHMENTS

This Notice includes the following attachments:

18717281-20240221_135455.jpg

18717277-20240221_135253.jpg

18717275-20240221_135324.jpg

18579675-workack_1318534458275458.pdf

18579670-alarm insp 1-15-24.pdf

18203577-298 Main Street Apline Annual Inspection 12192023.pdf

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled _____
Rec'd By _____
Page _____ of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☐ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodging House
☐ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	◉ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 197 Water Street, Keene NY 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: BSC-AHR Keene LLC	**NAME/COMPANY:** AH Keene LLC
MAILING ADDRESS: One Towne Square, Suite 1600 Southfield MI 48076	**MAILING ADDRESS:** 197 Water Street, Keene NH 03431
PHONE: (248) 203-1800	**PHONE:** (603) 352-1282
EMAIL: pstodulski@redico.com	**EMAIL:** keene@americanhouse.com
SIGNATURE: [signature] **DATE:** 1/25/24	**SIGNATURE:** [signature] **DATE:** 1/25/24
PRINTED NAME: Paul A. Stodulski **TITLE:** Authorized Repre	**PRINTED NAME:** Hilary Seifer **TITLE:** Executive Director

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY: Same as above	**NAME/COMPANY:** American House Management Company LLC
MAILING ADDRESS:	**MAILING ADDRESS:** 197 Water Street, Keene NH 03431
PHONE:	**PHONE:** (603) 209-6720
EMAIL:	**EMAIL:** keene@americanhouse.com
SIGNATURE: **DATE:**	**SIGNATURE:** [signature] **DATE:** 1/25/24
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Hilary Seifer **TITLE:** Executive Director

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Previously Submitted

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

144 licensed beds
Current occupancy - 100 Residents 1/25/24
Current Employees - 86
24/7 operation
1 building 110,000 sq feet

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

N/A

January 15, 2024

American House Keene Neighborhood Plan Updated:2024

American House works with numerous agencies throughout the community.

We currently host the rotary club once a week. On Wednesday and Thursday, we host two separate BNI groups. The east Keene neighborhood group meets once a month at our location. We hold a cookie auction fundraiser four times a year, and half the proceeds go to a local charity. This year we donated to the Monadnock Humane Society, The Amazing Grace Animal Sanctuary, Freedom Reins, and Rise for Baby and Family.

We collaborated with Rise for and Family for a multigenerational play group that ran over the course of 12 weeks.

American House hosted 2 car shows this year that were open to the public and allowed may local antique car owners to showcase their hobbies. We also continue to host the annual Alzheimer's silent auction which is the largest local fundraiser for this cause.

American House
SENIOR LIVING COMMUNITIES

Description of Services

American House Keene is an assisted and independent living facility. Composed of 109 apartments and 144 licensed beds. American House is a licensed 804 facility by the State of New Hampshire. American House is staffed 24/7 by nurses and LNA's.

American House Keene provides many services and amenities, including transportation, 3 meals per day, life enrichment activities, housekeeping and laundry services to all of our residents.

Assisted living residents are overseen by our nursing department. Medication management, daily assistance with ADL'S, coordination of medical appointments and treatment, long term care policy assistance, and regular reviews of plan of care, are provided by our nursing staff.

197 WATER ST | KEENE | NEW HAMPSHIRE | 03431
americanhouse.com | t 603 352 1262 | f 603 352 7627

American House
SENIOR LIVING COMMUNITIES

American House Keene is a 110,000 square foot building, licensed through the State of New Hampshire under the 804 regulations. American House is licensed for 144 beds, with 109 apartments. Average census is between 85-88%, with average number of residents being 102. American House employees 82 employees, known of who reside at the property. American House operates 24/7 with a minimum of 2 staff on site.

197 WATER ST | KEENE | NEW HAMPSHIRE | 03431
americanhouse.com | t 603 352 1282 | f 603 352 7627

Training

American House requires all new employees to have a TB screening, health physical, BEAS screening and criminal back group prior to hire. All new employees complete a 2 day orientation (see attached list), as well as an annual mandatory training (see attached list). American House uses Relias online training, as well as the orientation packet and videos for training.

American House
SENIOR LIVING COMMUNITIES

Employee Orientation Checklist

Employee Information **DOH: ____/____/____**

Name: _____

Department: _____ Position: _____

Orientation List

Reading Material Provided

Green Folder

Pre-Hire Documents:

[ ] American House Letter-Chief Cultural Officer
[ ] Welcome To American House Letter-Benefits
[ ] Chain of Command
[ ] Dayforce Instructions
[ ] Resident Bill of Rights
[ ] Complaint Procedure (2 pages)
[ ] Protective Services to Residents
[ ] Protective Services to Minors
[ ] HIPAA policy and Practices
[ ] Medical Orientation
[ ] Dos & Don'ts
[ ] Alzheimer's Disease
[ ] Hepatitis Vaccine
[ ] Universal Precautions/Hand Washing
[ ] Payroll Processing
[ ] Employee Handbook

[ ] Application/Resume
[ ] Info Cubic Consent Form & Record
[ ] BEAS Consent Form & Record
[ ] Criminal Record Form & Record
[ ] Affidavit
[ ] 2 Reference Checks
[ ] License Verification
[ ] Youth Parental Permission Slip
[ ] Youth Employment Certificate

Green Folder, Continued

Post-Offer-Documents: Payroll

[ ] Paystub Review
[ ] W-4 Form
[ ] Employee Status Form
[ ] Employee Information
[ ] Personnel Form

Post-Offer Documents: Signature

[ ] Job Description
[ ] Complaint Is A Gift
[ ] Handbook Acknowledgement
[ ] Benefits Accept or Decline
[ ] 401k Acknowledgement
[ ] Advertisement Disclaimer
[ ] Infection Control/Fire Safety Video & Test
[ ] Emergency Preparedness Orientation
[ ] Dementia & Alzheimer's Test
[ ] Abuse & Neglect Policy
[ ] Abuse & Neglect Test
[ ] Resident's Rights Test
[ ] Resident's Rights/Responsibilities
[ ] Restraint Policy
[ ] Sexual Harassment/Unlawful Harrassment
[ ] Notice of Nondiscrimination
[ ] Confidentiality Agreement
[ ] Food Protection
[ ] Advance Notice
[ ] *Motor Vehicle Release Statement
[ ] *Driving Policy
[ ] Voice Friend
[ ] Phone Monitoring Policy
[ ] Work-Related Email Communications
[ ] Acknowledgement & Understanding
[ ] Walkie-Talkie Code
[ ] Relias Dementia Training Certificates

Blue Folder

[ ] I-9 paperwork (2 forms of Valid ID's)

(*Note: Copy both sides of documents)

Red Folder

Pre-Hire: Health Assessment Documents

[ ] Employee Health Screen
[ ] TB QuantiFERON Testing Results

Post-Offer: Orientation Documents

[ ] Influenza Vaccine Consent/Declination
[ ] Hepatitis B Vaccine Consent/Declination
[ ] Consent for Covid 19 Testing
[ ] Covid Vaccine Consent/Declination

Employee Signature: _____ **Date:** ____/____/____

BOM Signature: _____ **Date:** ____/____/____

Executive Director Signature: _____ **Date:** ____/____/____

Double Checked Before Filing: _____ **Date:** _____

Print Name:_____

American House
SENIOR LIVING COMMUNITIES

Annual Review 8/24/2022

The list below includes ALL Items that must either be reviewed or submitted annually. PLEASE REVIEW EACH DOCUMENT OR AGREEMENT

Please initial next to each item as you complete them and then sign below.

	Initial
1.) I have signed the Affidavit.	
2.) I have completed and signed the "BEAS State Registry Consent Form".	
3.) I have reviewed the Chain Of Command.	
4.) I have reviewed and understand the "Patient Bill of Rights".	
5.) I have reviewed and understand the "Resident Complaints" policy.	
6.) I have reviewed the "Protective Services to Adults".	
7.) I have reviewed and understand the "Child Protection Services".	
8.) I have reviewed, understand and signed the "Confidentiality Agreement".	
9.) I have reviewed, understand and signed the "Restraint Policy".	
10.) I have reviewed and understand the "Employee Handbook" and signed the acknowledgement. Found in the employee break room.	
11.) I have reviewed and understand the "Safety & Health Policy". Found in the employee break room.	
12.) I have reviewed and understand the "Emergency Preparedness and Evacuation Plan". Found in the employee break room.	
13.) I have reviewed and understand the "Infection Control Policy". Found in the employee break room.	
14.) I have reviewed, understand and signed the "Fire Safety" Guidelines.	
15.) I have reviewed, understand and signed the "handwashing and Blood Borne Pathogens Guidelines".	
16.) I have reviewed, understand and signed the "Food Protection Policy".	

Annual Review 8/24/2022

The list below includes ALL Items that must either be reviewed or submitted annually. PLEASE REVIEW EACH DOCUMENT OR AGREEMENT

Please initial next to each item as you complete them and then sign below.

	Initial
17.) I have reviewed and understand the "Complaint Procedure".	
18.) I have reviewed, understand and signed the "Complaint is a Gift" Policy.	
19.) I Have reviewed and understand the "Emergency Medical Orientation".	
20.) I have reviewed, understand and signed the "Medication Administration".	
21.) Are there any changes to your personal information? If so, have you filled out the change form? YES / NO (PLEASE CIRCLE)	
22.) Have you ever had the Pneumococcal Vaccine? YES / NO (PLEASE CIRCLE)	
23.) I have reviewed and signed the Influenza Vaccine Form.	
24.) I have reviewed and signed all of your job descriptions.	
25.) I have completed and signed the infection control quiz.	
26.) I have reviewed and signed the Hippa Guidelines.	
27.) I have reviewed and signed the Abuse and Neglect Policy.	
28.) I have completed 4 hours of Dementia training.	

Employee Signature: _____ **Date: _8__/__24__/__22**

Building and Site Maintenance Procedures

American House uses the Direct Supply TELS system for regulatory inspections. American House contracts with Vermont Life Safety for quarterly service for backflow, sprinkler, fire hydrant and fire extinguisher inspection. American House is contracted with Impact Fire for fire damper inspection. American House contracts with Powers generator for quarterly services and testing. American House contracts with Hood Pro for hood cleaning and dryer vent cleaning. American House contracts with Dead River for quarterly grease trap cleaning. American House contracts with K.E Bergeron for semiannual HVAC inspections.

Hilary Seifer

Tasks Work Orders Unit Turns Services Assets Reports Resources

Manage tasks for this facility

Showing completed tasks | Regulatory | Filter by recurrence | Save Filters | Restore My Defaults | Clear Filters

Tasks due this week

Category	Title	Assigned To
Emergency Power Generators	Exercise generator (with no load), perform routine checks, create entry in logbook.	Chris Proudman
Oxygen Storage	Gas Equipment - Cylinder and Container Storage	Chris Proudman

Tasks due this month

Category	Title	Assigned To
Ansul Systems	Clean hood filters (use dishwasher if appropriate)	Chris Proudman
Ansul Systems	Owner's Inspection	Chris Proudman
Defibrillators (AED)	In-House Maintenance	Chris Proudman
Dryer Vent	Complete In-House System Cleaning	Chris Proudman
Emergency Lighting	Conduct a 30 second functional test.	Chris Proudman
Fire Doors	Inspection - Latch and Gap	Chris Proudman
Fire Sprinkler System	In-house inspection.	Chris Proudman
Water Systems	Inspect eye wash stations.	Chris Proudman

COMMUNITY DEVELOPMENT DEPARTMENT
CITY OF KEENE

LICENSE TO OPERATE
A FOOD SERVICE ESTABLISHMENT

For year ending September 30, 2023

Class	I
License No	177
Establishment	American House Keene
Address	197 Water St.
Operator	Hilary Seifer
Title	Executive Director

John Roger
Health Director

This license must be posted and may be suspended or revoked in accordance with the provisions of the City of Keene Code, Chapter 46, Sections 386-391.

Date: 09/20/2022

STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
P.O. BOX 2160
CONCORD, N.H. 03302-2160
(603) 271-2585

INVOICE: **000441524**

Elevator, Boiler and Pressure Vessel Inspection Division
Include address changes if applicable

AHSLC AMERICAN HOUSE KEENE
PO BOX 7763
MERRIFIELD VA 03431

CP
Due Date: 10/20/2022
Amount Due: 100.00

Please detach and submit upper portion with your payment.

**** Certificates for units without violations have been issued and are available upon payment. ****

N.H. Unit Number	Inspection Date	Location of Unit	Initial Charge	Balance Due
Elevator NHE000005830	09/15/2022	AMERICAN HOUSE AT KEENE 197 WATER ST KEENE NH 03431 Inspected By: JEREMY ALAN LAWLER STANLEY ELEVATOR CO (800-258-1016) Inspection Certificate Fee	50.00	50.00
Elevator NHE000005829	09/15/2022	AMERICAN HOUSE AT KEENE 197 WATER ST #1 KEENE NH 03431 Inspected By: JEREMY ALAN LAWLER STANLEY ELEVATOR CO (800-258-1016) Inspection Certificate Fee	50.00	50.00

Invoice: 000441524 Due Date: 10/20/2022 Amount Due: 100.00

To make a credit card payment via MasterCard or Visa, go to www.nh.gov/labor. No refunds unless authorized by NH Dept of Labor. Make checks payable to Treasurer State of NH. Mail to NH Dept of Labor, PO Box 2160, Concord, NH 03302-2160. Checks returned due to insufficient funds or closed account may be charged an additional $100.00 penalty fee. By RSA 7:15a, unpaid debt may be assigned to the Attorney General for collection. Any questions, please call (603) 271-2585.

PIN016P1A4.doc

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: AMERICAN HOUSE KEENE
Located at: 197 WATER ST
KEENE NH 03431

To Operate: Assist Living/Residential Care Facility

This annual license certificate is effective under the conditions and for the period stated below:

License#: 04305
Effective Date: 09/01/2022
Expiration Date: 08/31/2023
Administrator: HILARY SEIFER
Waivers:

Comments:
1. CRIM WAIVER He-P 804.18 (e)(2)
2. TEMP WAIVER 804.15(a)(2)&(3)

Total Number of Beds: 144

Chief Legal Officer

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS
AMERICAN HOUSE KEENE
197 WATER ST
KEENE, NH 03431

CLIA ID NUMBER
30D1103134

EFFECTIVE DATE
08/04/2021

LABORATORY DIRECTOR
HILARY C SEIFER

EXPIRATION DATE
08/03/2023

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Monique Spruill

Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

American House Keene: Emergency Plan

Statement of Purpose

American House Keene's emergency preparedness plan outlines a comprehensive integrated plan to provide information about emergency procedures. The purpose of this plan is to identify vulnerability to disasters, plan of action in emergency situations, and ensure the safety of all staff and residents. The plan includes appropriate delegation, modes of communication, alternative sites in case of evacuation, resources to ensure all basic needs are met during a disaster and until normal operations can be resumed.

Section I- General Information

IN THE EVENT OF EMERGENCY:

Immediately notify:

Executive Director, Hilary Seifer [redacted]

Health Service Director, Patrice Aguda Brown [redacted]

Maintenance Director, Chris Proudman (603-903-7804)

Executive Director will initiate phone tree as appropriate **(See Attachment A)**

Direct all CLINICAL questions to: Health Service Director-Patrice Aguda-Brown

Direct all BUILDING questions to Maintenance Director- Chris Proudman

Direct all Media/Communication questions to Executive Director-Hilary Seifer

See attachment F for a list of emergency numbers and American House Vendors.

A copy of the **EMERGENCY PLAN** is kept at the **FRONT DESK IN RED BINDER.** Copies of the plan in red binders can also be found in the Kitchen, Maintenance Office, Nursing Office, Executive Director Office and Business Office.

A current **Resident List** is kept at the front desk, nursing office and with every department head. The list is in order by apartment number and is updated with every new admission, room change, and discharge. In an emergency a copy will be provided to the fire department and any other emergency personnel requesting it.

The emergency plan will be reviewed and revised as necessary, at the very least annually, by American House Keene emergency committee. American House Keene will conduct a least two emergency drills a year, and one will include mass causality situation.

American House Keene is an Assisted/Independent Residence located at 197 Water Street Keene NH 03431. Telephone number is 603-352-1282.

American House Keene is a wood frame building, brick mortar and stucco exterior. 10 apartments are located above the front lobby and are referred to as the mill building apartments. The remaining apartments are in the main building first-fourth floor. American House has 9 studio apartments, 23 two bedroom apartments, and 77 one bedroom apartments.

HAZARD VUNERABLITY ANALYSIS (See attachment G)

American House Keene opened in 2008 and has experienced no disasters or damage.

Hazards identified in our 2018 analysis were likely to be natural hazards, weather related, ice storm, blizzard, severe thunderstorm, and flood.

Human Vulnerability would likely be an active shooter or civil disturbance.

Biological hazards are likely to be flu epidemic, or norovirus. American House does require any staff member who does not receive a flu shot to wear a mask for the duration of the flu season. We require any staff member to be out of work for 48 hours post illness symptoms, as determined by the Health Services Director. In the event of a norovirus outbreak we would clean with bleach, serve meals on paper, and require anyone with symptoms to stay in their apartments until they are 48 hours symptom free.

Technological Hazards would likely be a power outage, or gas leak. American House Keene has a generator on site that will provide emergency power to the building. American House Keene also has on-site water and food supply.

American House Keene is at low risk for a radiological or chemical hazard at this time.

Security

American House Keene has 4 panic buttons that are directly linked to mutual aid. **The Four Panic Buttons are located in the Executive Director Office, The Business Office, The Front Desk, and The Nurses Station.**

American House Keene has security cameras on premises; they monitor the parking lots, elevator doors, main entrances, nurses station and med room.

American House Keene uses a call pendant system for all residents, there are also pendants located in the Dining Room, Theatre Room, Front Entrance and Elevator Entrance. All public and resident restrooms have emergency pull cords.

Exit Doors (1st floor) (See Attachment B- Floor Plan)

-Main Lobby front door to staff parking lot - Main Lobby rear door to resident parking lot.

-Stairwell #1 located next to beauty salon

-Stairwell #2 located at the back of the dining room

-Resident Entrance in front of elevators

-Stairwell #3 located at the end of first floor hallway

Exit Doors (2nd floor) (See Attachment C-Floor Plan)

-Stairwell #1 end of mill building hallway

-Stairwell #2 end of hallway high side second floor

-Stairwell #3 end of hallway low side second floor

Exit Doors (3rd floor) (See Attachment D-Floor Plan)

-Stairwell #2 end of hallway high side third floor

-Stairwell #3 end of hallway low side third floor

-Stairwell #2 end hallway high side fourth floor

-Stairwell #3 end of hallway low side fourth floor

Fire Alarm System: (See list of **Emergency Vendors- Attachment F)**

Emergency fire and smoke alarms are in place and monitored and maintained. The fire alarm system is hard wired to the Keene Fire Department as well as Central Alarm.

-Fire Alarm System- Central Alarm 1-800-639-2066

-Fire Alarm Maintenance Company RB Allen 603-964-8140

-Sprinklers Southern VT Sprinkler 802-254-2242

-Emergency call system SMD 1-800-899-7264

Fire Alarm signal is received by Central Alarm- call monitoring and dispatched to the Keene Fire Dept. **The Front Desk Concierge or Nursing Supervisor must check the fire panel and call 911,** they would announce over the hand held radio system for all staff to switch to channel two, to ensure uninterrupted communication.

Fire Extinguishers are located in all the laundry rooms, behind every set of fire doors, in front of every elevator door, off every elevator to the right, in the kitchen, water heater room, and electrical room, outside of the oxygen closet, in the Bistro, in the theatre room, and the front desk. They are inspected every month in house by maintenance staff and quarterly by VT life safety.

Fire Boxes are located at all the exits, including stairwell, and at every elevator entrance.

Section II- Emergency Plan

Emergency Control:

In the event that American House Keene emergency plan is implemented, **Executive Director Office will serve as command center.** Location of emergency operations, direction and control will emanate from this office. If an alternate central site is needed the marketing office is to be used.

It is the decision of the Executive Director to declare an emergency situation, and/or his/her designee, who shall serve as Emergency Operations Coordinator. Duties would be relinquished to local law enforcement/emergency personnel as needed. Or his/her designee, in the Executive Directors absence.

The command center is to be staffed by the Executive Director.

An Emergency Log Book is located at the front desk, outside of the Executive Director office, in the Emergency Box. The executive director and/or his/her designee will appoint a staff member to be a scribe, all pertinent information regarding emergency will be logged, including time of each incident, and the name and position of persons involved. Any action taken during the emergency to regain control or prevent any further events will also be recorded.

The Emergency box includes flashlights, yellow florescent vest, land line phone, first aid kit, paper, pen, batteries, battery-less radio, log book.

In the event of a Fire Alarm, American House Keene residents should be advised to evacuate the building and proceed to designated staging areas; Emergency Coordinator and staff should begin evacuation. Any resident needing assistance out of the building during drills or alarm activations will come from American House Keene staff. Fire Department personnel should not be considered as being the primary agent responsible for this. Initial crews arriving to American House Keene will be assessing the situation and beginning tactics to respond to and mitigate the fire or emergency. Should an actual rescue need to be performed for a resident in imminent danger, fire department crews would then be reassigned to conduct the rescue. In the event of evacuation, staff and residents will remain in designated staging areas until given permission by authorities to return to the building or relocate.

Residents will proceed to the nearest staging area outside the building;

Exit Door by room 101 (Meet in the middle of the lawn)

Stairwell exit door by kitchen (Meet in front of the dumpster)

Stairwell exit door by theatre room (Meet on the sidewalk to the right)

Back entrance by elevator (Meet on the sidewalk to the right)

Exit door through the patio (Meet in the middle of the lawn)

Exit door main entrance (Meet on the sidewalk to the right)

During an evacuation staff may allow residents to remain inside the building should they note no presence of smoke and flames or any of the following apply:

Inclement weather: rain, sleet, snow, or electrical storm.

Excessive temperatures: over 90 degrees in the summer, or below 40 degrees in the winter, overnight into darkness.

Indoor staging areas are the 3 stairwells and the dining room for residents exiting through the patio doors.

Internal Functions

Each Department within the facility is responsible for emergency functions in addition to normal duties. During a declared emergency, all Department Heads or designees will be responsible for coordinating their assigned duties with the Emergency Director.

Emergency Fire Drill/Training

An Emergency disaster/fire drill will be conducted at least once per month. Each drill is to be documented and maintained by the maintenance director. Documentation will include names of participating personnel and residents, with signatures from each participating staff member. The date, and time the drill was conducted. The total time necessary to evacuate the facility, the exits utilized, any issues encountered during the drill, with action taken to rectify. At least 3 drills per year will be conducted between the hours of 10pm and 6am. These 3 drills will be conducted in different quarters of the year.

Each employee shall participate in at least one drill every calendar quarter and each drill shall include the transmission of a fire alarm signal, evacuation of the facility and simulation of emergency fire conditions.

All new employees shall receive an orientation to the building, including tour with maintenance director and viewing of fire safety video.

Fire/Disaster Evacuation

At the First sign of fire and/or smoke, staff member with a radio or the Concierge must dial 911 and pull the nearest fire box.

Evacuation Policy

The city of Keene Fire Department advises, that because American House Keene is a full-sprinkler multi story facility housing complex for elderly residents, and emergency evacuation can be difficult and traumatic, all staff will be trained and retrained in emergency evacuation techniques and protocols in the event of actual physical fire or other disaster requiring immediate evacuation.

Evacuation Procedure

******The following procedure is to be used in the event of a fire emergency:

Always Call 911 for immediate emergency reporting; specify the area of smoke and fire evacuation plan, if in place and operational.

*****Notify all staff in the building via hand held radio **"Code Red" All staff switch to channel 2 on the hand held radio system.**

When evacuating, residents shall proceed to the nearest staging area.

Staff should begin immediate evacuation of residents in immediate danger from smoke or flames. Upon arrival and assessment of the situation, the Fire Dept. will assist as needed in the evacuation.

Shut all doors behind you when clearing a room, move red scrunchie to the outside of the door to indicate room has been cleared.

If able to turn off all fans.

Kitchen staff should shut down all fans, ovens, stoves and any other running machinery.

Keep residents away from building and Fire Dept. access areas, safe and secured.

Verify the presence of all residents and staff upon completion of evacuation.

Do not re-enter the building until Fire Dept. determines and issues an **"All Clear"**. Staff should ensure all phone lines and emergency call systems are in working order.

Potential Evacuation Sites

1. **Genesis Applewood 8 Snow Rd, Winchester, NH 03470 603-239-6355**
2. **Best Western of Keene 401 Winchester, St Keene NH 03431 603-357-3038**
3. **Keene Recreation Center 312 Washington St, Keene NH 03431 603 357 9829**
4. **Genesis Westwood Center 298 Main St, Keene NH 03431 603 352-7311**
5. **Keene High school 43 Arch St, Keene NH 03431 603-352-0640**

In the event of evacuation, the marketing office would contact all families and determine if residents could stay with relatives for the duration of the evacuation.

All assisted living residents have a medical chart; these should be collected as time permits. All assisted living residents also have electronic medical records through Eldermark. This system can be accessed on-site or off-site and does not require internet to access.

Expansion of Residents

In the event of a major or minor disaster, this Community and its staff may be utilized by local hospitals and other health care facilities to care for their patients as necessary, and as space permits.

In the event of unplanned admissions resulting from an external disaster, the Health Services Director will work in collaboration with the Executive Director and Marketing Director. The facility will only accept admissions within the scope of care unless directed by health authorities or regulatory agency. There would be an expectation that staff from the sending facility would stay with their residents.

Any new admission will be provided with a name tag.

Specific Emergency Procedures

Power/Heat Outage

In the event of sustained power outage/heat loss, the following procedure will be followed. In all situations, immediately contact the Executive Director or his/her designee.

Immediately ensure any resident who is on oxygen, is switched over to an emergency outlet.

Emergency outlets are located in all the hallways and are labeled with silver label tape.

Call to report outage to **Eversouce 1-800-662-7764,** attempt to determine extent of problem and probable time frame for restoration of service. Emphasize that American House is an assisted living residence for elderly (85-100 y/o) and request immediate assistance.

Verify that emergency lighting system is working. Distribute available flashlights to staff and residents as needed.

Go room to room and check on residents, encourage them to come out to community areas.

For any prolonged periods of power outage, staff phone tree will be activated **(See Attachment A)**. All available staff will be asked to come in, and round every half hour to ensure resident safety.

Monitor building temperature every 4 hours, if any resident areas reach 85 degrees for 4 or more consecutive hours, staff will monitor resident temperatures every 4 hours. Any resident with a temperature over 100 degrees will be relocated, physician contacted and treatment orders obtained and initiated.

Utilize cell phones and hand held radios for communication if phone line is affected.

Emergency food and water are kept on hand, to provide for staff and residents for 72 hours. Gordon's Foods will deliver to a relay point if roads are not accessible. The Food Service Director has emergency contact numbers for Gordon's Foods.

Gas Leak

A gas leak can occur in one area of the building, such as the kitchen, or throughout the entire building. Due to the seriousness of this situation, quick response and professionalism are essential:

Contact **911** immediately to report a gas leak

Contact Liberty Utilities to report the gas leak, **603-352-1230**

Contact Maintenance Director and Executive Director or Designee.

Shut off main gas valve (if possible) Located outside of employee entrance to the right. **(See attachment G)**

If evacuation is necessary, activate emergency phone tree **(See attachment A)**

Water Failure:

Notify the City of Keene **Public Works Department 603-352-6550**

Immediately contact Maintenance Director and Executive Director/designee.

Each water heater contains 48 gallons of potable water. There are 109 water heaters in the building.

There is emergency water supply in the dry storage closet in the alley way. This can be accessed from the electrical room out the door and to the left. Water is also kept behind the bar in the Bistro.

If it is determined that residents are to be evacuated staff is to assist with evacuation and in accordance with evacuation plan.

Hurricane or Blizzard Conditions

Monitor weather reports and storm watches.

Notify the Executive Director and Maintenance Director.

In the event of the possible threat of heavy wind storm or hurricane, notify key staff and advise all residents and staff to stay indoors.

Secure all outdoor furnishings and lightweight items.

Cancel all recreational outings.

Ensure all residents requiring oxygen have access to emergency outlet if needed.

Keep battery operated radio tuned to local emergency station.

Maintain close communication with local emergency agencies. (MACE)

Keep flashlights/emergency lighting accessible.

Close all doors, drapes and blinds.

Move residents to interior areas away from window if necessary, in the event of high winds/hurricane conditions. These areas would include:

-Resident Bathrooms

-Interior hallway

-Common Space near the fireplace in the dining room

Flash Flood

Notify Executive Director and Maintenance Director.

Keep battery operated radio tuned to local emergency station.

Maintain close communications with local emergency agencies.

Keep everything off of the floor, elevate/protect community records.

Maintain potable water, fill pots, pans, sinks and tubs with clean water.

If evacuation is necessary, follow the community evacuation plan.

Bomb Threat

In the event of a bomb threat, the Executive Director/designee, and Maintenance Director are to be notified immediately.

*If you are near one of the four panic buttons, press the button.

*Keep the caller on the phone as long as possible.

*Ask the caller the location and type of bomb.

*Ask the caller for time of detonation.

*Listen closely for background noises (i.e. music, voices etc) voice quality (male/female)

Notify a supervisor as soon as possible.

The Supervisor will call **911** and provide all the information obtained.

Follow instructions given by authorities.

Instruct staff not to touch or move any suspicious objects.

If it is determined that the building needs to be evacuated, staff is to follow the building evacuation plan.

Medical Emergency

Notify nursing department

Call **911 for medical emergencies**

Instruct staff not to touch or move any suspicious objects.

Missing Resident

*Communicate internal notification (Code Yellow) for missing resident, via hand held radio.

*Check the resident LOA logs

*Begin a coordinated search throughout the building, search every room in the center.

*Send two staff members outside, each should go in opposite directions and meet back at the front of the building. Check all cars in the parking lots.

If the resident is not found within a reasonable amount of time of initiating the search the nurse supervisor should:

1. Notify Executive Director and Health Services Director.
2. Call 911 and report the missing resident.
3. Notify responsible family member.
4. Notify resident's physician.
5. Upon arrival of a search team, transfer authority to team members.
6. Supply resident's phone number to search team members.

Terrorism

Enemy attacks and terrorism can take on many forms that could result in situations that are outlined within this plan (disruption of utilities, structural damage to the building, etc....) and should be addressed as such. For incidents of chemical or bioterrorism the following precautions/actions should be implemented:

Mail Handling: Handling Suspicious Letters or Packages

Be observant for suspicious envelopes or packages.

Look for:

-Envelopes/packages with discoloration, strange odors or oily stains, powders or powder- like residue.

-Protruding wires, aluminum foil, excessive tape or string.

-Unusual weights for size, lopsided or oddly shaped envelopes.

-Poorly typed or Written addresses, no return address, incorrect titles, misspelling of common words, a postmark that does not match the return address and restrictions such as personal or confidential.

General Mail Handling Suggested Guideline:

1. Open all mail with a letter opener or method that is least likely to disturb contents, do not rip letters open.
2. Open letters and packages with a minimum amount of movement.
3. Do not blow into envelopes
4. Do not shake or pour out contents.
5. Keep hands away from nose and mouth while opening mail.
6. Wash hands after handling mail.

Handling Suspicious Mail:

1. Stay calm and do not shake or empty contents of any suspicious package or letter.
2. Keep hands away from mouth, nose and eyes
3. Isolate package or letter (do not carry or show to others) and cover gently with clothing, paper, inverted trashcan.
4. Do not try and clean up any spills or walk through any spilled material.
5. Alert others in area and leave area closing all doors.
6. Wash hands with soap and water.
7. Notify supervisor/designated responder who will call 911, local FBI Field Office (http://www.fbi.gov/contact/fo/info/htm), Regional and Corporate leadership.
8. Do not allow anyone to enter the room until proper authorities arrive.
9. List all people who were in the room or area when the package or letter was recognized. Give the list to the health and law enforcement officials.

Chemical and Biological Agents

American House Keene maintains SDS sheets on all chemicals in the building.

Eye wash stations are located in the laundry room and the housekeeping closet on first floor.

Any employee who recognizes symptoms of exposure to any chemical or biological agent or notices any unusual patterns of illness is to immediately notify his/her supervisor.

Supervisor/ Administrator or designee contacts 911 or the local or State Health Department and Regional leadership.

Employees promptly evacuate the area, as directed by the Centers evacuation plan. Disturb the physical environment as little as possible; the area will be considered a "crime scene" by investigating agencies.

Employees cooperate with all first responding fire, EMS, and law enforcement.

Employees promptly evacuate the area, as directed by the Centers evacuation plan. Disturb the physical environment as little as possible; the area will be considered a "crime scene" by investigating agencies.

Employees remain on the premises until cleared by the appropriate authorities.

Release of Radioactive Material

1. Notify Administrator or designee.
2. Tune radio to local emergency broadcast station.
3. Close all door, windows and drapes.
4. Move residents to the hallways and close the fire doors
5. If directed by local authorities, evacuate residents per Center Evacuation plan.

Radiation Syndrome

Occurs when the entire body (or most of it) receives a high dose of radiation, usually over a short period of time.

People exposed to radiation will get ARS only if:

The radiation dose was high

The radiation was penetrating (that is, able to reach internal organs)

The person's entire body, or most of it, received the doses, and

The radiation was received in a short time, usually within minutes.

Symptoms:

Initial symptoms are typically nausea, vomiting and diarrhea which start within minutes to days after exposure and will last for minutes up to several days, and they may come and go.

A brief return to health, after which, he or she will become sick again with loss of appetite, fatigue, fever, nausea, vomiting, diarrhea, and possibly even seizures and coma.

People with ARS typically also have some skin damage that can start to show within a few hours of exposure and can include swelling, itching and redness of the skin (like a bad sunburn).

Complete healing of the skin may take from several weeks up to a few years depending on the radiation dose the person's skin received.

The chance of survival for people with ARS decreases with increasing radiation dose. Most people who do not recover from ARS will die within several months of exposure. The cause of death in most cases is the distribution of the person's bone marrow, which results in infections and internal bleeding. For the survivors, the recovery process may last from several weeks up to 2 years.

Hostage Situation

Utilize panic button if possible.

Immediately call or have someone call 911 and explain the situation to the police. Be prepared to provide specifics with regard to:

*Subject

*Victim (s)

*Exact Location

*Weapon(s)

*Injuries

***Stay on the phone

*Have someone call the Executive Director or designee as soon as possible and activate the emergency plan.

*Evacuate the affected area per the Center's Evacuation plan, attempt to isolate the subject, and secure the perimeter.

*Remain calm; follow the subject's directions.

*If the subject is talking-listen do not argue.

*Avoid heroics: no sudden movements; don't over crowd the subject.

Be prepared to brief responding law enforcement personnel regarding your observations, and any additional information you may have involving the subject or victim.

Pandemic

Be aware and follow all guidelines issued by the CDC and the Department of Health.

Take Inventory of PPE, assess accessibility of PPE.

Close to all outside groups to protect residents.

Designate an entrance for all staff with access to hand washing.

Utilize phone tree to notify families of updates.

Clean all high touch areas 3x a day.

Close any room where social distancing is not obtainable.

Use consistent care assignments.

Screen all staff and visitors for fever.

Take resident temperatures daily.

Order back up emergency food supply.

Designate a wing for infected residents.

Quarantine as needed.

Maintain a space to store PPE that is fire compliant.

Open windows to improve ventilation.

Staffing Coverage & Assignments

All essential personnel are expected to remain on site, until relieved. This may require sleeping on site overnight. Every effort will be made to provide safe and comfortable resident and staff accommodations.

*All personnel will be called if there is an emergency situation at American House Keene that jeopardizes the resident safety and wellbeing.

Initiate:

Resident List for evacuation attendance

- Meals will be provided free of charge as able during emergency period.
- All staff members available on-site are to report to the designated emergency person (Executive Director or designee) for instructions.
- Residents are to be assisted in evacuation as needed.

Night Shift (10p-6a)

Lead Nurse on duty will implement the emergency plan and contact the Executive Director or designee. Executive Director or designee will activate emergency phone tree.
(See attachment A)

Day Shift (6a-2p)

LNAS as scheduled	Executive Director
Concierge	Health Service Director
Activities Staff	Nurse as scheduled
Maintenance Director	Business Office Manager
Food Service Director/ Chef/Wait staff	Marketing Staff
Housekeeping	

Evening Shift 2p-10p

Concierge (until 8p)	Dishwasher (until 8)
Wait staff (until 8)	Activities Staff (until 6p)
Nurse as scheduled	Chef
LNA's as scheduled	

Structural Damage

Structural Damage can be caused by both internal causes (explosions, floods) or external causes (falling trees, car accidents). Should an event cause structural damage to the community, follow these guidelines:

Notify the highest-ranking person on site. This person will call 911 and activate the disaster plan by notifying the Executive Director or designee.

Assist residents to an area of the building that has not suffered damage.

Provide first aid as appropriate.

If you smell gas contact 911 immediately, shut off gas valve (if possible)(**See attachment H)**

If damage to wiring is suspected, do not use any appliances and shut off electrical power, notify utility company.

Evacuate the Community as directed by authorities or if imminent danger exists.

If evacuated follow the community evacuation plan.

Active Shooter

In the event there is an active shooter in the building, **press a panic button if able, utilize hand held radio and clearly state "active shooter, intruder in the building".**

Run- Fast (hard to shoot a moving target) and early (given time the shooter will search you out)

Staying at the scene for any reason, good or bad, will increase your chances of being a victim.

Hide- If running is not an option. Temporarily hide until you get an opportunity to run. Play dead if it will increase your chances of survival.

Fight- Last resort. Do not freeze, make an attempt save yourself.

Look and Listen- be aware of what is happening around you, have a survivor mindset.

Save who you have the power to save. If you are able to escape do not reenter the scene for any reason.

Communications

American House Keene uses a hand held radio system, all staff is able to communicate and the resident pendant system is directly linked to the hand held radios.

American House Keene has one cell phone 603-803-1263.

The generators maintain the pendant system in the event of an emergency. Emergency outlets can be utilized to charge cell phones and hand held radios.

In the event that the Media is involved, the Executive Director would be the spokesperson, and in their absence the Sales and Marketing Director would be appointed. The media should be directed to stay away from the main entrances, they can set up in the resident parking lot near the wrought iron fence.

Transportation

American House Keene has a bus that can accommodate 14 people, plus the driver.

American House Keene also has a company car that can transport 3 people, plus the driver.

In the need for evacuation both vehicles could be used to assist with transport.

American House would work with local taxi services, City of Keene Shuttle, HHC Shuttle, staff members and family members to transport as needed.

Recovery and Restoration

Immediately following the emergency situation, the Emergency Director (Executive Director or designee) will take the following provisions necessary to complete the following actions:

Coordinate recovery and restoration operations with the City of Keene Emergency Management team and all other agencies with jurisdiction to restore normal operations, perform search and rescue and re-establish essential services.

Provide local authorities with a master list of displaced, injured, or dead and notify next of kin/responsible party.

Provide information on sanitary precautions for contaminated food and water to staff, residents, families and appropriate personnel.

Work with contracted pharmacy to ensure minimal disruption of medications and supplies.

Contact all contracted vendors and communicate needs and time line of resuming operations.

Identify essential services needed on a daily basis, utilize staff from non-essential services to fill in any gaps in coverage.

Utilize City of Keene's national flood insurance as needed if affected by a flood.

Provide crisis counseling for residents, staff and families as needed.

Emergency Numbers and Contacts Attachment F

Fire, Police, Ambulance	**Keene**	**911**
Police Department (non-emergency)	**Keene**	**(603) 357-9815**
Fire Department (non-emergency)	**Keene**	**(603) 357-9861**
Pharmacy		**Health Direct (800)861-1903**
Emergency Room		**Cheshire Medical Center (603) 354-5400**
Gas		**Liberty Utilities (603) 352-1230**
Electric		**Eversource (800-662-7764)**

Sewer	**City of Keene Public Works (603) 352-6550 after hours (603)357-9813**
Water	**City of Keene (603)352-6650 after hours (603)357-9813**
Oxygen supplies	**Lincare (802)251-1003**
Heating and Air Conditioning	**K.E. Bergeron (603)-563-8305 or (603) 358-0546**
Fire Alarm Maintenance Company	**RB Allen (603)964-8140**
Fire Alarm (Alarm Company)	**Central Alarm (800) 639-2066**

Center Administrative Staff

Executive Director	**Hilary Seifer** [redacted]
Director of Nursing	**Patrice Aguda-Brown** [redacted]
Business Office Director	**Angie Michaud** [redacted]
Maintenance Director	**Chris Proudman** [redacted]
Food Service Director	**Trina Morin** [redacted]
Activities Director	**Eric Walther** [redacted]
Director of Community Relations	**Christy Thomas** [redacted]

Additional Resources and Contacts

State Emergency Management Agency	(800)735-2964
Federal Emergency Management (FEMA)	(800)621-3362
NH Ombudsman Office	(603)271-4375
Elder Abuse	(603)217-4680
Poison Control	(800)562-8236
Alzheimer's Association	(800)272-3900
Deaf Interpreting Services	(603)224-1850 TTY (603)224-0691

American Red Cross	(603)225-6697
OSHA	(603)225-1629
Consumer Affairs/Fraud	(800)952-5210
Foreign Language Interpreter	(603)271-6692

National Weather Service Watches, Warnings, and Advisories www.weather/alerts-beta/nh

AMERICAN HOUSE SENIOR LIVING

SAFETY AND HEALTH POLICY STATEMENT

January 2022

At American House Senior Living we believe that integrating safety and health into every operation at our company is of the utmost importance. The health and safety of our employees continues to be the first consideration in our operations.

To this extent, American House Senior Living strives to comply with all applicable laws and regulations that govern our operations. In so doing, we conduct our processes and operations in a manner that reduces or eliminates the conditions that are unhealthful or could cause injury to our employees. Employees are consistently urged to report unsafe conditions in their workplace, and work with American House Senior Living management to alleviate these conditions where they may exist.

Quality or production goals do not supercede the safety of our employees. With this in mind, American House Senior Living management and staff have implemented a Safety Management Program. This program provides for:

- The continual commitment of improving safety at our workplace
- Employee awareness and training with regard to safety issues
- A commitment to visitors, neighbors, and our community to lessen or eliminate any safety-related issues from our corporation that could impact them

Within the scope and applicability of our Safety Management Program, American House Senior Living has established a goal to have injury and illness incident rates below the industry average. To accomplish this goal, we ask each of our employees to commit not only to their own safety but to the safety of their co-workers and their community as well.

Building Manager
American House Senior Living

Safety Officer
American House Senior Living

General Safety Rules

1. Personal protective equipment appropriate to your department duties is mandatory.
2. Drugs and alcohol are strictly forbidden. Smoking is permitted in designated areas only.
3. Incident reports are to be completed for all incidents, even if medical attention is not needed.
4. Lift properly, using good lifting techniques. Call for assistance as needed.
5. Equipment will be inspected in accordance with local, state, and federal regulations. Any unsafe equipment will be taken out of service.
6. All employees must review and complete required documents on an annual basis.

Communication

1. Each Employee reviews the safety and health program on orientation, and on an annual basis. Copies of the Safety and Health program are available to all employees.

2. Our Emergency plan, exposure plan, MSDS binders are available in the staff lounge, nurses station, concierge's desk, and with all department heads.

3. Joint Loss/Safety Committee meeting minutes are posted on the employee notice board in the staff lounge.

Hazard Identification

- **Kitchen:** Burns, Fires, back and muscle strain, cuts, falls, lifting and chemicals used for cleaning.
- **Housekeeping and Laundry:** Chemicals used in cleaning, lifting, muscle strain, cuts, falls, contamination, burns, electrical hazards.
- **Maintenance:** Lifting, chemicals, outdoor equipment, falls, cuts, burns, electrical hazards, muscle strain, motor vehicle operation.
- **RN, LPN, LNA, RA:** Lifting, muscle strain, contamination, falls, cuts, buns, and motor vehicle operation.
- **Office:** Muscle and eye strain, lifting, cuts, falls, chemical and electrical hazards.

Personal Protective Equipment

Hazards exist in every working environment; PPE is the first line of defense against physical hazards of various sorts. PPE is the equipment worn to minimize exposure to a variety of hazards. If you do not know where to find PPE, please ask your supervisor.

It is important to recognize when PPE is needed, the importance of PPE and know how to correctly put on and take off PPE.

Types of PPE commonly used are gowns, gloves, masks, eye protection, and aprons.

If medical attention is required, ensure your supervisor is aware and provide documentation of any medical treatment.

Medical Emergency

In the event of an emergency, 911 should be called. Employees should use the in house walkie talkie system to communicate who is completing what task, including who will meet emergency personnel at the entrance.

All employees receive medical emergency training during orientation and then on an annual basis.

All employees are trained to notify the Executive Director and Wellness Director in the event of an emergency.

American House does not mandate that staff are trained in CPR, an AED is available and located on far right wall in the dining room.

Department Safety Rules

Kitchen:

- Be alert for spills, place wet floor sign as needed, clean up and mop immediately.
- Keep walking areas free of boxes, crates, broken down boxes ect.
- Follow all directions and warning labels on all chemicals being used.
- Follow knife safety rules.
- Clean and sanitize preparation surfaces regularly.
- Wash hands frequently, wear gloves when handling food, change gloves when handling different foods.
- Use proper lifting techniques

Housekeeping and Laundry

- Wear gloves when handling contaminated items. Bag any soiled contaminated items and place in marked containers.
- Be aware of placement of cords and cleaning supplies while working.
- Follow directions and warning labels when using chemicals
- Use proper lifting techniques.
- Lock housekeeping cart at all times.
- Return all items to housekeeping office at the end of shifts.
- Wear gloves and use good hand washing techniques.

Office Staff

- Use proper lifting techniques
- Keep floors free of clutter and obstacles.
- Be aware of ergonomic problems with use of computer and being in a seated position for several hours.

1. **Safety Director.** Our Maintenance Supervisor has been designated as the American House Safety Director. That person will enforce all safety rules, investigate accidents, and maintain all required paperwork. He/she will be responsible for monthly safety inspection of the building and have full authority to take corrective action on any unsafe conditions or hazards noted.
2. **In-Service Coordinator.** Our Wellness Director will be responsible for providing training to Safety Committee members and to all employees. He/she will conduct In-Service meetings, which are mandatory for all employees.
3. **Joint Loss Management Committee.** A minimum of four committee members consisting of at least one member of management, (never to exceed equal representation of management vs. employees) and reprsentative members of the employee population as selected by employees. State law determines specific responsibility of the committee. The committee will meet as least quarterly to carry out duties and responsibilities. The committee will keep minutes of meetings which shall be made available for review of all employees. Review of workplace accident and injury data will occur, to help establish the committee's goals and objectives.

Duties and Responsibilities of the Employer

1. Respond in writing to recommendations made by the committee, or make a verbal response that is recorded in the committee's minutes.
2. Pay any employee who participates in committee activities in her/his role as a committee member, including but not limited to attending meetings, training, and inspections, at his/her regular rate of pay for all time spent on such activities.

Responsibility for Supervisors

- Take immediate action to correct any unsafe conditions.
- Provide PPE and training as appropriate.
- Promptly investigate and report all accidents incidents.
- For violations, issue warnings per company policy

Responsibility of Employees

- Report all accidents and incidents to supervisors.
- Report any unsafe conditions.
- Obey all safety and health recommendations with the safety policy.
- Attend trainings as required.

Disciplinary Policy

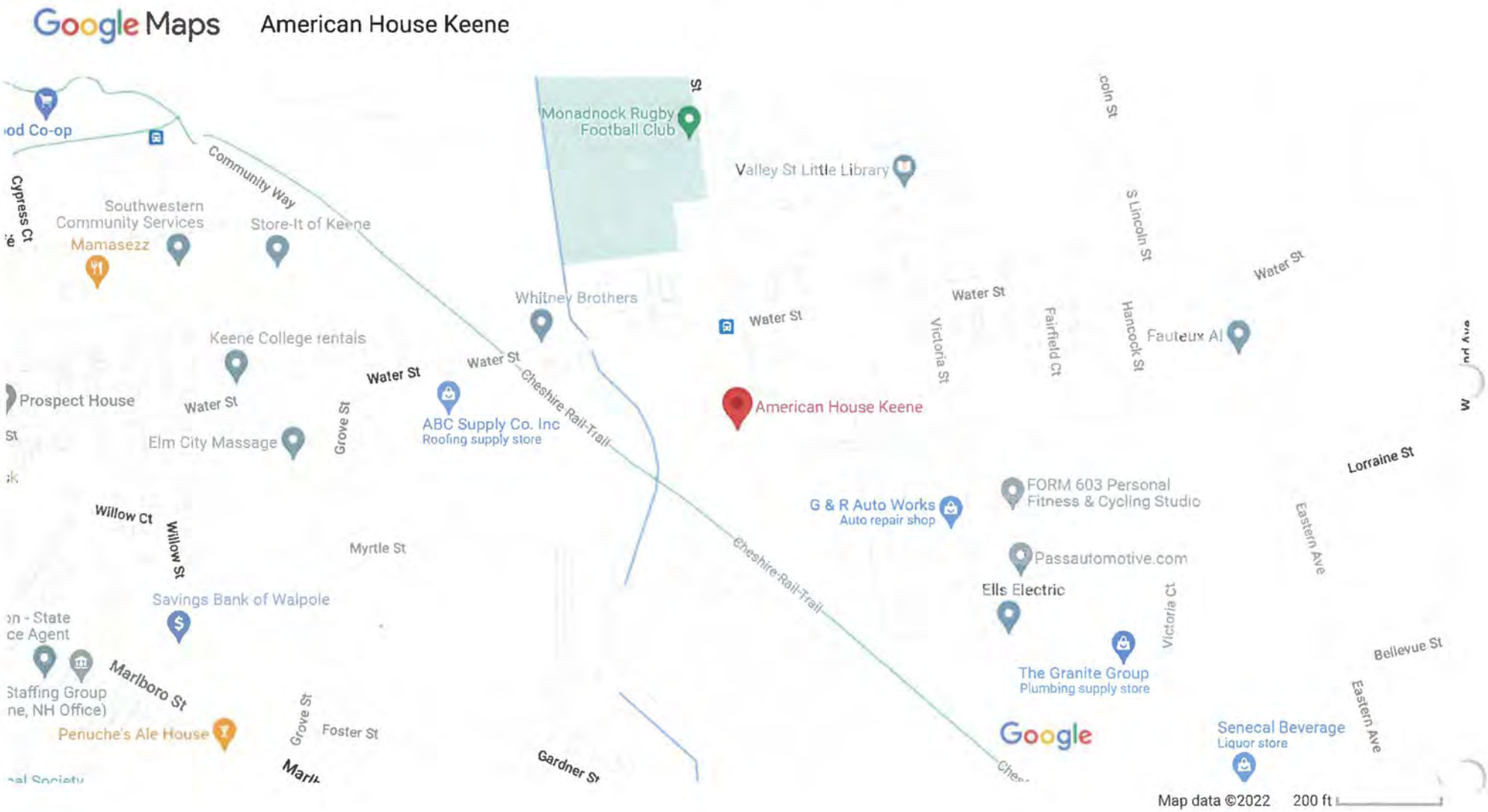
Enforcement of Safety Rules and Policy is a key element of its success. The following penalties apply for Violation of Safety Policy.

1st Offense- Verbal Warning

2nd Offense- Written Warning

3rd Offense-Final Written Warning

4th Offense- Termination


Google Maps
American House Keene
Monadnock Rugby Football Club
Valley St Little Library
Community Way
Cypress Ct
Southwestern Community Services
Mamasezz
Store-It of Keene
Whitney Brothers
Water St
Keene College rentals
Prospect House
Water St
Grove St
ABC Supply Co. Inc
Roofing supply store
Cheshire Rail Trail
American House Keene
Victoria St
Fairfield Ct
Hancock St
Fauteux Al
S Lincoln St
Elm City Massage
Lorraine St
FORM 603 Personal Fitness & Cycling Studio
G & R Auto Works
Auto repair shop
Willow Ct
Willow St
Myrtle St
Passautomotive.com
Eastern Ave
Ells Electric
Savings Bank of Walpole
Victoria Ct
Bellevue St
The Granite Group
Plumbing supply store
Marlboro St
Staffing Group
Penuche's Ale House
Foster St
Gardner St
Google
Senecal Beverage
Liquor store
Map data ©2022
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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled_____
Rec'd By_____
Page _____of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

○ Drug Treatment Center	○ Group Home, Small	○ Homeless Shelter
○ Fraternity/Sorority	○ Group Resource Center	○ Lodging House
○ Group Home, Large	○ Residential Drug/Alcohol Treatment Facility	◉ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 91 Maple Avenue Keene NH

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Jay Hayston	**NAME/COMPANY:** Cedarcrest, Inc.
MAILING ADDRESS: 91 Maple Ave, Keene NH 03431	**MAILING ADDRESS:** 91 Maple Ave, Keene NH 03431
PHONE: (603) 358-3384	**PHONE:** (603) 358-3384
EMAIL: jhayston@cedarcrestcenter.org	**EMAIL:** jhayston@cedarcrestcenter.org
SIGNATURE: [signature] **DATE:** 2/21/24	**SIGNATURE:** [signature] **DATE:** 2/21/24
PRINTED NAME: Jay Hayston **TITLE:** CEO	**PRINTED NAME:** Jay Hayston **TITLE:** CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY:	**NAME/COMPANY:**
MAILING ADDRESS:	**MAILING ADDRESS:**
PHONE:	**PHONE:**
EMAIL:	**EMAIL:**
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** **TITLE:**

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Cedarcrest serves children who are medically and developmentally complex. Cedarcrest is a resource and support for families and a safety net when families are not able to continue to provide care. The organization is licensed by the State of NH as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The residential capacity is 26 children ranging in age from birth to twenty-two years old. For the time frame of July 1, 2023 through July 1, 2024 the State of NH granted Cedarcrest one additional bed to accommodate an additional individual at times when demand exceeds bed limits. The addition of one bed did not require any construction or alteration of our building. Children come from communities throughout the state and from neighboring Vermont and Maine. The center provides both intermediate and skilled nursing care. An increasing proportion of children served have more complex medical needs, many requiring high-tech respiratory support including ventilators.

Cedarcrest served more than 40 children and families over the course of the past year, many for short term stays. Cedarcrest's short stay program provides support to families at times when community services may not be available or there is a family need or emergency. Short stays support a family's goal of keeping their children home in the long term by providing caregiver respite. Children staying for short stays are integrated in activities, participating with their peers in a range of recreation and leisure opportunities indoors and outdoors on the beautiful grounds. Cedarcrest provided care for a number of children transitioning from the hospital to home. These stays are typically longer than a short stay but are transitioned home as soon as they are medically able to, the families are trained, and community support services are in place.

Cedarcrest's team includes nurses, therapists, special educators, and nursing assistants, all specially trained to care for children with complex medical needs. They are supported by administrative and support team members. Cedarcrest staff are able to expedite admissions when an emergency arises for a family, for DCYF, or for other community care teams. While children requiring extended stays make up a majority of the census, children in need of (see additional sheet)

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Cedarcrest Center has a 26 bed maximum (27 beds granted by state of NH July 1, 2023 through July 1, 2024). Census as of today's date is 25. We are a 24 hour residential facility and have a private day school that operates 8:30 am to 2:30 pm.

Cedarcrest employs more than 120 caring staff (including per-diems) who provide round the clock care to the children, 365 days a year, and meet their educational needs during a 240 day school year (year round with multiple week long breaks).

The residential and school services are housed in the main building. The other structures on site include two garages and a car port. See site map for buildings. We have a parking area as well as green space, and a fully accessible playground that is open to the public and part of the "Lets Play Together" playful city playground map of Keene.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

Residents who come to Cedarcrest Center have a length of stay that is dependent on their needs. Our long term residents can be here for a minimum of thirty days until they potentially age out, which may be years. The length of stay is determined but their functioing level and medical need as well as where and how they might reside in the community.

We also offer respite care. These individuals would stay from two to twenty-nine days. Cedarcrest Center encourages community-based care, but we understand that from time to time a family may need to have a child cared for outside of their home. Whether for post-operative rehabilitation, during interruptions in community-based services, or in response to a specific family need, we are able to provide short-term care.

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. LB23-01
Date Filled 11/9/23
Rec'd By CM
Page 1 of 153

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☐ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodginghouse
☐ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☑ Residential Care Facility

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I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Jay Hayston	NAME/COMPANY: Cedarcrest Center
MAILING ADDRESS: 91 Maple Ave Keene, NH 03431	MAILING ADDRESS: 91 Maple Ave Keene, NH 03431
PHONE: (603) 358-3384	PHONE: 6033583384
EMAIL: jhayston@cedarcrest4kids.org	EMAIL: jhayston@cedarcrest4kids.org
SIGNATURE: J Hayston	SIGNATURE: J Hayston
PRINTED NAME: Jay Hayston	PRINTED NAME: Jay Hayston

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY:	NAME/COMPANY:
MAILING ADDRESS:	MAILING ADDRESS:
PHONE:	PHONE:
EMAIL:	EMAIL:
SIGNATURE:	SIGNATURE:
PRINTED NAME:	PRINTED NAME:

SECTION 3: PROPERTY INFORMATION

PROPERTY ADDRESS:	TAX MAP PARCEL NUMBER:
91 Maple Ave Keene NH 03431	227-018-000-000
ZONING DISTRICT: LD	☑ **LOCATION MAP:** *Please attach*

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Cedarcrest Center for Children with Disabilities serves children who are medically and developmentally complex. The Center is a resource and support for families and a safety net when families are not able to continue to provide care. The Center is licensed by the state of New Hampshire as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The residential capacity is twenty-six children, ranging in age from birth to twenty-two years. Children come from communities throughout the state and from neighboring Vermont and Maine. The Center provides both intermediate and skilled nursing care. An increasing proportion of children served have more complex medical needs, many requiring high-tech respiratory support including ventilators.

Cedarcrest served more than thirty-five children and families over the course of the past year, many for short term stays. Cedarcrest ' s short stay program provides support to families at times when community services may be less available or there is a family need or emergency. Short stays support a family ' s goal of keeping their children home in the long term. Cedarcrest provided care for a number of children transitioning from the hospital to home. Cedarcrest staff are able to expedite admissions when an emergency arises for a family, for DCYF, or for other community care teams. While children requiring extended stays make up much of the census, children in need of comprehensive evaluations, post-op care, or medical stabilization are also regularly served. As these services are not readily available to this population elsewhere, they represent a critical continuum of care option for those with complex medical and developmental needs. Cedarcrest staff provide the medical and therapeutic services appropriate to a child ' s needs, as well as training for families and foster families in preparation for a return to the community.

Cedarcrest ' s school is approved by the state of New Hampshire as a private school provider of special education for children from ages 2 through 21. Most students in the Cedarcrest School are from the residential program though day education services are also available and are regularly provided to multiple members of the local community. The IEP team for each child determines where best that child should be educated. Our average school census for 2021-2022 is seventeen students. We currently have three students who reside in the community with family and attend our school as day students. An infant-toddler program is offered to the youngest residents, focused on socialization, functional skill acquisition, and preparation for more structured learning environments. Therapy services are offered to both residents and school students based on the child ' s IEP and/or medical orders.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: CEDARCREST INC
Located at: 91 MAPLE AVENUE
KEENE NH 03431

To Operate: ICF/IID

This annual license certificate is effective under the conditions and for the period stated below:

License#: 01709
Effective Date: 08/01/2022 Expiration Date: 07/31/2023
Administrator: JESSE J HAYSTON
Medical Director: KATHLEEN COLLINS, MD

Number of Beds: 26

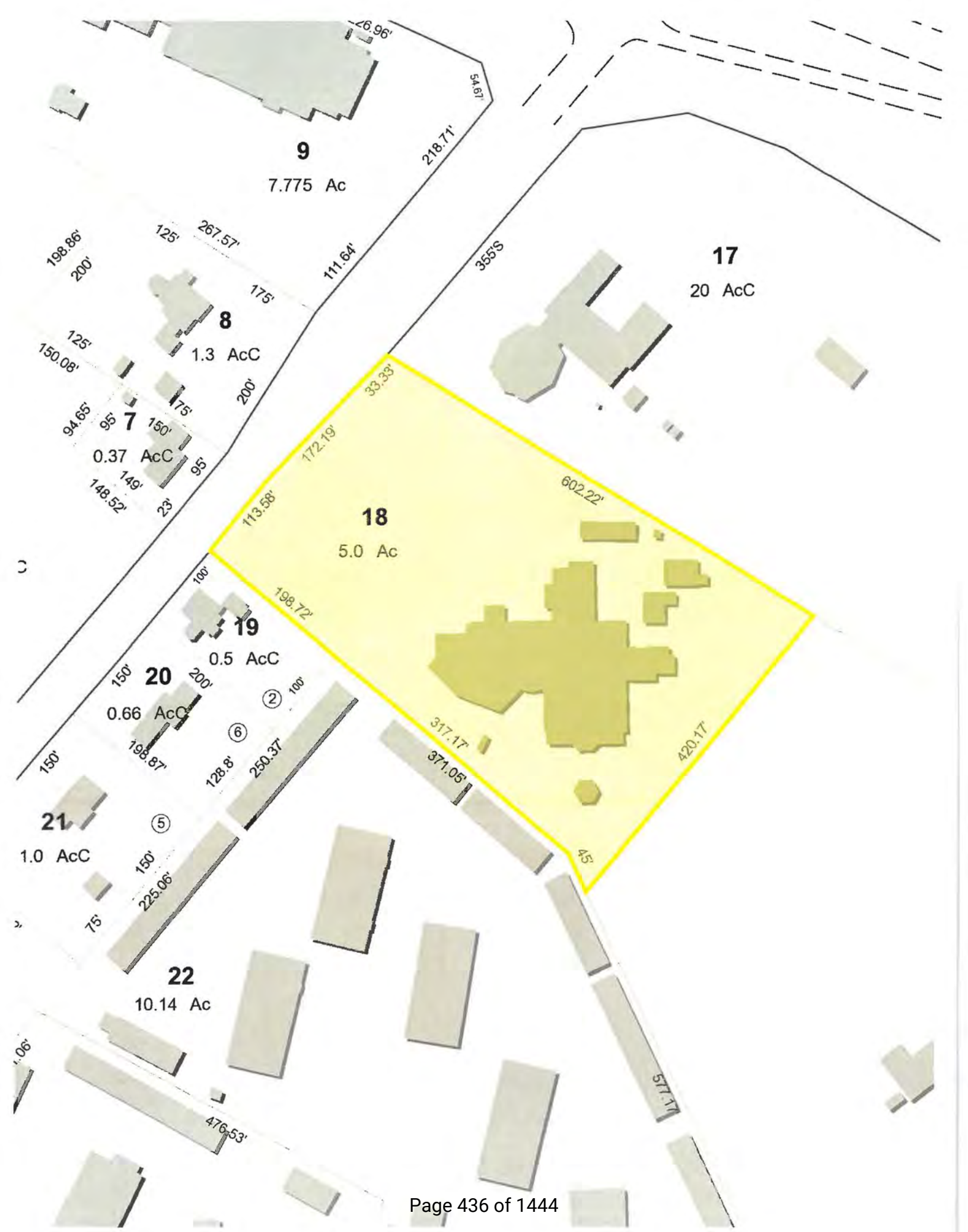
Chief Legal Officer

Notes on Cedarcrest Center:

Bldg. area: 29,521 gross sq. ft. – 29,431 interior sq. ft

Parcel area: 5 ac

Tax Map: 227-18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7.775 Ac
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0.5 AcC
20
0.66 AcC
21
1.0 AcC
22
10.14 Ac
218.71'
111.64'
355'S
602.22'
420.17'
371.05'
317.17'
577.17'
476.53'
250.37'
225.06'

91 MAPLE AVE.

Location	91 MAPLE AVE.	**Map/Lot #**	227/ / 018/000 000/000
Acct#	227018000000000	**Owner**	CEDARCREST INC
Building Name		**Assessment**	$3,592,500
Appraisal	$3,592,500	**PID**	7153
Building Count	1		

Current Value

Appraisal

Valuation Year	Improvements	Land	Total
2022	$3,415,300	$177,200	$3,592,500

Assessment

Valuation Year	Improvements	Land	Total
2022	$3,415,300	$177,200	$3,592,500

Parcel Addreses

Additional Addresses

No Additional Addresses available for this parcel

Owner of Record

Owner	CEDARCREST INC	**Sale Price**	$0
Co-Owner		**Book & Page**	2449/0439
Address	91 MAPLE AVE.	**Sale Date**	07/11/2007
	KEENE, NH 03431		

Ownership History

Ownership History

Owner	Sale Price	Book & Page	Sale Date
CEDARCREST INC	$0	2449/0439	07/11/2007
CEDARCREST INC	$245,000	1248/0751	06/01/1988

Extra Features

Extra Features — Legend

Code	Description	Size	Assessed Value	Bldg #
PR2	Porch, Enclosed	528.00 S.F.	$9,800	1
PR1	Porch, Open	90.00 S.F.	$1,100	1
PR1	Porch, Open	32.00 S.F.	$400	1
PR1	Porch, Open	264.00 S.F.	$3,100	1
SPR3	SPRINKLERS DRY	29500.00 S.F.	$43,700	1
PR2	Porch, Enclosed	108.00 S.F.	$2,000	1
PR1	Porch, Open	720.00 S.F.	$8,500	1
PR1	Porch, Open	576.00 S.F.	$6,800	1
ELV1	ELEV PAS 2-3 STOPS	1.00 UNITS	$33,800	1

Land

Land Use

Use Code	977
Description	Charitable Bldg
Zone	LD
Category	

Land Line Valuation

Size (Acres)	5
Depth	
Assessed Value	$177,200
Appraised Value	$177,200

Outbuildings

Outbuildings — Legend

Code	Description	Sub Code	Sub Description	Size	Assessed Value	Bldg #
FGR1	GARAGE- AVE			1120.00 S.F.	$14,000	1
FGR1	GARAGE- AVE			864.00 S.F.	$10,800	1
SHD1	SHED			182.00 S.F.	$1,000	1
CAB1	CABIN- MINIMAL			256.00	$4,900	1
PAV1	PAVING- ASPHALT			15600.00 S.F.	$15,600	1
LGT1	POLE & SINGLE LIGHT			5.00 UNITS	$1,500	1
CAB1	CABIN- MINIMAL			528.00	$15,000	1
FCP	CARPORT			1280.00 S.F.	$10,600	1

Valuation History

Appraisal

Valuation Year	Improvements	Land	Total
2021	$3,415,300	$177,200	$3,592,500

Assessment

Valuation Year	Improvements	Land	Total
2021	$3,415,300	$177,200	$3,592,500

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Cedarcrest Center currently has a 26 bed maximum, our census as of todays date is 22. We are a 24 hour residental facility and have a private day school program that operates 8:30 am to 2:30 pm.

Cedarcrest employs a staff of 120 caring staff (including per-diems) who provide round-the-clock care to the children, 365 days a year, and meet their educational needs 240 days per year

The residentalial and school services are housed in our main bulding, The other structures on site include two garages and a car port. See site map for buildings. We have a parking area as well as green space, and a fully accessible playground that is open to the public and part of the "Lets Play Together" playful city playground map for Keene.

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

Residents who come to Cedarcrest Center have a length of stay that is dependent on their needs. Our long term residents can be here for a minimum of thirty days until they potentially age out, which would be years. . The length of stay is determined but their functioing level and medical need as well as where and how they might reside in the community.

We also offer respite care. These individuals would stay from two to twenty-nine days. Cedarcrest Center encourages community-based care, but we understand that from time to time a family may need to have a child cared for outside of their home. Whether for post-operative rehabilitation, during interruptions in community-based services, or in response to a specific family need, we are able to provide short-term care.

Cedarcrest's Emergency Operation Plan is reviewed on an ongoing basis and updated as needed during the year, and is more formally reviewed at least twice a year. The plan is approved by the Keene Fire Department as well as by the Life Safety inspector of the Bureau of Health Facilities Administration and by Homeland Security as a part of the school review process.

Security Plan
Physical Security: Cedarcrest security measures include lighting in the parking areas and at all entrances of the building. We have a security camera the can view the front door area when the doors are locked. Windows are closed as we are a temperature regulated building. All doors are locked to outside individuals and some exterior doors are alarmed for children's safety.
We strictly follow HIPAA guidelines for all confidential information including written and electronic forms.
Systems and Staff: Cedarcrest has all visitors sign in and logs are maintained. All employees wear name tags identifying their name and role at Cedarcrest Center.
Preparedness: Please see Emergency Preparedness Plan. Staff are trained on this plan at the time of orientation as well as a yearly mandatory in-service, and practice of the plan in regularly scheduled drills.
At the time of admission, the guardian agrees to and signs a form acknowledging that we do not allow drugs, alcohol or weapons on the property.
Staff can complete Maintenance Request form if an issue arises.
Please see check list that is done daily.
Please see Emergency Preparedness Plan

See attached:
Maintenance Security Check List
Emergency Codes Policy and Procedure
Emergency Communication Plan
Emergency Preparedness Planning Policy
Security Systems
Visitor Policy

Life Safety Plan
See attached:
Emergency Light testing check list
Fire Drill Log
Fire Extinguisher check
Fire Hydrant Check
Available upon request: Fire Alarm checklists, Door inspection checklist, Fire Door Inspection, Sprinkler Inspection logs

Staff Training and Procedures Plan
Staff are trained at the time of hire at orientation, they attend annual mandatory in-services, and participate in practice drills as appropriate.

Health and Safety Plan
See attached:
Standard and Transmission based Precautions
Abuse Prevention Policy

Building Maintenance Procedures
We have staff who do regular maintenance checks. These check lists are maintained at our facility please request to see completed logs if necessary.
See attached:
Preventative Maintenance Program
Facility Maintenance and House Keeping Policy
Weekly Boiler Room Check List
Weekly Facility Check List

Emergency Response Plan
Cedarcrest Center's Emergency Plan is written in support of emergency management and is built upon the National Response Framework (NRF) as a scalable, flexible, and adaptable coordinating structure to align key roles and responsibilities. Cedarcrest Center serves a group of children who are medically complex with limitations in multiple areas of development including mobility and communication as well as compromised medical stability. Staff are specially trained to be able to assist in the response process to assure their safety regardless of the type of hazard encountered.

As a licensed medical facility, Cedarcrest follows the requirements of the Centers for Medicaid and Medicare with guidance from American Health Care Association and its state affiliate. As a Private Special Education program, Cedarcrest strives to meet the requirements of Homeland Security designated for schools. The Center participates in Hazard Vulnerability Analyses done as a region or on a state-wide basis and participates in regional and state trainings. This plan and its contents applies to all Cedarcrest Center staff, children, families, consultants and volunteers and others participating in the preparedness efforts.

Cedarcrest's plan is based on the Incident Command Systems. The organization maintains additional procedures supporting the Emergency Operations Plan. Given the medical nature of its services, Cedarcrest uses the New Hampshire Hospital Emergency Code system. All staff are required to actively participate in the training, exercise, and maintenance needed to support this plan. Information is provided to other staff to introduce this structure and it is practiced in monthly drills.

See attached:
Emergency preparedness plan
Evacuation Route
Emergency Preparedness Planning Policy

Neighborhood Relations Plan
Cedarcrest Center for Children with Disabilities maintains active and friendly relationships with our neighbors both next door and throughout the city. Neighbors are always invited and often participate in our community events, recently including a Walk and Roll walk, a 75th Anniversary Barbecue, and cookies and carols during an outdoor holiday tree lighting. Cedarcrest is the landlord for three residential properties adjacent to the 91 Maple Avenue location, and maintains a great relationship with the leadership and parishioners of the First Baptist Church next door. Cedarcrest provides exceptional care and education to children with complex medical and developmental needs in a 24/7 setting. While there are occasional medical emergencies requiring first responders, Cedarcrest has no history of noise or other property complaints and enjoys very positive relationships with our neighbors.
Additionally, we maintain a relationship with area schools including Keene Middle School and Trinity Christian School for student/peer interactions with our school program.

See attached:
Emergency Communication Plan
Evacuation Route Sheet

Please feel free to ask questions or request to see a document that may not have been included in an application.

Security Plan Attachments

Maintenance Weekly Facility Check List

Month & Year _____

	Week 1	Week 2	Week 3	Week 4	Week 5
Date					
Initials					
Temp-Maintenance Room					
Temp-Atrium					
Temp-West Hall Home					
Check Night Lights					
Fire Alarm Panel Power On yes/no					
Fire Alarm Panel Trouble yes/no					
Temp-East Hall Home					
Temp-Attic					
Humidity-Attic					
AHU4 Return Fan Hz					
AHU4 Supply Fan Hz					
AHU4 Discharge Air Temp					
Temp-Dining Room					
Temp-Kitchen					
Kitchen Storage Area Visual Check					
Education Hallway Visual Check					
Temp-Yellow Classroom					
Temp-Peach Classroom					
Temp-Green Classroom					
Entry/Reception Area Visual Check					
Surge Protector Readings					
Electrical Room Visual Check					
Generator Xfer Switch Normal yes/no					
Battery Charger DC Volts					
Outside Facility Visual Check					
Interior Lights Visual Check					
Exterior Lights Visual Check					
Fire Exit Lights Visual Check					
Attics Visual Check					
Domestic Hot Water Temp					

Preventative Maintenance Program

2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly Procedures																
Roof rake roofs after each snow storm (10x per yr)	2	5	10.0	50	1/17/22	2/7/22	3/16/22								N/A	12/12/22
Clean Kitchen Grease Trap every two weeks	2	0.75	1.6	20	1/12,17/22	2/9,23/22	3/9,23/22	4/6,20/22	5/4,18/22	6/1,15,29/22	7/13,27/22	8/10,24/22	9/6,21/22	10/5,19/22	11/2,16,23/22	12/14,26/22
Check Play structures in day rooms	4	0.5	2.0	24	1/5/22	2/2/22	3/3/22	4/5/22	5/2/22	6/3/22	7/7/22	8/2/22	9/6/22	10/5/19/20/22	11/3/22	12/2/22
Check Beds for Safety	27	1	27.0	324	1/18/21	2/9/22	3/7/22	4/8/22	5/4/22	6/3/22	7/12/22	8/17/22	9/13/22	10/14/22	11/18/22	12/5/22
Clean Company Vehicles 3 per month	6	2	12.0	144	1/21/22	2/10/22	3/4/22	4/22/22	5/4/22	6/9, 23	7/21/22	8/16/22	9/26/22	10/21/22	11/30/22	
Check Nurse Call System	10	0.05	0.5	6	1/27/22	2/23/22	3/30/22	4/27/22	5/26/22	6/29/22	7/21/22	8/30/22	9/30/22	10/31/22	11/30/22	
Test Exterior Door Alarms	1	1	1.0	12	1/27/22	2/23/22	3/30/22	4/27/22	5/26/22	6/29/22	7/27/22	8/30/22	9/30/22	10/31/22	11/30/22	
Eye Wash Stations Flushed Weekly	10	0.1	1.0	12	1/3,11,18,22	2/1,10,15,21	3/2,11,15	4/1,6,11	5/3,10,18	6/3,10,23,28	7/7,19,29	8/2,11,16,29	9/1/22	10/7/22	11/8/22	12/2,5
Generator #9	1	0.5	0.5	6	1/4,11,18,25	2/1,8,15,22	3/1,8,15,22,29	4/5,12,19,26	5/3,10,17,24,31	6/7,14,21,28	7/5,12,19,26	8/2,9,16,23,30	9/6,16/22	10/3	11/1,29/22	12/2,5
Checking Oxygen System	1	0.33	0.3	4	1/3/22	2/1/22	3/1/22	4/1/22	5/1/22	6/1/22	7/6/22	8/1/22	9/1/22	10/3/22	11/1/22	12/1/22
Checking Stretchers	4	0.25	1.0	12	1/24/22	2/21/22	3/11/22	4/19/22	5/4/22	6/6/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Standers	4	0.1	0.4	5	1/24/22	2/21/22	3/11/22	4/14/22	5/4/22	6/6/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Walkers/Gait Trainers	6	0.1	0.6	7	1/24/22	2/21/22	3/15/22	4/13/22	5/4/22	6/6/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Bikes	3	0.33	1.0	12	1/6/22	2/2/22	3/15/22	4/18/22	5/19/22	6/6/22	7/7/22	8/17/22	9/13/22	9/7/22	11/4/22	12/9/22
Check Patient Lifts - Added 4/20/22					N/A	N/A	N/A	4/22/22	5/19/22	6/9/22	7/12/22	8/17/22	9/13/22	10/14/22	11/18/22	12/5/22
Glider Rockers	2	0.1	0.2	2	1/3/22	2/10/22	3/4/22	4/8/22	5/4/22	6/6/22	7/8/22	8/17/22	9/13/22	10/11/22	11/16/22	12/5/22
Test emergency lights and exit signs	1	1	1.0	12	1/3/22	2/1/22	3/1/22	4/1/22	5/1/22	6/2/22	7/6/22	8/2/22	9/1/22	10/3/22	11/1/22	12/1/22
Fire Extinguishers #4 & AED's	1	1	1.0	12	1/10/22	2/1/22	3/1/22	4/1/22	5/1/22	6/2/22	7/8/22	8/2/22	9/1/22	10/3/22	11/1/22	12/1/22
Vehicle Oil Levels	6	0.15	0.9	11	1/10/22	2/11/22	3/7/22	4/8/22	5/18/22	6/3/22	7/5/22	8/5/22	9/13/22	10/13/22	11/3/22	12/6/22
Vehicle Safety check (including tire pressure	6	0.3	1.8	22	1/6/22	2/11/22	3/7/22	4/8/22	5/18/22	6/6, 23	7/5/22	8/17/22	9/13/22	10/13/22	11/3/22	12/8/22
School Fire Drill	1	1	1.0	12	1/6/22	2/23/22	3/30/22	4/20/22	5/26/22	6/29/22	7/28/22	8/29/22	9/27/22	10/25/22	11/29/22	
Fire Drill evening/ overnight	1	1	1.0	8	1/26/22	2/2/22		4/12/22	5/5/22		7/29/22	8/30/22		10/31/22	11/30/22	
Check attics for ice damming (winter months)	1	0.5	0.5	3	1/25/22	2/2/22	3/3/22								N/A	12/14/22
Winter months check for frozen fire sprinklers	1	0.5	0.5	3	1/25/22	2/2/22	3/3/22								11/28/22	
Nutrition & Med Room Drain - pour 5 gal of hot water down	2	0.25	0.5	6	1/7/22	2/2/22	3/1/22	4/11/22	5/2/22	6/28/22	7/29/22	N/A	9/19/22	10/17/22	11/3/22	
Bathroom Sink Drains - Pour 5 gal of hot water	21	0.25	5.3	63	1/6/22	2/10/22	3/1/22	4/13/22	5/3/22	6/28/22	7/29/22	N/A	9/19/22	10/17/22	11/7/22	
Classroom Sink Drains - Pour 5 gal of hot water	6	0.25	1.5	18	1/6/22	2/10/22	3/2/22	4/13/22	5/3/22	6/28/22	7/29/22	N/A	9/1/22	10/11/22	11/7/22	
Oil Tank DES Monthly Checksheet	1	0.5	0.5	6	1/18/22	2/14/22	3/21/22	4/12/22	5/18/22	6/15/22	7/14/22	8/18/22	9/15/22	10/20/22	11/22/22	12/16/22
Sub-total			41.5	498												

Preventative Maintenance Program **2022**

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Quarterly Procedures																
Check Toilet Seats, Hopper, Shower Heads	38	0.15	5.7	23	1/13/22			4/20/22			7/8/22			10/7/22		
Dinning room chairs	30	0.25	7.5	30	1/6/22			4/13/22			7/8/22			10/14/22		
Check all doors for proper gaps& latching	1	1	1.0	4	1/28/21			4/14/22			7/12/22			9/30/22		
Service hot water mixing valves	2	1.5	3.0	12	1/4/22			N/A			7/13/22			N/A		
GFI Receptacle Testing	29	0.1	2.9	12		1/26/21			5/2/22			7/8/22			11/2/22	
Check Electric High/Low Tables	3	0.2	0.6	2		1/28/21			5/4/22			8/16/22			11/11/22	
Replace water filters for building	3	0.2	0.6	2		2/2/22			5/4/22			8/31/22			11/22/22	
Check storage rooms for 18" sprinkler clearance	1	0.6	0.6	2		1/28/21			5/4/22			8/15/22			11/1/22	
Sprinkler system Quaterly Due			0.0	0		1/28/22			5/17/22			8/19/22			12/2/22	
Heat pump water heaters - clean filters	2	0.3	0.6	2		N/A			4/28/22			8/17/22			11/1/22	
Refrigerators - Clean coils & inspect gaskets	7	0.75	5.3	21			3/2/22			6/30/22			9/13/22			
Air Handlers AHU 1	1	1	1.0	4			2/28/22			6/1/22			9/8/22			12/9/22
Air Handlers AHU 2	1	1	1.0	4			2/28/22			6/1/22			9/8/22			12/9/22
Air Handlers AHU 3	1	1	1.0	4			3/2/22			6/8/22			9/8/22			12/8/22
Air Handlers AHU 4	1	1	1.0	4			2/14/22			6/8/22			9/8/22			12/7/22
Air Handlers AHU Kitchen	1	1	1.0	4			2/23/22			6/24/22			9/13/22			12/8/22
Fire Alarm System Quaterly			0.0	0			3/29/22			6/8/22			9/28/22			12/21/22
Inspect CyberMedix panel/components	1	1	1.0	4			3/22/22			6/29/22			9/19/22			
Fertilize lawns April, June, Sept	1	3	3.0	12				4/2/22		n/a			9/13/22			
Sub-total			20.1	80												

Preventative Maintenance Program 2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Semi-Annual Procedures																
Clean Floor Drains	19	0.5	9.5	19	1/7/22						7/18/22					
Clean multipurpose room range hood	1	0.5	0.5	1	1/4/22					6/28/22						
Clean Bathroom and all Other Exhaust Vents	65	0.5	32.5	65		1/27/21						N/A				
Kitchen Range Hood Fire Suppression			0.0	0		2/23/22						8/29/22				
Clean sediment trap Gym sink	1	1	1.0	2		1/26/22						8/15/22				
Clean sediment trap rehab maintenance sink	1	1	1.0	2		1/26/22						8/15/22				
Heat pump in Shop - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump in Server Room - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump 2nd Fl Office - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump in Family Overnight Rm - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Washer/Dryers	6	1.5	9.0	18			3/31/22						9/26/22			
Checking and Cleaning Door Hardware	134	0.1	13.4	27			3/22/22						9/13/22			
CK sprinkler heads in/ext corrosion/ alinment	1	1	1.0	2			3/16/22						9/19/22			
Vehicle Lift Check/and tie down maintenance	3	1	3.0	6			3/7/22						9/14/22			
Check playground equipment for safety	1	2	2.0	4			3/31/22				7/8/22				11/2/22	
Clock login for battery life	1	0.5	0.5	1					5/2/22							12/2/22
Check, Clean, Lube Conf Rm Chairs	24	0.1	2.4	5				4/13/22						10/13/22		
Weeding of Mulch Areas and Playground	1	24	24.0	48				4/25/22	5/11/22	6/20/22	7/6/22	8/15/22	9/19/22			
Roof top Exaust ventilators	8	0.5	4.0	8				4/12/22						10/11/22		
Check Emergency supplies at church	1	1	1.0	2				4/12/22						10/17/22		
Replace/check batteries in flash lights & emergency tote	1	0.75	0.8	2				3/25/22						10/3/22		
Clean out play ground drain	1	0.75	0.8	2				4/4/21						10/7/22		
Clean dryer Vents - vendor			0.0	0				4/14/22						11/3/22		
Kitchen range hood cleaning			0.0	0				4/14/22						11/3/22		
Sub-total			45.5	91												

Preventative Maintenance Program

2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Annual Procedures																
Hire out Christmas tree light removal			0.0	0	N/A											
Service Patient lifts in Bedrooms & Bathrooms	20	0.5	10.0	10	1/25/21											
Test 25 percent of fire dampers yearly	1	20	20.0	20		12/30/21										
Fire Exttinguisher Annual Inspection			0.0	0		2/23/21										
Generator Minor Service			0.0	0				4/4/22								
Mulch all flower gardens	1	40	40.0	40				3/11/22	5/11/22							
Spring Yard clean up/ reseeding bare spots	1	80	80.0	80				4/4/5,7,11,12,13,14,15								
Inspection and testing of oxygen system			0.0	0					5/3/22							
Clean VFD's cooling fins (AHU1,2,3,4 & Boiler Pumps)	10	0.3	3.0	3					5/5/22							
Unwinterize play ground water supply	1	1.5	1.5	2					4/26/22							
Grub prevention	1	3	3.0	3						n/a						
Wash Condenser Coils AHU 1&2	2	2	4.0	4						6/2/22						
Wash Condenser Coils Chilled Water	1	2	2.0	2						6/24/22						
Wash Condenser Coils Kitchen MUA	1	1	1.0	1						6/24/22						
Wash Condenser Coils Kitchen Freezer	1	1	1.0	1						6/24/22						
Wash Condenser Coils Split systems/ Heat pumps	4	1	4.0	4						6/24/22						
Flush Water Heaters	4	1	4.0	4						6/24/22						
Generator Annual Load Test	1	1.5	1.5	2							7/5/22					
Emergency Light 90 minute test(July School Break)	79	0.08	6.3	6							7/6/22					
Clean and seal all cement patios and cement walks	1	12	12.0	12							N/A					
Trim Shrubs and Trees	1	60	60.0	60								8/11				
Clean Wall Heater Units	32	0.75	24.0	24								N/A				
Generator Major Service			0.0	0										10/14/22		
Clean Boiler #1	1	8	8.0	8									9/19/22			
Clean Boiler #2	1	8	8.0	8									9/21/22			
Change heating oil filters	4	0.25	1.0	1									9/1/22			
Fire Door Inspection	20	0.5	10.0	10									9/30/22			
Clean ceiling hung heaters	4	0.5	2.0	2									9/30/22			
Fall Yard Clean up	1	100	100.0	100									9/19/22	10/17/22	11/11/22	
Clean fin tube baseboard heaters	42	2	84.0	84										10/31/22		
Winterize play ground water supply	1	3	3.0	3										10/13/22		
Hire out Christmas tree light installation 14 strings			0.0	0											11/23/22	
Service Sprinkler Compressor (oil & air filter)	1	0.75	0.8	1												
Sub-total			127.5	128												

CEDARCREST CENTER
Weekly Boiler Room Check List

Month	Week 1	Week 2	Week 3	Week 4	Week 5
Date					
Outside Temp (X1)					
Boilers	-----	-----	-----	-----	-----
Supply - Header Water Temp					
Return - Header Water Temp					
Pump 1 - Discharge Pressure					
Pump 2 - Discharge Pressure					
Boiler 1 On/Off					
Boiler 1 Pressure					
Boiler 1 Temperature					
Boiler 2 On/Off					
Boiler 2 Pressure					
Boiler 2 Temperature					
Expansion Tank Level					
Fuel Oil	-----	-----	-----	-----	-----
Oil Pump Vacuum					
Oil Level - Gallons					
Oil Delivered - Gallons					
Oil Average Daily Usage					
Oil Level - Inches					
Domestic Hot Water Meters	-----	-----	-----	-----	-----
#1 Main Hot Water (gal)					
Main Hot Water - Avg Daily Usage					
#2 Kitchen Sinks Water (gal)					
Kitchen Sinks Water - Avg Daily Usage					
#3 Dishwasher/ Laundry Water (gal)					
Dishwasher/ Laundry - Avg Daily Usage					
Domestic Hot Water Temperature	-----	-----	-----	-----	-----
#1 Central Bathing/ Restrooms 100-120°F					
#2 Kitchen Sinks 100-130°F					
#3 Dishwasher/ Laundry 140-150°F					
Fire Sprinkler System	-----	-----	-----	-----	-----
Air Compressor Run Hours (xxxx.xx hrs.)					
Air Compressor Run Hours - Avg Daily Hours					
Visual Check					
Air Compressor Oil Level					
Check/ Drain					
Air Pressure					
Water Pressure					
City Domestic Water	-----	-----	-----	-----	-----
City Water Pressure					
Building Water Pressure					
Main Cold Water Meter (x,xxx,xxx ft^3)					
Main Cold Water Meter - Avg Daily Usage ft^3					
Chlorine Level (once per month)					

Cedarcrest Center
for Children with Disabilities
Security Systems

POLICY: Cedarcrest Center provides a number of security systems to ensure the safety of the children and staff.

PROCEDURES:

Reception area quick lock: The receptionist is able to lock the front door using a switch at the desk. This may be used at any time there is an unwelcome person outside or if the receptionist needs to step away from the desk.

Doorbell/intercom System:
The doorbell rings remotely at the Nurses' Station. The monitor shows the image of the person at the door. To speak to the person at the front door, pick up the receiver on the panel at the Nurses' Station and speak. To release the door, press the key button.

Staff access may be disabled overnight with use of the switch in the vestibule.

Door Alarms at the Day Room exits:
The doors nearest the Day Room have an integrated alarm system. To exit through the doors a sustained pressure on the push bar must be maintained. To silence when the alarm sounds: [redacted] then rearm system when ready.
The doors will release when the Fire Alarm is sounding and must be reset at the conclusion of the Fire Alarm.

Security Alarm System for all exterior doors other than the front door:

To set the alarm, use the panel at the Nurses' Station:
- Turn on.
- Check display, should say "READY TO ARM".
- If so, enter, [redacted]
- If not ready, look at door location on display
- Close that door and then arm system.

To disarm or to turn off:
- Enter, [redacted].

To reset when the alarm sounds:
- Enter [redacted].
- Then rearm system as above, when ready.

Residential area security system:

- The hallway doors lock at 8:00 PM and unlock at 5:00 AM
- If needed there is an override switch on the wall outside the Med Room. The switch should be left in the "Normal" (center) position.
- The "Lock" (or up) position will lock the doors regardless of the time of day.
- The "Unlock" (or down) position will unlock the doors regardless of the time of day.
- Staff entering the residential area are to use the finger scanner. The hold-open magnet will be active for one minute once the door is open.
- To exit the residential area, the door will release with a motion sensor or after the Release button is pushed.
- Visitors may use the call box in the atrium (next to the override switch). They may push to talk with the staff at the nurses' station. The Key button releases the door.
- All door magnets release when the fire alarm is activated.

Security Cameras at front entrance: These cameras project images on the computer in the nurses' workroom. If the image on the monitor is lost:

- REBOOT THE COMPUTER
- CLICK ON THE "BLUE IRIS" ICON TO START VIEWING

All malfunctions or questions about the security systems are to be directed to the Facility Manager.

Approved: _____ _____

Jay Hayston, President and CEO Date

_____ _____

John Hamler, Facility Manager Date

Copy to Nursing Procedure Manual

Cedarcrest Center
for Children with Disabilities
Visitor Policy

POLICY: Cedarcrest Center welcomes visitors including families, team members, business associates, vendors and volunteers.

PROCEDURE: The Center provides a number of resources and strategies to welcome visitors while ensuring the safety of the children and staff. A sign-in log is maintained daily. From 8:00 am to 4:00 pm the log is kept at the reception desk. Visitors arriving before 8:00 am or after 4:00 pm must sign in and out at the nurses' station. The sign-in log assures accountability in the event of an emergency and assures the safety and security of the children.

Visitors will be given a visitor name tag unless wearing one from their place of business. Ongoing volunteers and family members who visit routinely will have a name tag prepared for them as will Trustees and volunteers. Children under fourteen do not need their own name tag. Other visitors will be given an adhesive name tag.

As a visitor signs in, the receptionist may ask the visitor for his/her name in order to confirm that the individual is not listed as a restricted visitor.

During major facility projects an additional sign-in sheet may be available in the maintenance area. The Facility Manager oversees vendors working on site and is to provide them with a name tag unless they are wearing appropriate identification.

In the event of significant illness of the children, the Illness-related Visitor Restriction Policy may be activated. (See Illness Related Limitation for Visitors Policy)

It is the family's responsibility to notify Cedarcrest Center as well as the individuals that they would like to restrict from visiting. If the receptionist is unsure of the status of a visitor he/she may contact the Social Worker or Charge Nurse as needed.

After hours: Name tags are available on/near the clipboard where visitors sign in. If someone comes to the door and they are not known to staff, they are not to be allowed in the building until a staff member goes to the front door to see the individual's ID.

The reception desk should be staffed with an employee Monday through Friday 8:00 to 4:00. When away from the front desk the receptionist is to lock the door. If a staff member is not available, the door is to remain locked and a volunteer may then sit at the desk, allowing staff to screen visitors.

Approved: J Hayston 12/15/2022

Jay Hayston, President and CEO — Date

Kristin Targett 12/14/22

Kristin Targett, Director of Programs and Operations — Date

Emergency Preparedness Plan

Cedarcrest Center
for Children with Disabilities

Emergency Preparedness Plan

Revisions: April 2003, December 2004, December 2005, May 2006, October 2006, February 2007, December 2008, December 2009, July 2010, February 2011, October 2011, January 2012, August 2012, October 2014, April 2016, June 2017, September 2017, April 2018, October 2018, December 2018, April 2019, November 2019, January 2020, April 2020, September 2020, November 2020, April 2021, July 2021, August 2021, September 2022

Keene Fire Department Reviews: February 28, 2002, April 2003, December 28, 2005, January 22, 2009. September 18, 2018

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Contact Information

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Addendums in Emergency Suitcase

Plan Introduction

Cedarcrest Center's Emergency Plan is written in support of emergency management and is built upon the National Response Framework (NRF) as a scalable, flexible, and adaptable coordinating structure to align key roles and responsibilities. Cedarcrest Center serves a group of children who are medically complex with limitations in multiple areas of development including mobility and communication as well as compromised medical stability. Staff are specially trained to be able to assist in the response process to assure their safety regardless of the type of hazard encountered. Cedarcrest Center participates in the Granite State Health Care Coalition and takes advantages of the resources and exercises available. As a licensed medical facility, Cedarcrest follows the requirements of the Centers for Medicaid and Medicare with guidance from American Health Care Association and its state affiliate. As a Private Special Education program, Cedarcrest strives to meet the requirements of Homeland Security designated for schools. The Center participates in Hazard Vulnerability Analyses done as a region or on a state-wide basis and participates in regional and state trainings. This plan and its contents applies to all Cedarcrest Center staff, children, families, consultants and volunteers and others participating in the preparedness efforts. Cedarcrest's plan is based on the Incident Command Systems. The organization maintains additional procedures supporting the Emergency Operations Plan. Given the medical nature of its services, Cedarcrest uses the New Hampshire Hospital Emergency Code system. All staff are required to actively participate in the training, exercise, and maintenance needed to support this plan. Managers are encouraged to participate in Incident Command Training. Information is provided to other staff to introduce this structure and it is practiced in monthly drills.

Review and approval of the plan:
Cedarcrest's Emergency Operation Plan is reviewed on an ongoing basis and updated as needed during the year, and is more formally reviewed at least twice a year. The plan is approved by the Keene Fire Department as well as by the Life Safety inspector of the Bureau of Health Facilities Administration and by Homeland Security as a part of the school review process.

Training Requirements
Fire Drills and All Hazard
Response Drills/Exercises

:
Cedarcrest Center confers with local public safety, emergency management and public health officials and is a part of the regional health care emergency planning group. The Facility Manager is responsible to plan drills as required in health facility life safety code and those required for schools. To meet Homeland Security Emergency Management requirements, the Facility Manager plans to conduct four all-hazard exercises, including which is a response to an armed assailant, which may be done as a tabletop drill.

The four, all-hazard exercises may include:

- Act of violence
- Bomb threat
- Flooding
- Hurricane
- Earthquake
- Hazardous Materials incident
- Medical Emergency
- Structural Fire
- Threat (general)
- Tornado
- Wildfire
- Wind storms
- Any other hazard identified by school officials and local emergency response authorities

New Hampshire Statewide Hospital Emergency Codes

Code Amber

Missing Patient/Person

Code Red

Fire

Code Blue

Cardiac Arrest/Medical Emergency

Code Silver

Hostage Situation/
Person with a Weapon

Code Grey

Violent/Combative
Person

Code Orange

Hazardous Materials
Release/Spill

Code Black

Bomb Threat

Code Purple

Surge Capacity

Code White Internal

Internal Situation

Code White External

External Situation

Cedarcrest Center
for Children with Disabilities
Exceptional Medical Care and Education
91 Maple Avenue
Keene, NH 03431

Unified Command

(*Responsible for overall management of the incident*)

- Cedarcrest Center Representative _____
- Fire Department Representative _____
- Police Department Representative _____

Safety Officer

_____

Monitors and assessed safety of site, Develops measures to assure safety

Liaison Officer _____

Coordinates with representatives of cooperating and assisting agencies (e.g. Red Cross, hospital) and/or families

Public Information Officer

_____

Interfaces with public, media and other agencies

Operations Chief _____

Responsible for the operations of the site

Staging Area Manager

Accountability Director _____

Evacuation Director _____

Medical Needs Director _____

Planning Chief _____

Provides support for maintaining the site and for collection of needed information for the action plan

Vendor/Resources Director _____

Documentation Director _____

Logistics Chief _____

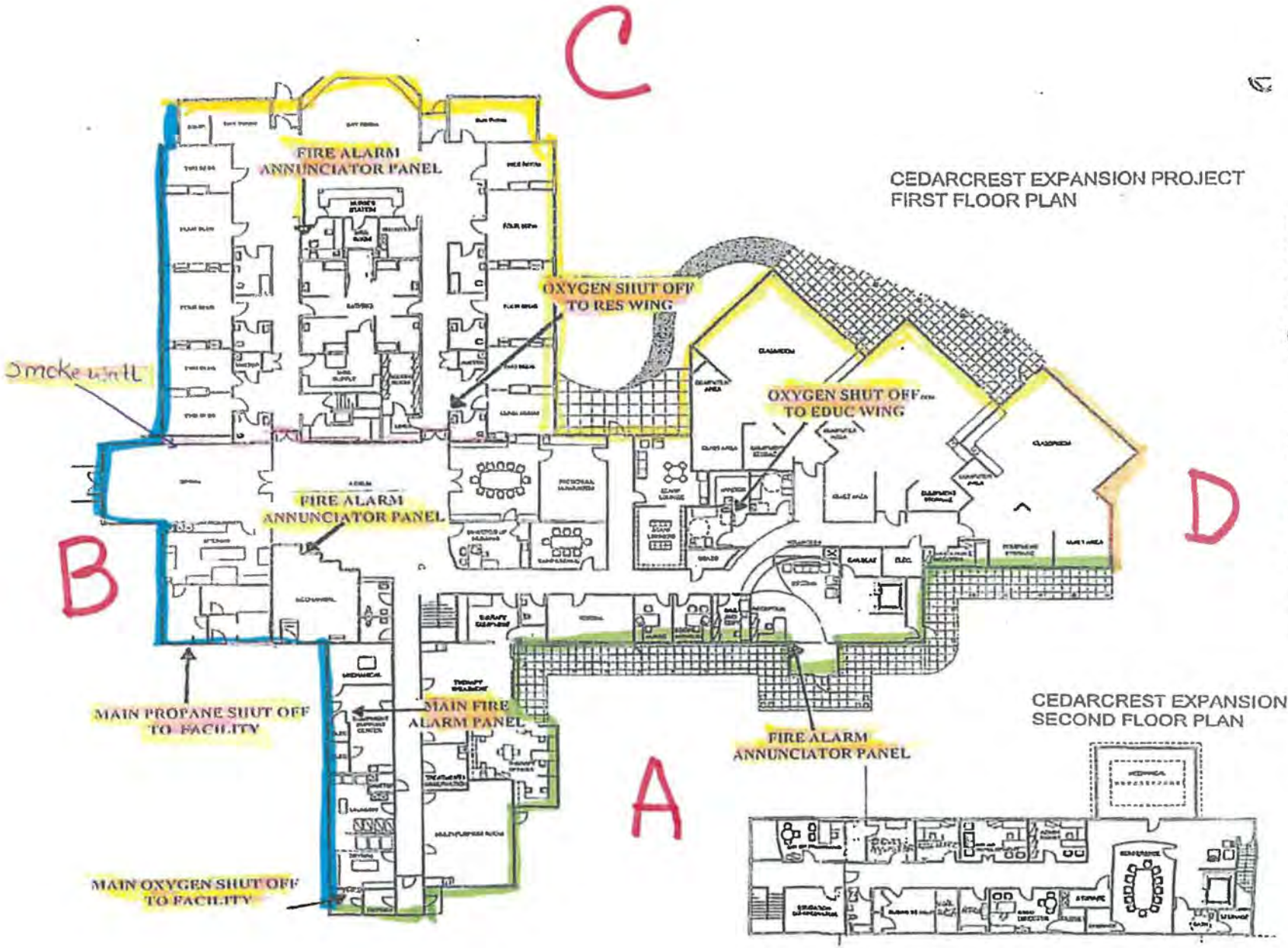
Coordinates access to needed resources

Supplies Director _____

Staff/Personnel Director _____

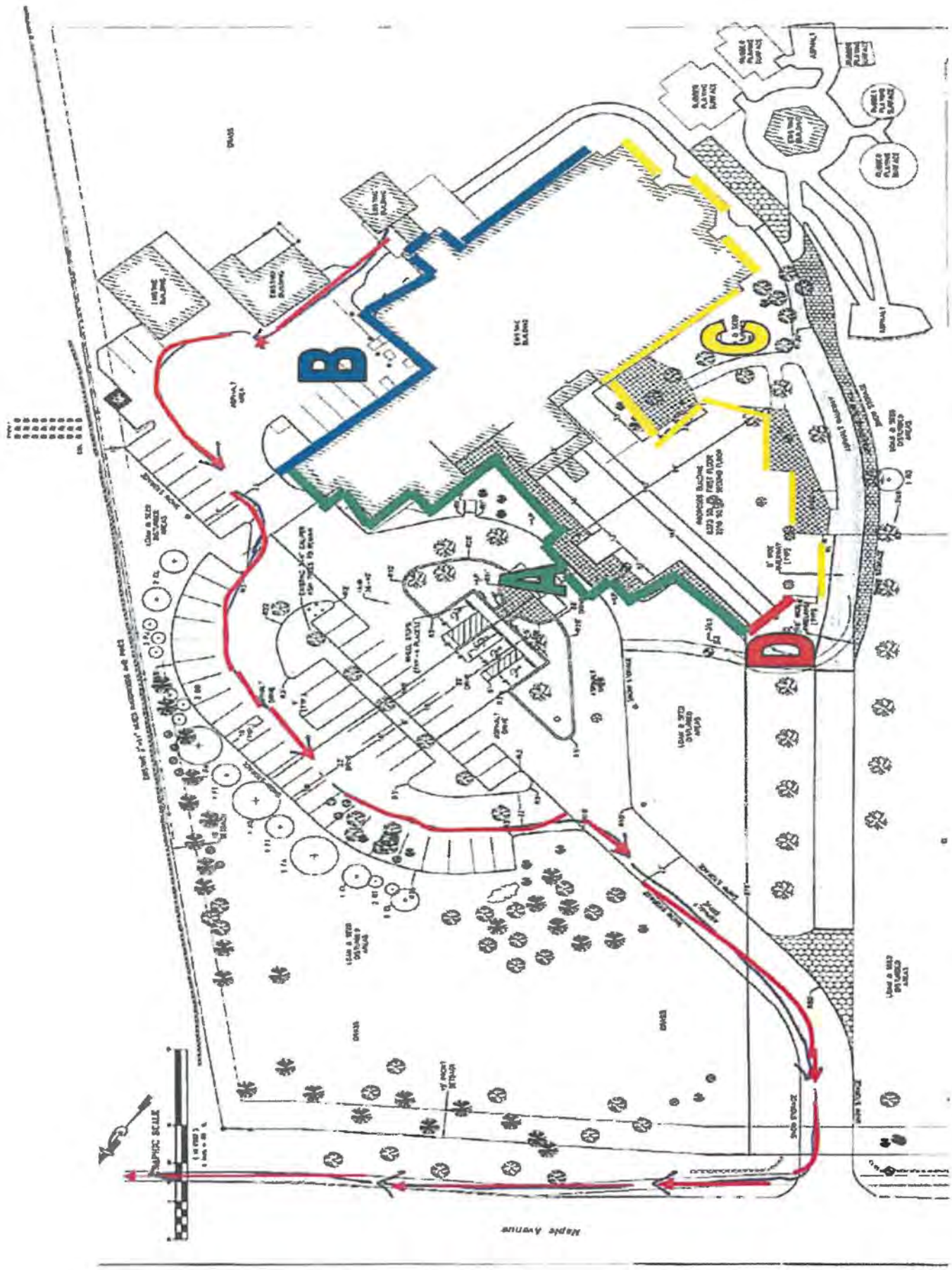
Unified Command Functions in Basic Emergencies

Notes: Members of the Unified Command determine what functions are needed in an emergency. In most drills and basic emergencies at Cedarcrest Center, the primary functions opened will be Accountability and Medical Needs. If evacuating off site, the Evacuation function will also be needed. If the emergency is extended beyond an hour, additional functions will be opened.


C
FIRE ALARM ANNUNCIATOR PANEL
CEDARCREST EXPANSION PROJECT
FIRST FLOOR PLAN
OXYGEN SHUT OFF TO RES WING
Smoke wall
OXYGEN SHUT OFF TO EDUC WING
D
B
FIRE ALARM ANNUNCIATOR PANEL
MAIN PROPANE SHUT OFF TO FACILITY
MAIN FIRE ALARM PANEL
A
FIRE ALARM ANNUNCIATOR PANEL
CEDARCREST EXPANSION
SECOND FLOOR PLAN
MAIN OXYGEN SHUT OFF TO FACILITY

Evacuation Routes from building

Site Plan Evacuation Routes



Code Red
Fire/Emergency

Fire Seen / Identified:
Yell, "Fire in the (location)!"

↓

Pull Fire Alarm
Pull stations are located by each exit.
Call 911.

↓

Notify Charge Nurse

↓

Decision to Defend-in-Place or Evacuate
is made by Charge Nurse

↓

Charge Nurse/Operations Chief calls Fire Department
911
Nurse brings roll call list, keys,
cell phone. Direct someone to get Emergency Bag in Nutrition Room

↓

Relocation **("defend in place")** within building far side of smoke barrier wall. atrium/residents wing)

Evacuation via back walkways where possible (avoid leaving via the front of the building, unless necessary)

on (Separate

↓

Screen house: for roll call
(Alternate location: driveway by classroom porch)

↓

Roll Call
by Accountability Director

↓

Operations Chief reports to Fire Department/Incident Command to report status of children, staff and building

↓

The Unified Command determines if the children should be moved to an alternate location as indicated and approved by Fire Department.

Fire Watch

(implemented during periods of testing the fire protection devices, construction, or as otherwise deemed necessary)

Maintenance notifies

Fire Department Shift Commander at 603-357-9861
at beginning and end of "Fire Watch".

↓

Maintenance or Receptionist announces
Fire Watch and posts sign at time clock

↓

Staff are alert to smoke or fire
If noted they are to pull area pull station
and call 911 and notify Charge Nurse

↓

Activate Fire/Emergency Protocol
Nurse determines whether to Defend in Place or Evacuate;
Announcement must be made
to alert staff to nature of emergency and plan

Note: Pull stations in areas affected by Fire Watch and direct communication to Fire Department will not work. A call to 911 is critical.

Code White Internal
Potential Facility Gas Leak

Smell of Gas is Detected

↓

Move the children
out of harm's way

↙ ↘

Kitchen Area	**Laundry Room**
↓	↓
Shut off gas outside or behind stove (Stove must be pulled out to reach the lever)	Shut off gas outside or behind dryers
Do not turn any electrical switches on or off; do not use phone in immediate area.	Do not turn any electrical switches on or off; do not use phone in immediate area.
↓	↓
Open Windows	Open Windows
↓	↓
Evacuate the area	Evacuate the area
↓	↓
Turn off main gas if needed (outside the kitchen door)	Turn off main gas if needed (outside the kitchen door)
↓	↓
Report to Nurses and facilities staff	Report to Nurses

↘ ↙

CALL FIRE DEPARTMENT

↓

Gas is to remain off and Lock-out/Tag-out to remain in place for stove and/or dryers until the Fire Department gives an all clear.
The respective departments will be notified by the Facilities staff when the all clear has been issued.

Code White External Vehicle Emergency

MECHANICAL

Activate four-way flashers/hazard lights

↓

Pull vehicle to safe place and park vehicle

↓

Call Cedarcrest Center maintenance staff and AAA (card in glove box)

↓

Announce nature of emergency/concern

↓

Activate flares away from vehicle

↓

Tie white cloth on the antenna and open hood

↓

Cedarcrest Center to dispatch alternate vehicle to return children and staff

ACCIDENT and/or Potential Fire

Activate four-way flashers/hazard lights

↓

If possible, pull vehicle to safe place and park vehicle

↓

Call 911, Cedarcrest Center maintenance staff and AAA (card in glove box)

↓

Evacuate children and staff as far away from vehicle as possible

↓

Activate flares away from vehicle

↓

Use fire extinguisher only after evacuation of passengers

↓

Report information to Police Obtain information from driver of other vehicle if emergency is an accident

↓

Cedarcrest Center to dispatch alternate vehicle to return children and staff

Code White External
Severe Weather

Staff track impending severe weather (including hurricanes, tropical storms, ice storms, snow squalls, other hazardous winter weather phenomena)

↓

Facility Manager/Maintenance staff
Serves as Incident Commander if available
and opens necessary Incident Command functions

↓

Contact 9-1-1
if any significant hazard arises

↓

Staff are to :

- Conduct roll call
- Locate flashlights
- Check that all children's equipment is plugged into red/generator outlets
- Move children away from windows
- Charge Cedarcrest Center cell phone to be ready in the event phone coverage is out
- Do not turn lights switches on or off if gas is compromised
- Report hazards to Incident Commander or Safety Officer
- Staff may be asked to remain on shift to assist with coverage for those who cannot travel in the storm

↓

All staff follow direction of Incident Commander
who opens other functions as needed.

Code White Internal
Building System Failure

System malfunction/failure noted

↓

Charge Nurse notified

↓

Facility Manager/Maintenance staff/CEO notified

↓

Facility Manager/Maintenance staff
Serves as Incident Commander

↓

Incident Commander calls Eversource 1-800-662-7764 to report outage and get an estimated restoration time

↓

If power/electricity service is interrupted all children's equipment moved to red outlets.

↓

Incident Commander assigns a staff member to check level of propane available.

↓

As needed, call Dead River to refill tank 603-352-5240

If water service is disrupted, Incident Commander notifies

- Fire Department
  603-357-9861
- Keene Public Works
  603-352-6550

↓

Retrieve back-up water from Medical Records Room.

↓

Back-up water contact:

- Monadnock Mtn Spring Water
  603-654-2728
- Monadnock Vending
  603-352-7694

Code White - Internal
Loss of Communications

Loss of phone communications

↓

Incident Commander or Nurses identify whether the copper line (603-355-1093) which is the red phone in work room is operational; activate nurses' cell phone

↓

Contact phone vendor "**Consolidated Communications**"
If the Phones or Internet are not working call 1-855-588-9300
[redacted]
Account Phone #(603) 358-3384
Internet Circuit [redacted]
We have "managed services", if they ask.
Ask that **(603)358-3384, (603)358-3387, (603)-358-3389** be forwarded to **(603)355-1093** (copper line);

If the Copper line or Faxes are down call [redacted]
Account Phone #(603) 352-2139

make note of the ticket number;
provide a primary e-mail address & phone contact

↓

If the problem is with the phone/system contact
Arcomm 603-464-4600

↓

Notify nursing staff to limit outgoing calls and minimize the duration of incoming calls on the red phone

↓

Notify "on-call" Maintenance and Administrative staff of problem

↓

When the problem is resolved, if the phones were forwarded, contact the number above to have the phones un-forwarded using the ticket number to access our information

Notify staff that the problem has been resolved

NOTE: If phones cannot be forwarded, information may be posted on our Facebook page or families and key individuals may be notified in another manner.

Code White External
Potential for Flooding

Staff track impending severe weather

↓

Notify the Facilities Manager and/or Administrator

↓

Call 9-1-1, if flooding is imminent;
Monitor conditions

↓

Move all staff and children to a safe location if accessible

↓

Conduct roll call

↓

On Call Notifications:
President/CEO
Director of Nursing
Facilities Manager

Cedarcrest Center Incident Commander
meets responding city Emergency personnel

↓

Unified Command determines
Incident Action Plan; evacuate or defend-in-place

Code White External
Active Wildfire Threat

Outside fire, smoke or smell a burning odor outdoors
Staff track status of fire

↓

Notify emergency services via 9-1-1

↓

On Call Notifications:
President/CEO
Director of Nursing
Facilities Manager

↓

Move staff and children to safe location or defend-in-place
away from exposure to the hazard

↓

Conduct roll call

↓

Unified Command determines
Incident Action Plan; evacuation

Code White External
Tornado Watch/Warning

Staff track impending severe weather

↓

Facility Manager/Maintenance staff called;
Serves as Incident Commander if available

↓

Incident Commander tracks impending weather and
opens necessary Incident Command functions

↓

Staff are to :

- Conduct roll call
- Locate flashlights
- Check that all children's equipment is plugged into red/generator outlets
- Move children away from windows
- Secure equipment/toys that are outside
- Charge Cedarcrest Center cell phone to be ready in the event phone coverage is out
- Be aware of potential hazards caused by tornado
- Do not turn lights switches on or off
- Report hazards to Incident Commander or Safety Officer

↓

All staff follow direction of Incident Commander
who opens other functions as needed.

After action:

Incident Commander assigns Safety Coordinator to assess damage and inform Incident Command. Actions taken based on this assessment

Code White External Earthquake

Facility Manager/Administrator
Serves as Incident Commander if available

↓

Incident Commander evaluates the severity of the earthquake and opens necessary Incident Command functions

↓

Staff are to :

- Conduct roll call to determine all children and staff are accounted for
- Locate flashlights
- Check that all children's equipment is plugged into red/generator outlets
- Move children away from windows
- Secure equipment/toys that are outside
- Charge Cedarcrest Center cell phone to be ready in the event phone coverage is out
- Be aware of potential hazards caused by earthquake
- Do not turn light switches on or off if gas may be compromised
- Report hazards to Incident Commander or Safety Officer

↓

All staff follow direction of Incident Commander who opens other functions as needed.

After action:

- Incident Commander assigns Safety Coordinator to assess damage and report to Unified Command. Actions taken based on this assessment

Code Black
Suspicious Package

Identification of suspicious package

↓

Secure area; DO NOT touch
or move item

↓

Notify Charge Nurse

↓

Call 911

↓

Cedarcrest Center Incident Commander
meets responding city Emergency personnel

↓

Unified Command determines
Incident Action Plan

On Call Notifications:
President/CEO
Director of Nursing
Facilities Manager

Code Black
Bomb Threat

Phone call
Bomb Threat

↓

Listener takes in as much
information as possible,
using Bomb Threat form if available.
(speaker phone may be used if appropriate)

↓

Alert Charge Nurse

↓

Call 911

↓

Cedarcrest Center Incident Commander
meets responding City Emergency Personnel
Follow 911 instructions

↓

On Call notifications:

Director of Nursing
Nurse on Call
Facilities Manager or on call

BOMB THREAT CHECKLIST

Date: _____ Time: _____ a.m. / p.m.

Exact words of caller: _____

_____

_____

QUESTIONS TO ASK:

When will the bomb explode? _____

Where is the bomb right now? _____

What kind of bomb is it? _____

What does it look like? _____

Why did you place the bomb? _____

TRY TO DETERMINE THE FOLLOWING (circle as appropriate)

CALLER'S IDENTITY	male	female	adult	juvenile	age ____ years		
VOICE:	loud	soft	high-pitched				
	deep	raspy	pleasant	intoxicated			
ACCENT:	yes	no	local	not local	foreign	region	
SPEECH:	fast	slow	distinct	distorted	stutter	nasal	slurred
LANGUAGE:	excellent	good	fair	poor	foul	other _____	
MANNER:	calm	angry	irrational	incoherent			
	emotional	righteous	laughing				
BACKGROUND NOISES:	office machines	factory machines	trains	animals	party atmosphere		
	music	quiet voices		airplanes	street traffic		

A copy of this form shall be kept at the nurses' station and with reception.

Code Orange Internal
Hazardous Material Release

Identification of hazardous materials release in building

↓

Move staff and children from active or potential hazardous materials to a safe location

↓

Call 9-1-1

↓

Conduct roll call

↓

On Call Notifications:
President/CEO
Director of Nursing
Facilities Manager

↓

Cedarcrest Center Incident Commander meets responding city Emergency personnel

↓

Incident Command determines Incident Action Plan; evacuate or defend in place

Code Orange External
Hazardous Material Release

Identification/Notification of hazardous materials release near building/property

↓

Move staff and children from active or potential hazardous materials in a safe location

↓

Call 9-1-1

↓

Conduct roll call

↓

On Call Notifications:
President/CEO
Director of Nursing
Facilities Manager

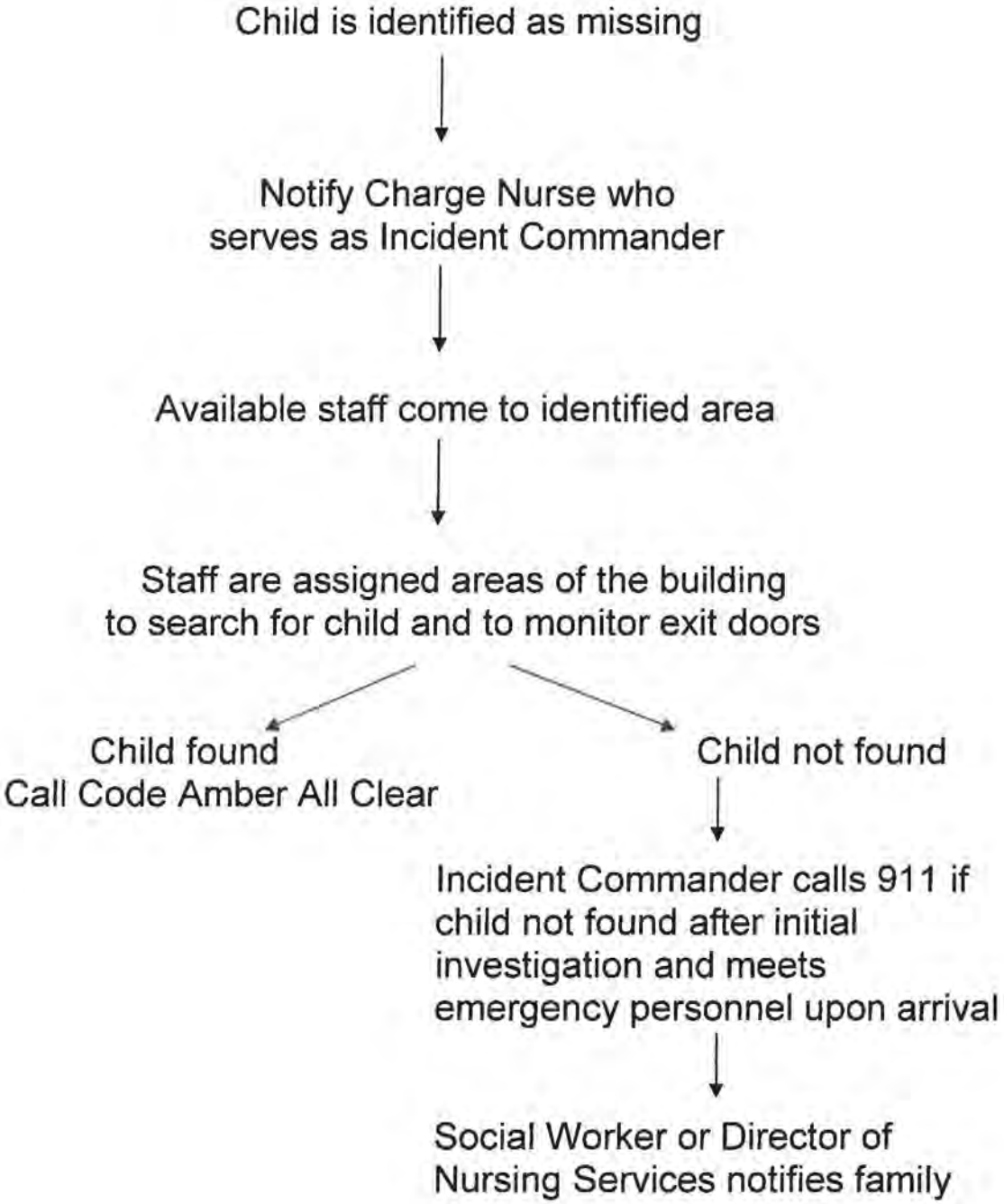
↓

Cedarcrest Center Incident Commander meets responding city Emergency personnel

↓

Incident Command determines Incident Action Plan; evacuate or defend in place

Code Amber
Missing Child



Code Blue
Medical Emergency
(Resident, Visitor or Staff)

↓

Code Blue Announced (with Specific location)

↓

Available Nursing, Respiratory Therapy Staff respond
Administrative staff serve in supportive role

↙ ↘

911 Called
Staff at front door to direct
EMT upon arrival

Copy of Transfer Sheet, Medication
List, etc. made available

Notification of CEO, DNS and Family

↓

Medical interventions
Provided until EMT Services arrive

↓

Individual transferred to receiving
Healthcare Organization

↓

All Clear Announced
(Specify code and location)

First Aid Provided
Emergency Bag and AED
available

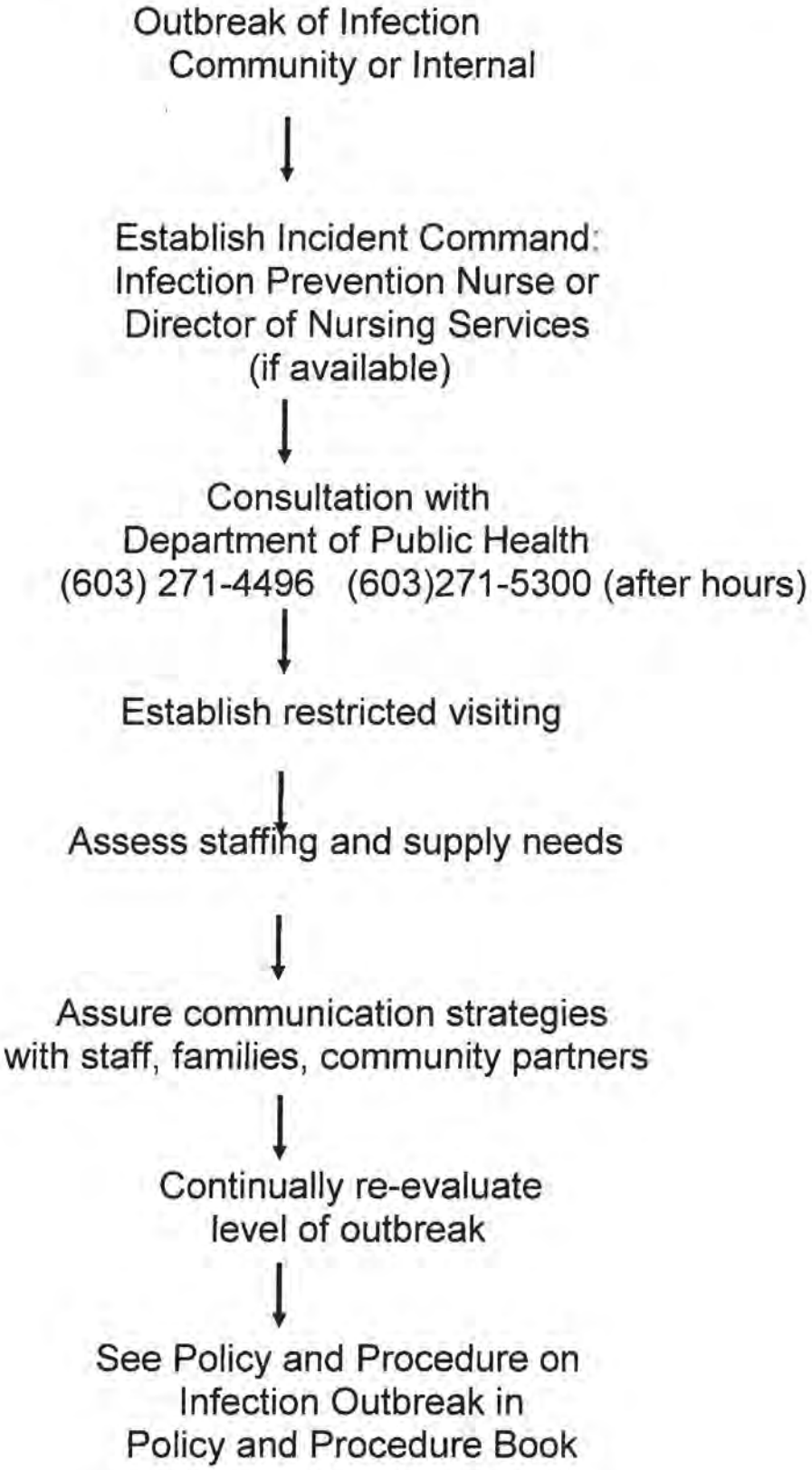
↓

No further action indicated

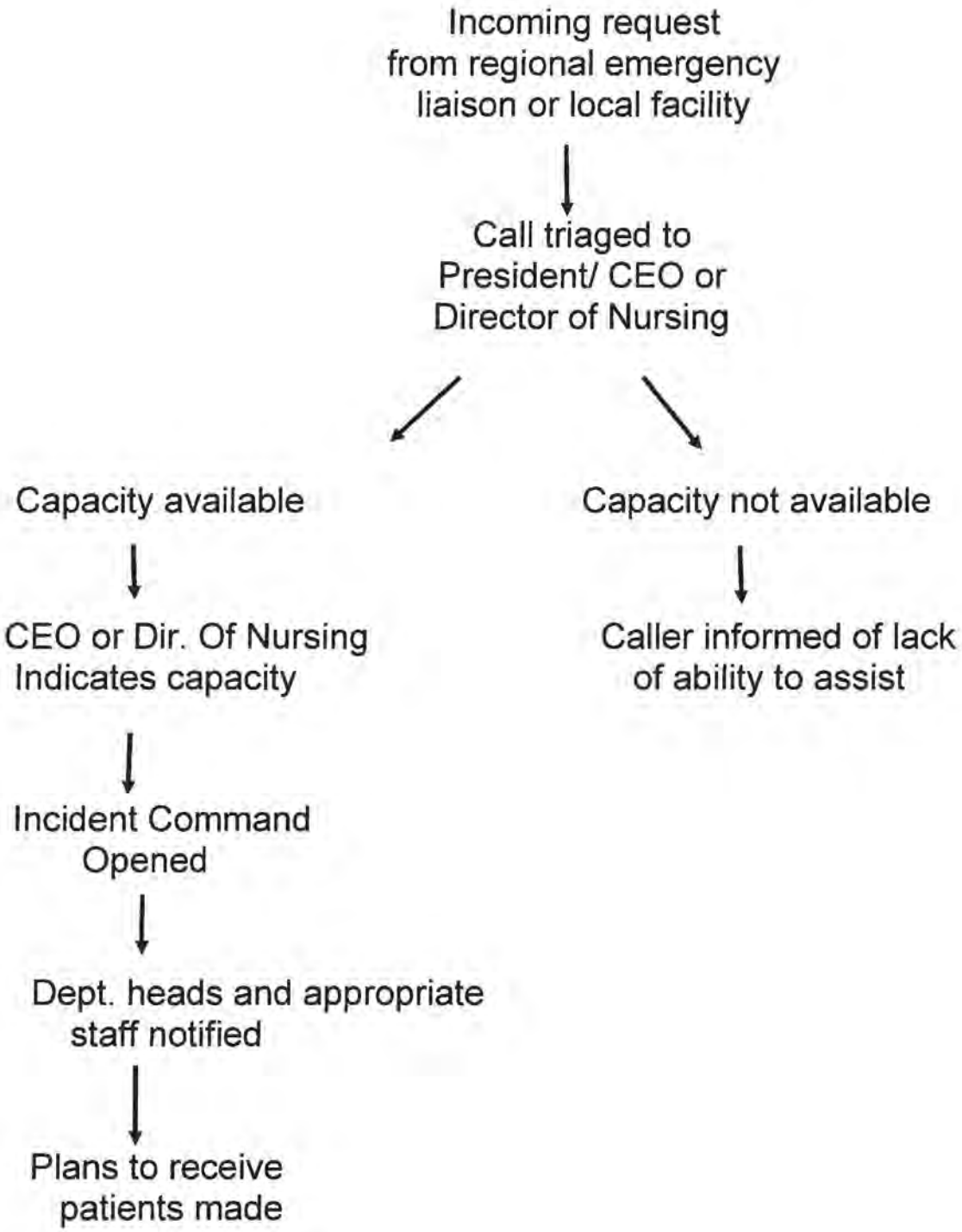
↓

All Clear Announced
(Specify code and location)

Outbreak of Infection/Pandemic



Code Purple
Surge Capacity



Code Grey
Lock-down

Intruder or angry/threatening individual
in the building

Person seen attempting access to the building

↓

Call 911

↓

Nurses' station and staff notified of event

↓

Staff "Lockdown" areas including double doors to residential area
with all staying in place

↓

Charge Nurse (Incident Commander if off hours) appoints
Accountability Officer to take roll call;
one staff person to call nurses station with count/names
from each location, if children are in different areas

↓

If situation is clearly unsafe, staff are NOT to intervene.
Close observation is necessary to maintain information on
where the individual is, as much as possible.
Use 2-way radios to alert Incident Commander of the situation.

↓

Incident Commander or designee meets
emergency personnel out front

↓

Incident Commander announces "all clear" when given by police and
the person is calm and does not pose a danger or has left the property.

Code Grey
Lock-down
for Known Individual

Disgruntled individual comes into building or calls to announce plan to come

↓

On-site manager notified and serves as Incident Commander

↓

Receptionist notified of pending arrival; Other staff alerted as needed

↓

Manager greets individual upon arrival, attempts to go to area away from children in effort to de-escalate

↓

Receptionist notifies a second staff person (manager, trusted staff member, Social Worker) of where manager and individual are located. This individual or another person is to stay in proximity of situation as back up

↓

If situation is not deescalated, 911 is called

Code White
Protocol for Secure Building

Intruder or angry/threatening individual is outside the building

↓

Call 911

↓

Lock all doors/windows; close blinds/curtains
Activate Security Alarm

↓

Conduct Roll Call

↓

Cedarcrest Center Incident Commander determines plan with members of Unified Command

↓

Incident Commander or designee meets emergency personnel out front

↙ ↘

No access to building.
Staff, School districts and families notified of danger in area.

Limited access to building. A staff person is assigned to let identified staff/families come in the front door.

↘ ↙

Unified Command calls "All Clear" when appropriate

Recovery Procedures

Unified Command will determine when the operation can switch to recovery. The Incident Command team is convened to debrief and to strategize on needed actions and delegate responsibilities for recovery. Some of the steps in making the decision are as follows:

- The safety of the facility is determined.
    - The function of all basic operating systems is determined; Utilities are not to be turned on until determined to be safe.
    - The significance of damage to the facility is determined.
- The impact on the children and staff is identified.
- Alternative/relocation plans and the need for supplemental services are determined.

Once the plan has been made:

- Confirm notification of the insurance broker: Clark Mortenson (603)352-2121
- If necessary, contact the Bureau of Health Facilities Administration: (603) 271-4607
- Develop a follow-up communication plan.
- Contact vendors as necessary.
- Provide information/feedback to families and staff not on site, as appropriate.
- Plan any additional steps necessary to the recovery.

OFF SITE TRIAGE AREAS

Primary:

First Baptist Church of Keene

105 Maple Avenue, Keene, NH 03431

Phone: (603)352-0340

Contacts: Reverend Linda Overall

Office Assistant: Cindy

Areas to access: Enter through front door. Make left to Multi-purpose room. If needed may fold tables. Staff may access kitchen area if needed.

Secondary:

Genesis: Keene Center

677 Court Street, Keene, NH 03431

Phone: (603) 357 3800

Genesis: Applewood

8 Snow Road, Winchester, NH 03470

Phone: (603) 239-6355

Genesis: Langdon Place

136A Arch Street, Keene, NH 03431

Phone: (603) 357-3902

Rose Meadow Rose Meadow Acres, New Boston, NH 03070

Phone: 603-487-1568

Cedarcrest Center staff are to accompany children and bring available medications and supplies. Children will need to have ID tags on. The Evacuation Director is to provide the name of key contacts at Cedarcrest Center including the Administrator and Director of Nursing Services.

EMERGENCY SUPPLIES

Basic Emergency Supplies:

Emergency Suitcase at Nurses Station contains:

- AM/FM radio
- Batteries
- Lanterns Flashlight/batteries
- Masking tape
- Markers and pens
- Copy of emergency plan and contact list
- Paper
- Peel off stickers for name tags
- Phone book
- Two way radios
- Phone numbers of staff and families
- Reflective vests and clipboards
- Plastic bags
- Vehicle keys

Other Supplies needed:

- Building keys
- Cell phone
- Clip board with roll call list, Fire Drill Report sheet and key to offsite triage area
- Garage Door Opener
- Key to Med Room/Exit Doors
- Medication "to-do" list for shift, if possible
- Laptop computer
- Blankets and capes (at exit & in garage)
- Emergency Plan

Long-Term Evacuation Emergency Supplies

- Adhesive tape*
- Albuterol/neb set ups/machine
- Alcohol wipes*
- Ambu bag
- Band-aids*
- Batteries for GT feeds
- Bottle of antibacterial hand cleansing gel*
- Bottle of rubbing alcohol
- Bullets of saline solution*
- Bottle of distilled water*
- Car electric outlet adaptor (in minivan)
- CPR microshield
- Diapers*/briefs
- Extra trach, collar and mask
- Filled Oxygen Stroller, tubing, trach adapter/nasal prongs/mask
- First aid kit*
- Foleys*
- Food, feeding equipment, bibs
- Formula
- Gauze*
- Gloves*
- G-tube extension, feeding bag, pump, formula* (S hook if needed)
- Instant ice packs
- Insulin syringes*
- Meds, including narcotics and refrigerated meds
- Narcotic book
- Nebulizer set*, meds, tubing and Pulmo-Aide
- Oximeter with sensor
- Phone numbers of staff emergency contacts and volunteers
- Penlight*
- Pogon or wheelchair for long distance transportation of otherwise ambulatory children
- Portable oxygen tank(s)
- Scissors*
- Slip tip syringes*
- Standard size Sam Splint
- Sterile pads*
- Suction machine, tubing, catheters, water, saline bullets
- Trach emergency backpacks for each child having one
- Trach collar*
- Travel bag with 3-4 diapers, underwear, socks, set of clothing, neckerchiefs, toy/blanket
- Tweezers*
- Wipes*

If time allows, staff are to put a change of clothes and any supplies specific to that child in his/her backpack.

OFF SITE SUPPLIES

Emergency Box Inventory at Church in Room 2

- Adhesive tape
- Alcohol wipes
- Band-aids
- Bottle of antibacterial hand cleansing gel
- Bullets of saline solution
- Bottle of distilled water
- Diapers/briefs
- First aid kit
- Foleys
- Gauze
- Gloves
- G-tube extension, feeding bag, pump, formula
- Insulin syringes
- Nebulizer set
- Neckerchief
- Penlight
- Scissors
- Slip tip syringes
- Sterile pads
- Trach collars
- Tweezers
- Wipes

	First Run	Second Run	Third Run	Fourth Run
2017 Ford Transit (White)	Driver:__________ Seated Passengers: 1.__________ 2.__________ 3. __________ 4.__________ Tie downs: 1.__________ 2.__________ 3. __________	Driver:__________ Seated Passengers: 1.__________ 2.__________ 3. __________ 4.__________ Tie downs: 1.__________ 2.__________ 3. __________	Driver:__________ Seated Passengers: 1.__________ 2.__________ 3. __________ 4.__________ Tie downs: 1.__________ 2.__________ 3. __________	Driver:__________ Seated Passengers: 1.__________ 2.__________ 3. __________ 4.__________ Tie downs: 1.__________ 2.__________ 3. __________
2021 Ford Transit (Silver)	Driver: __________ Seated Passengers: 1.__________ 2.__________ 3.__________ Tie downs: 1.__________ 2.__________	Driver: __________ Seated Passengers: 1.__________ 2.__________ 3.__________ Tie downs: 1.__________ 2.__________	Driver:__________ Seated Passengers: 1.__________ 2.__________ 3.__________ Tie downs: 1.__________ 2.__________	Driver: __________ Seated Passengers: 1.__________ 2.__________ 3.__________ Tie downs: 1.__________ 2.__________
Caravan	Driver: __________ Seated Passengers: 1. __________ 2. __________ Tie down: __________ Small Wheelchair: __________	Driver: __________ Seated Passengers: 1. __________ 2. __________ Tie down: __________ Small Wheelchair: __________	Driver:__________ Seated Passengers: 1. __________ 2. __________ Tie down: __________ Small Wheelchair: __________	Driver: __________ Seated Passengers: 1. __________ 2. __________ Tie down: __________ Small Wheelchair: __________
White Forester	Driver: __________ Seated Passengers: 1.__________ 2. __________ 3. __________ 4. __________	Driver: __________ Seated Passengers: 1. __________ 2. __________ 3. __________ 4. __________	Driver: __________ Seated Passengers: 1. __________ 2. __________ 3. __________ 4. __________	Driver: __________ Seated Passengers: 1. __________ 2. __________ 3. __________ 4. __________

Cedarcrest Center

for Children with Disabilities

Facility Profile

Location: 91 Maple Avenue, Keene, New Hampshire
Acreage: 5.11 acres
Zoning: Low density, effective 7/1998
Buildings: Main Facility- 20,000 built 1989-1990; occupied June 6, 1990
Original construction: 17,000 sq. ft. of useable space
Facility addition: 10,629 sq. ft. added June 20, 2002
Garage- built in 1991
Screen Porch- built in 1994; renovated in 2009
Charles H. McMurphy Memorial Playground- redone in 2015
Storage Building- built in 1999
Building construction type: 5A
Roof structures: Original peaked roof and flat roof- 1989-1990 New shingles 2014
Laundry and rehab areas 1989-1990 New shingles 2013
Residential area- 1989-1990 New shingles 2014
School wing peaked roof and flat roof- 2001-2002
Heat: Oil-Firing two (2) Buderus Boilers Model GE315-New June 2002
Number 2 Oil tank (4000 gallon) - 2012
Hot water tanks -
Two 80 gallon heat pumps – 2015
Two 100 gallon Hot Water Heat Exchangers- 2010
Water and sewer: City of Keene
Fully sprinklered: dry system
Fire panel: R.B. Allen System for complete facility- March 2018- replaced system June 2002
Elevator: Stanley passenger elevator; 2002
Dumbwaiter to attic; 1997
Medical gases: piped in oxygen system installed by Beacon Medical Systems.
New in June 2002. Outlets throughout the facility.

Air Handlers:
AHU 1 Trane with Dri Steem Humidifier unit; new June 2002.
Serves Education wing classrooms
AHU 2 Trane with Dri Steem Humidifier unit; new June 2002.
Serves new wing Administration areas

AHU 3 York (new Dec 2012) Mod#XTI-048X072-SALA028A S/N:CMYMXT0047
Serves original building Atrium-Laundry.
AHU 4 York (new Dec 2012) Mod#XTI-060X078- SSML028A S/N:CMYMXT0065
Serves original building Atrium-Residential Area
Chiller York (new Dec 2012) Model YCAL0056… ,S/N2LYM017961, 56 Ton capacity, 4 stage scroll compressor, 30% glycol
Kitchen HVAC system: AAON Model # 48556 RK-07-2-FDSHAOBHOOMOX
with gas heat exchanger; serial # 200308-AKGF51122; new 2003
Server Room air conditioner: Sanyo Model #KS1271 new 2011
Evaporator Serial # 03596 13; Condenser Model CL1271
Computerized HVAC controls- 2012
Radiant heat- Baseboard throughout facility with reheat coils in all Air handling units and 2012 VAV's. Attic areas-Not heated.
Kitchen stove: Propane fuel-Vulcan-New-spring 2007
Vent Master Hood: Updated Fire suppression system-June 2002
Underground propane tanks:
500 gallon for the kitchen and laundry
500 gallon for the generator
Generator: Propane fuel-Kohler 60KW-Model 60RGZ-New June 2002
Laundry equipment:
Washers: SpeedQueen Model FTSAOAWN home style unit; New 2011
Milnor 35 lb. Model MWR16X5; New: 2013
Milnor 40 lb. Model 30015T5X; New: 2006
Dryers: Speed Queen Model ST030L; 30 lb. capacity
Speed Queen Model ST050L; 50 lb. capacity
Milnor Model MLG55D; 50 lb. capacity
Phone system: Avaya Phone System, SIP VoIP 100 DID lines fed on Fiber Optic Cable from Consolidated Communication 2020
Internet services- Spectrum cable- 2017
Computer equipment: Refer to IT inventory
Door entry: Virdi finger scanner with Aiphone video intercom

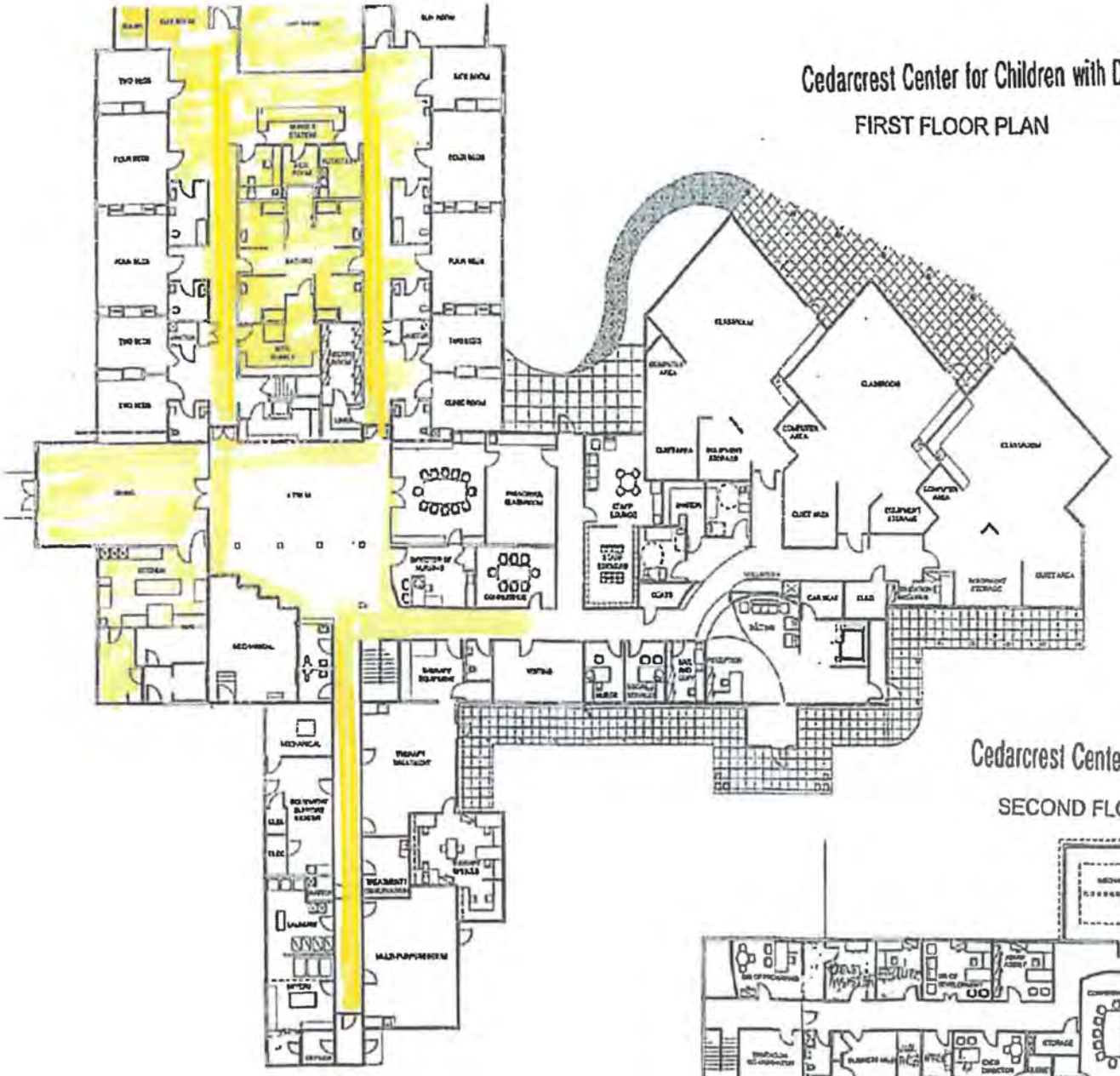
Additional property owned:
71 Maple Avenue: Built 1960, 1,675 sq ft, 8 rooms, 4 bedrooms, 1 full, 1-1/2 baths
79 Maple Avenue: Built 1910, 1,835 sq ft, 8 rooms, 4 bedrooms, 2 full baths
63 Maple Avenue: Built 1962, 2406 sq ft, 9 rooms, 4 bedrooms, 2 full, 1-1/2 baths

Cedarcrest Center
for Children with Disabilities
Emergency Generator
Run Time

Propane tank # 3 supplies propane to the emergency generator and heat for the maintenance garage.

- This tank has a capacity of 500 gals, when it is 100% full. Under the cover there is a gauge that tells you what % of capacity there is left in the tank. There is also a hole in the cover you may be able to view the gauge, without taking the cover off.
- By state code, our emergency generator is allowed to run at 75% of its full rated capacity.
- If the generator is running at 75% load, it will burn 7 gallons of propane per hour.
- Based on the tank gauge reading in % one is able to figure out how many hours the generator could run. See examples below.

Reading on gauge.	Gals. In tank	Gen. Run time
25%	125 Gals.	17½ Hrs
50%	250 Gals.	35¾ Hrs
75%	375 Gals.	53½ Hrs
Full	500 Gals.	71 Hrs



Cedarcrest Center for Children with Disabilities

FIRST FLOOR PLAN

GENERATOR LOAD

Shaded in yellow, the generator will power

- 1 washer
- 1 dryer
- 1 outlet in the kitchen
- all red outlets in the area shaded in yellow

Cedarcrest Center for Children with Disabilities

SECOND FLOOR PLAN

Cedarcrest Center
Incident Commander
for Unified Command

Role: Participates with emergency professionals of the police and/or fire departments to set the incident objectives, strategies and priorities. The Cedarcrest Center Incident Commander represents the organization at Unified Command which has overall responsibility for the incident and the coordination of all services. Unified Command serves as conduit for information to/from scene.

Key functions:

- Serves as a part of Unified Command.
- Develops and assists in implementation of strategies to manage the incident.
- Coordinates and communicates information to all assigned emergency "officers" and/or "chiefs".
- Directs emergency operations.
- Delegates responsibilities to others as indicated.

~~~~~~

Resources required:

- Vest
- Two-way radio and/or cell phone
- Floor plan

Specific responsibilities:

- Teams with emergency personnel to make decisions about the emergency response.
- Communicates key information and strategies to assigned "officers" and receive key information from them to guide incident management.
- Coordinates with assigned officers regarding the needs of personnel at evacuation site(s)

Functions reporting to the Incident Commander function (as needed):

- Safety Officer
- Public Information Officer
- Liaison Officer and/or Family Liaison Officer
- Operations Chief
- Planning/Facility Chief
- Logistics Chief

Follow-up Responsibilities:

- Conducts a de-briefing session after the event.
~~~~~~

Safety Officer

Role: Completes an assessment of the safety of the site and implements strategies to ensure safety of all involved.

Reports to Unified Command.

Key functions:

- Completes a facility and risk assessment.
- Identifies measures needed to assure safety.
- Assesses resources needed and available.
- Monitors conditions and safety.
- Advises Unified Command on issues of safety.

~~~~~~

Resources required:

- Vest
- Two-way radio and/or cell phone
- Keys to facility
- Floor plan
- Facility profile
- Vendor contact information

Specific responsibilities:

- Complete facility assessment:
  - Is the facility structurally sound? _____
  - Is there any structural damage? _____
  - If the roof intact? _____
  - Is there water damage: _____
  - Is access blocked? _____
- Assess facility resources available:
  - Is there electrical power? _____
  - Is the generator on? _____
  - Is there a normal supply of city water? _____
  - Is the water pressure normal? _____
  - Is the water contaminated? _____
  - What is the propane reserve? _____ (quarter, half, three quarters or full tank)(full generator load uses 7 gallons of propane per hour; full tank is 500 gallons;) _____
  - What is the approx. temperature within the building? _____
  - What other factors must be considered in determining the building safety? _____

Other functions may be assigned to report to the Safety Officer as needed.
~~~~~~

Public Information Officer

Role: Responsible for communications between Unified Command and the media and other key individuals.

Reports to Unified Command.

Key functions:

- Communicates appropriate information to media.
- Communicates appropriate information to key internal and external stakeholders and other key interested parties.
- Advises Unified Command of information dissemination plan and actions and status of media relations.

~~~~~~

Resources required:

- Two-way radio and/or cell phone
- Arm band
- Access to phones and meeting area outside of harms way.

Specific responsibilities:

- Communicate information to the media for public release
- With Unified Command, decides times for media update statements
- Develops press release, as indicated
- Communicates to key stakeholders

Key persons who may need to be contacted:

CEO: Jay Hayston [redacted]

Director of Nursing Services - Bridget Toepfer
[redacted]

Insurance agent: Clark Mortenson
603- 352-2121
~~~~~~

Liaison Officer

Role: Serves as primary contact and coordinates with representatives of agencies that are cooperating and assisting Cedarcrest Center in the emergency.

Reports to Unified Command.

Key functions:

Assists in identifying needed resources.

- Serves as lead individual in talking with and accessing resources from other agencies providing supportive services in the emergency.
- Communicates appropriate information to Unified Command.

~~~~~~

Resources required:

- Two-way radio and/or cell phone
- Access to cell and/or land line outside of primary operations communication systems.
- Meeting/work area.

Specific responsibilities:

- Assists in obtaining community resources needed during the emergency.
- Makes contact with identified agency/organization.
- Provides detailed information about type and amount of assistance needed.

Other functions may be assigned to report to the Liaison Officer (as needed).
~~~~~~

Family Liaison Officer

Role: Responsible for communications between Unified Command and the the families of the children at Cedarcrest Center.

Reports to Unified Command.

Key functions:

- Communicates appropriate information to families.
- Provides families with means to obtain current information.
- Communicates with Incident Command to approve families joining their children on site.

~~~~~~

Resources required:

- Two-way radio and/or cell phone
- Access to cell and/or land line outside of primary operations communication systems.
- Family contact lists
- Arm band

Specific responsibilities:

- Communicate information to families:
  - Children are safe
  - Children are at _____ location
  - Here's how to contact us: _____
- Provide updates to families as necessary
- Determines which families may come on site
- May identify children who can leave with their families

Other functions may be assigned to report to the Family Liaison Officer as needed.
~~~~~~

Operations Chief

Role: Responsible to communicate the needs for operation of the emergency site to Unified Command.

Reports to Unified Command.

Key functions:

- Assigns, organizes and supervises all tactical or response resources associated with the incident
- Manages the staging area (if used)
- Assess resources available
- Communicates with Unified Command to identify status of operations.

~~~~~~

Resources required:

- Vest
- Two-way radio and/or cell phone
- Emergency box
- Laptop
- Roll call and staff lists
- Keys to off site triage area
- Floor plan of triage area

Functions reporting to this function (as needed):

- Accountability Director
- Evacuation Director
- Medical Needs Director
- Staging Area Manager
~~~~~~

Accountability Director

Role: Completes roll call to account for children, staff, visitors and volunteers and provides information to emergency personnel (police and/or fire department) at Unified Command: Identifies anyone missing.

Reports to Operations Chief. If this function is not opened, reports to Incident Commander.

Key functions:

- Maintains accurate count of all involved in an emergency
- Assures safety of children, staff, visitors and/or volunteers
- Reports to Operations Chief and ultimately to Unified Command

Resources required:

- Census lists of children, staff, visitors/volunteers
- Megaphone
- Two-way radio and/or cell phone
- Vest

Specific responsibilities:

- Conducts roll call (at each evacuation location)
- Reports any missing individual(s) to Unified Command
- Assigns a "head" and "tail" to line of staff evacuating
- Requires personnel to check in/out when leaving group for any reason
- Provides ID tags for all children
- Initiates sign in/sign out list for staff, volunteers and families

Accountability Report:

	Report One Time:____	Report Two Time: _____	Report Three Time: _____	Report Four Time: _____
Number of children				
Number of staff				
Visitors/students				
Volunteers				
Families				
Unaccounted for				

Other functions may be assigned to report to the Accountability Officer as needed.

Medical Needs Director

Role: Responsible for the medical care of the children, and may report to Incident Command regarding the needs of staff, visitors and volunteers.

Reports to: the Operations Chief. If this function is not opened, reports to Incident Commander.

Key functions:

- Triages children based on medical need
- Identifies medical assistance and/or supplies needed
- Determines if transport to hospital is necessary
- Distributes available medical supplies
- Completes or delegates care and charting
- Assures the health and well-being of the children

~~~~~~

Resources required:

- Emergency medications
- Medication cart (if possible)
- Oxygen tank from Nurses work room
- First-aid supplies and personal care items
- Two-way radio and cell phone
- Laptop (see remote access procedure)
- 24 hour print-out of medications

Specific responsibilities (which may be delegated):

- Assesses the health/injuries of children, staff, visitors and/or volunteers
- Assigns staff to gather needed items
- Assign staff to print out medications, PRN and interventions
- Gathers available medical supplies and identifies staff resources needs.
- Informs Operations Chief or Incident Command of specific needs for medical supplies or resources
- Notifies Operations Chief or Incident Command of persons needing transport away from group
- Administers Medication and First Aide.
- Delegates specific medical and personal care needs of individual children to specific staff members.

Functions reporting to the Medical Needs Director (as needed):

Assistant Medical Director(s)
~~~~~~

Evacuation Director

Role: Responsible for the safe evacuation of all personnel in conjunction with emergency professionals.

Reports to Operations Chief unless this function is not opened, in which case the Evacuation Director reports to the Incident Commander.

Key functions:

- Communicates specific transportation needs for evacuation
- Goes ahead of group to prepare evacuation site
- Receives and assists evacuees into site

~~~~~~

Resources required:

- Two-way radio and/or cell phone
- Identifying vest
- Supplies at off-site location
- Floor plan of primary evacuation site

Specific responsibilities:

- Prepares evacuation site to receive children, staff, visitors and/or volunteers
- Locates and prepare stored supplies
- Identifies restrooms; water and other needs
- Identifies specific needs for evacuation to secondary site (if necessary)

Staffing:

Additional staffing needs: for next four hours:_____

Staffing needs beyond four hours: _____

Transportation needs: _____ lift/tie downs

_____ seats on vehicle(s) for children

_____ staff seats

**See the transport worksheet in the folder for available space in vehicles.

Functions reporting to the Evacuation Director (as needed):

- Secondary Evacuation Director
- Transportation Director
~~~~~~

Planning Chief

Role: Provides support for maintaining the site and for collection of needed information to develop an action plan.

Reports to Unified Command.

Key functions:

- Collect, evaluate and disseminate facility information related to the incident.
- Assess resources available and vendor relationships.
- Prepare and disseminate Incident Action Plan.
- Contact technical vendors needed as part of the Action Plan.
- Track status of resources.

~~~~~~

Resources required:

- Vest
- Two-way radio and/or cell phone
- Keys to facility
- Floor plan
- Facility profile
- Vendor contact information

What vendors will need to be contacted?

____ Electrical
____ Gas
____ Fire alarm
____ Sprinkler
____ Plumbing
____ Generator
____ Water

Contacts made:

Vendor	Date/Time Contacted	Response

Functions reporting to the Planning Chief function (as needed):

- Vendor/resource Director
- Documentation Director
~~~~~~

Logistics Chief

Role: Assures that supply and resource needs of all personnel are met.

Reports to Unified Command.

Key functions:

- Communicates to Unified Command what is needed in all areas to promote the safety and wellness of children, staff, visitors and/or volunteers
- Orders, obtains, maintains and accounts for personnel, equipment, supplies.

~~~~~~

Resources required:

- Cell phone and/or two-way radio
- Vest
- Clipboard to capture lists of needs
- Access to supplies in triage area

Specific responsibilities:

- Identifies resource needs as for staff and supplies
- Communicates what is needed by whom and where to Unified Command
- Provides updates from Unified Command to staff on site

On-site (main building) supply resources are as follows:

- Oxygen: 12 H tanks; one liquid canister; and oxygen concentrators;
- Formula: three to five day supply
- Medication
- Water: three day supply of one gallon per person per day
- Food: three to seven day supply

Off site supplies:

Box of supplies is in Room 2 of the Church
Meds are primarily ordered from the Pharmerica (888-836-8930)

Functions reporting to the Logistics Chief (as needed):

- Supplies Director
- Staff Personnel Director
~~~~~~

Staff/personnel Director

Role: Assures proper staff coverage for care and safety of the children

Reports to Logistics Officer. If this function is not opened, reports to Incident Commander.

Key functions:

- Reaches key staff to assist in care of children during emergency
- Activates phone/communication tree.

~~~~~~

Resources required:

- Cell phone(s) and/or land line(s)
- Staff contact lists

Specific responsibilities:

- Determines staffing needs in collaboration with Logistics Officer
- Communicates with off-duty staff
- Identifies staff to come to evacuation site to assist with care of children

Core staffing needs

- Days and evenings coverage of three nurses and six to seven LNAs; Night coverage of three nurses and two LNAs;
- Dietary staff – one member;
- Environmental Services – two to three staff for days)
- Alerts incoming staff to check in at Unified Command.
- Notifies Accountability Officer of new staff pending arrivals
- Notifies Accountability Officer of staff released from duty

Other functions may be assigned to report to the Staff/personnel Director as needed.
~~~~~~

Supplies Director

Role: Assures that supplies (including food, water, formula, medications, personal care supplies) and resource needs are met.

Reports to Logistics Chief. If this function is not opened, reports to the Incident Commander.

Key functions:

- Identifies needed equipment, supplies.
- Communicates to Logistics Chief what is needed in all areas to promote the safety of children, staff, visitors and/or volunteers.

~~~~~~

Resources required:

- Cell phone and/or two-way radio
- Vest
- Clipboard to capture lists of needs
- Access to supplies in triage area

Specific responsibilities:

- Identifies resource needs such as for supplies
- Communicates what is needed by whom and where to Logistics Chief.

On-site (main building) supply resources are as follows:

- Oxygen: 12 H tanks; one liquid canister; and oxygen concentrators;
- Formula: three to five day supply
- Medication
- Water: three day supply of one gallon per person per day
- Food: three to seven day supply

Off site supplies:

Box of supplies is in Room 2 of the Church
Meds are primarily ordered from Pharmerica (888-836-8930)

Other functions may be assigned to report to the Supplies Director as needed.
~~~~~~

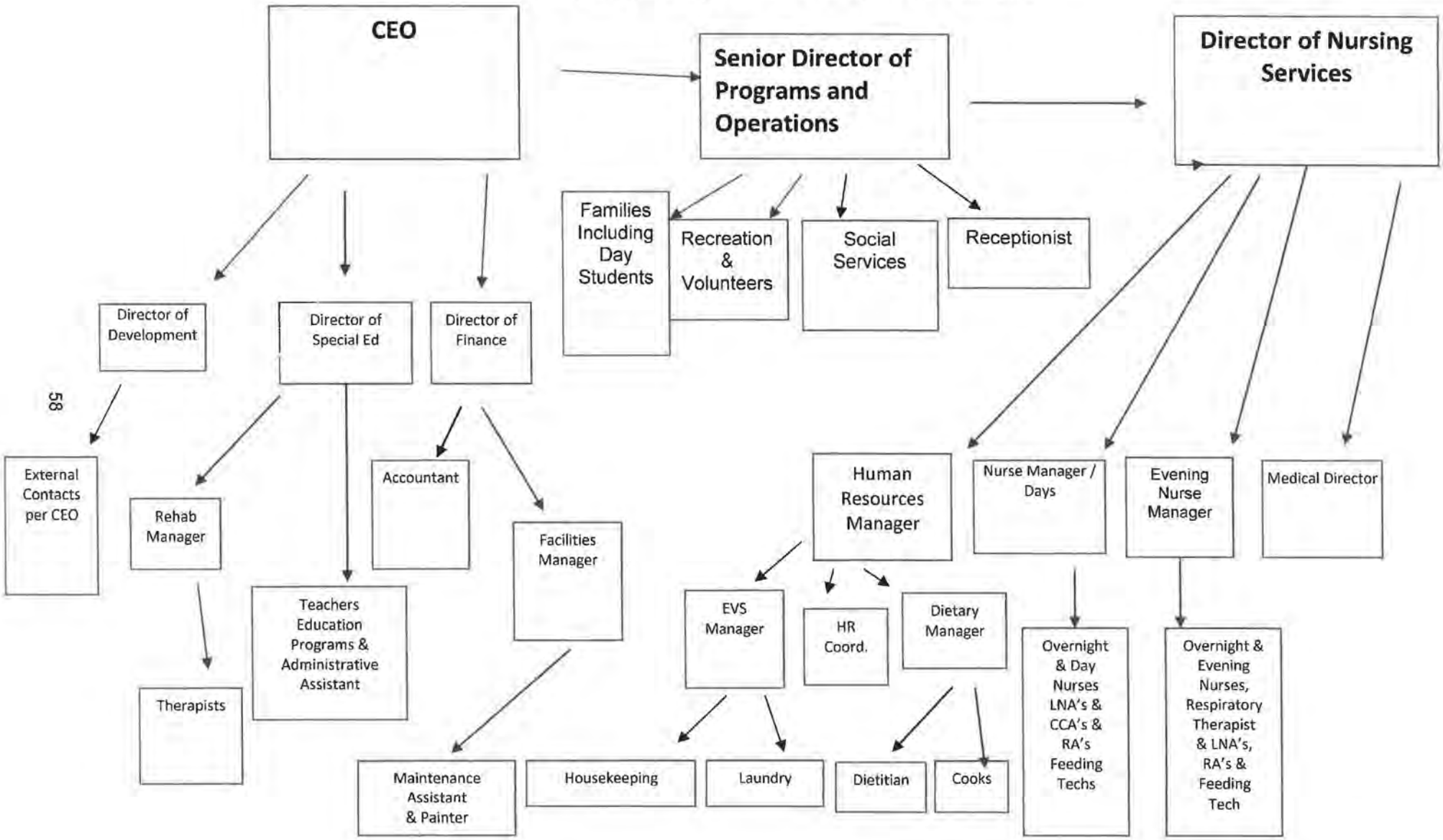
Cedarcrest Center
***for* Children with Disabilities**
91 Maple Avenue
Keene, NH 03431

INTERNAL EMERGENCY CALL LIST

NAME	HOME PHONE	ALTERNATE
John Hamler Facilities Manager		Cell– [redacted]
Phil Buffum Maintenance	[redacted]	Cell - [redacted]
Jim Yannizze Dir. of Finance		Cell - [redacted]
Jay Hayston CEO		Cell [redacted]
Bridget Toepfer Director of Nursing		Cell- [redacted]
Jen Ritter Nurse Manager		Cell- [redacted]
Amanda Babcock Nurse Manager		Cell- [redacted]

Cedarcrest Center copper line ([redacted]) to be used in times of emergency. Use red phone in nurse's workroom.

Cedarcrest Center
Emergency Telephone Tree by Department



The appropriate supervisor would also contact their per diem staff and any students /interns expected in their department

EXTERNAL EMERGENCY CONTACT LIST

LOCAL POLICE DEPARTMENT

GENERAL EMERGENCY PHONE NUMBER: 911

Police Dispatch: (603) 357-9813

EMERGENCY OPERATION CENTER (EOC)

For information on community disasters (603) 357-9813

STATE POLICE: 1-800-525-5555:

Local Phone: (603) 358-3333

FIRE DEPARTMENT

GENERAL EMERGENCY PHONE NUMBER: 911

Non-emergency contact: Lt. John Bates 603-209-2574

Main Number: (603) 357-9861

EMS - DILUZIO AMBULANCE SERVICE

Contact Name: Robert DiLuzio

Office Phone: (603) 357-0341

NEAREST HOSPITAL – Cheshire Medical Center

Contact Name: Emergency Care Center (603) 354-6600

Office Phone: (603) 354-5400

PUBLIC HEALTH (DHHS)

(603) 271-4496 (603) 271-5300 (after hours)

LOCAL EMERGENCY MANAGEMENT AGENCY

Contact Name: Fire Chief Mark Howard, Keene Fire Department

Office Phone: (603)757-1862, Cell (603) 209-1733

CITY OF KEENE – PUBLIC WORKS

Office Phone: (603) 352-6550

Water & Sewer Dept: (603) 352-6550

EMERGENCY WATER SUPPLY

Monadnock Vending Office Phone: (603) 352-7694

Monadnock Mountain Spring Water Office Phone: (603) 654-2728

EVERSOURCE: for business power outage: 800-468-0034

POSION CONTROL - Northern New England Poison Center

Phone: (800) 222-1222

OFF-SITE SHELTER LOCATIONS

First Baptist Church: (603) 352-0340

Genesis Keene Center: (603) 357-3800

Langdon Place of Keene – (603) 357-3902

Applewood – (603) 239-6355

Rose Meadow – 603-487-1568

Cedarcrest Center
for Children with Disabilities
Facility Vendors

Note: BOLD letters indicate primary vendor

Alarm systems and security:

Fire Alarm System:
James Lawrence – Electrical -603-355-8222
RB Allen – 1-800-258-7264 (964-8140) 24/7

Door Alarm System:
One Source Security- 800-570-6478; (603) 645-5969
Arcomm – (603) 603-4600 x 328

Front Entry Video System
One Source Security- 800-570-6478; 645-5969
James Lawrence – Electrical – 603-355-8222
Arcomm – (603) 603-4600 x 328

Door Lock & Keys
Ken Fairbanks – 603-352-0868

Front Entry Doors, ADA & Slider
Door Control Inc. 1-800-258-9742 603-216-9222

Security:
Hunter North Security – 603-363-8200

Computer Networks

Horne & Benik Networks- (603) 499-4400
Mobile-603-209-4646; Pager 603-596-6051
Spectrum: 603-352-6421 (Internet)
Web Hosting: Keene Web Works 603-357-0643

Electrical:

Eversource 1-800-662-7764

James Lawrence – Electrical – 603-355-8222

Hamblet Electric - 603-352-2330

Emergency Generator Service
Powers Electrical Service 800-853-7202

Electric Parts Supplier – outlets-cover plates-bulbs
CED – 603-352-3347

Electric Motor Repair –
Farrar Electric Inc. 603-352-4316

One Source Security- 800-570-6478; 645-5969
Stanley Elevator 603-882-6918 out of Nashua

Fire Suppression:

Sprinklers- **Hampshire Fire Protection Co. Inc. – 603-432-8221**
Fire Alarm System- RB Allen- 1-800-258-7264; 24 hour line: 603-964-8140
James Lawrence Electric – 603-355-8222
Kitchen Hood- **Hampshire Fire Protection Co. Inc. – 603-432-8221**

General Repair: Ingram Construction- (603) 357-0759;
Jeff Ingram cell (603) 355-7034

Heating and Air Conditioning:

Dead River- 603-352-5240

Boiler Repair: Associated Heating Services--603-357-1198 Mike Neylan

HVAC-Equipment – A/C Units- Air Handlers-Humidifiers-Pumps
Dead River- 603-352-5240
Stromgren Plumbing and Heating (603) 352-5959
Zitta Refrigeration (603) 762-3416
Oil Tank and Piping Troubles: **Gold Eagle Contracting Inc. 603-528-1991**

Keene City

City Manager – (603) 357-9804
Public Works/Water & Sewer – (603) 352-6550

Oxygen System

0^2 Safe Solutions 1-800-847-0745
Beacon Medical Office: 603-429-1981; Cell: 603-440-8581

Pest Control- J P Chemical – 603-673-2908

Plumbing Repair

Toilets- Baths – Plumbing Fixtures
Bob Bedaw – 603-352-4323
Keating Plumbing & Heating – 603-876-4016
Stromgren Plumbing & Heating– 603-352-5959

Propane supplier:

Dead River 603-352-5240

Property Maintenance – **K&L Lawn Care – 603-357-2065**
Fax: 603-357-0865

Roofing – The **Melanson Co. Inc. 603-352-4232**

Telephone System –

In House: **Arcomm Communications 603-464-4600 x 328 or 800-992-7266 ask for Rick Dietrich or e-mail rick.dietrich@arcomm1.com**

Telephone Line Service Provider

Consolidated Communications – Account Phone # 603-352-2139
Fax/Copper Line [redacted], [redacted] [redacted]
Phone System – Call Advanced Services Team – 855-588-9300
[redacted]

EQUIPMENT

Hardware & Lumber supplies

Hamshaw Lumber & Hardware – 603-352-6506
Jacks True Value Hardware – 603-352-1517
Paints – Sherwin Williams Paints – 603-352-2554

Kitchen Equipment:

Dishwasher- **Hobart** 800-234-6202 603-623-3622
Gas Stove- **Dead River** 603-352-5240

Laundry Equipment

Washer Repair**: Yankee Equipment Systems- 603-868-6691;**
Daniels – 888-836-9663
Korvin Appliance – 603-352-3547
Dryer Repair: **Yankee Equipment Systems – 603-868-6691;**
Daniels – 888-836-9663
Dead River 603-352-5240

Patient Equipment

Lifts – **Procare 1-855-528-0421**
Wheelchair Scale - **Advance Scales Inc. 603-626-0242**
BioScrip – 1-800-660-6264 or 626-6200

VEHICLES

Auto Repair

Leon's Auto Center – 603-357-7004
Monadnock Ford – 603-283-5900
Subaru – 603-355-5000

Vehicle Equipment – lifts- tie –downs
MobilityWorks – 603-210-4610

WATER

Monadnock Mountain Spring Water - (603) 654-2728
City of Keene, Public Works – 603-352-6550

RENTAL PROPERTY

Rental Properties

Heating - Dead River- 603-352-5240
Heating – Pinney Plumbing & Heating – 603-357-0944
Electrical – Lawrence Electric – 603-355-8222
Hamblet Electric - 603-352-2330

Cedarcrest Center
for Children with Disabilities
Emergency Planning
Vendor Back-ups

Type of supplies	Primary Vendor	Primary Back-up	Secondary Back-up
Medical Supplies	McKesson	Geriatric Medical	Bioscrip MedLine
Medications	PharMerica	Rite-Aid	Walgreens
Personal Care Products	McKesson	Geriatric Medical	MedLine
Respiratory Equipment	Bioscrip	Keene Medical Products	McKesson
Oxygen	O_2 Solutions	Airgas	Keene Medical
Food	US Foods	PFG Springfield	Hannaford
Formula	Geriatric Medical	McKesson	Walgreens/ Walmart
Drinking Water	City of Keene, Public Works	Monadnock Mountain Water	US Food
Oil	Dead River	Davis Oil	Any Oil delivery Co.(residential truck)
Propane	Dead River	Keene Gas	L & G

Cedarcrest Center *for* Children with Disabilities Emergency Preparedness Plan

Appendices

Mutual Aid and Assistance Agreement
Healthcare Organizations in the
Greater Monadnock Region

The healthcare organizations within the Greater Monadnock Region (hereinafter "Participant"), by affixing their signature to this memorandum of understanding, agree in principle to voluntarily coordinate mutual aid services with each of the signatories in a good faith effort to minimize risk to patient/client care and health care facility operations. The Greater Monadnock Public Health Network Coordinator is responsible for maintaining signed agreements and contact information for all Participants.

I. SCOPE AND APPLICABILITY

The Participants agree that in the event of a declared or undeclared event affecting healthcare services as a result of natural, man-made or technological causes or a mass casualty incident (hereinafter "Disaster") which impacts the operational capabilities of any other Participant, the affected Participant may request assistance from the other Participants as is more generally set forth herein.

In the event of a Disaster, an affected Participant should first contact the other Participants. If the disaster affects the entire region or multi-healthcare organizations, then they will contact the Greater Monadnock Public Health Network Coordinator (GMPHNC) or the Multi-agency Coordinating Entity (MACE), if activated during a public health emergency, to facilitate the implementation of this Memorandum of Understanding. The Participant will use the guidelines established herein to coordinate the care and services necessary to maintain continuity of operations during the disaster.

Each Participant shall agree to take all appropriate actions during a disaster without regard to race, color, creed, national origin, age, sex, religion, or handicap of any individual involved and to assist all Participants as necessary. No Participant shall be required to provide treatment, care, medical supplies, equipment, services or personnel over and above that which is necessary to meet its own needs, existing or anticipate, or beyond its own resources.

In the event that any Participant is unable to continue patient care for some or all of its patients, all other Participants agree to act as receiving facilities for these patients or assign staff to work at the affected facility.

All Participants agrees to follow the guidelines set forth herein to the extent possible. There shall be no cause of action or basis of liability for breach of this Memorandum of Understanding by any Participant(s) against any other Participant(s).

This Memorandum of Understanding is not intended to replace each facility's disaster plan or to adversely affect existing transfer agreements between facilities, but is intended

to support those plans and agreements. Each Participant shall incorporate this Memorandum of Understanding into its disaster plan consistent with the principles agreed to herein.

II. GUIDELINES

1. Staff Personnel

Whenever it is deemed advisable by a Participant that personnel are needed at their facility, Receiving Participant will initiate call to the GMPHNC or the MACE to facilitate process of getting needed personnel from other Participants in a timely fashion.

A. Receiving Participant will provide specifics of need:
    1) Provide the position(s) needed
    2) Licensing or certification requirements if applicable
    3) Hours and days of week personnel are needed
B. GMPHNC or MACE will contact all Participants of this Memorandum of Understanding to determine availability of resources.
C. Sending Participant will provide Receiving Participant with name, contact information, etc
D. GMPHNC or MACE will maintain documentation of requests for personnel.
E. Receiving Participant will maintain documentation of staffing assignments to include hours worked each shift.
F. Employment and credential verification is the responsibility of each individual organization. As requested, the Sending Participant will provide the Receiving Participant with necessary documents.
G. Receiving Participant is responsible for providing orientation/just in time training to personnel.

2. Medical Supplies and Equipment

Whenever it is deemed advisable by a Participant that medical supplies and equipment are needed at their facility, Receiving Participant will initiate call to the GMPHNC or the MACE to facilitate process of getting needed supplies and equipment from other Participants in a timely fashion. Medical supplies may include: PPE (masks, gloves, and gowns), bedding, patient clothing, office supplies and cleaning supplies.

A. Requesting Participant will provide specifics of need: identify the equipment or provide specific amounts of each supply needed
B. GMPHNC or MACE will contact all Participants of this Memorandum of Understanding to determine availability of resources.
C. Sending and Receiving Participants will coordinate transportation of supplies and equipment.
D. GMPHNC or MACE will maintain documentation of requests and receipts of supplies and equipment.

3. Transfer of Patients
   A. Refer to each participants existing policies for emergency transfer or temporary relocation.

4. Cost of Services, Equipment, and Personnel

   The cost of services, equipment and personnel will be mutually agreed upon at the time of the event.

5. Administrative Services

   Each Participant will provide the following administrative services for themselves and will assist other Participants by:
   A. Maintaining a list of all patient/client transfers made to and from their facility.
   B. Maintaining a current listing of all discharges, their assigned areas and location.
   C. Notifying the Sending Participant when patients or personnel can be returned to their facility.

III. EFFECTIVE DATE, FUTURE AMENDMENTS AND CONSTRUCTION

This Memorandum of Understanding shall become effective on the date signed. A Participant may terminate its participation in this Memorandum of Understanding by giving a thirty (30) day written notice to the other Participants of its intentions to so terminate.

This Memorandum of Understanding shall be reviewed as requested by organizations involved and after each activation.

This Memorandum of Understanding is in no way meant to affect any of the Participants' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

This Memorandum of Understanding waives all claims against the other party or parties for compensation for any loss, damage, or personal injury or death occurring in consequence of performance of this agreement.

IN WITNESS WHEREOF, we have set our hands and seals that date below written.

Cedarcrest Center for Children with Disabilities
Healthcare Facility

Administrator/Chief Executive Officer

September 29, 2009
Date

Revised 6.1.09; 8.3.09, 9.21.09

Memorandum of Understanding for Point of Dispensing Push Site

The Greater Monadnock Public Health Network (hereinafter "GMPHN"), is working with local facilities to establish local dispensing sites for the Strategic National Stockpile or State pharmaceutical cache, in the event that the stockpile is requested to address a large scale communicable disease outbreak or bio-terrorism event.

Cedarcrest Center for Children with Disabilities (hereinafter "Facility") hereby acknowledges the intent to serve as a "push" site for its organization to dispense oral medications or vaccinations to its residents, employees and employees' family members in the event of an occurrence of an emergency epidemic which results from a communicable or non-communicable illness or condition caused by bioterrorism, pandemic influenza, or a novel or highly fatal infectious agent or biological toxin. Prophylaxis or treatment resources will come from the Strategic National Stockpile or other supply sources and be provided by GMPHN.

In making this acknowledgment, Facility agrees to the following:

1. Complete a Facility Registration Form that provides numbers of residents, employees and family members and submit to the GMPHN. (To be updated annually)

2. Dispense the prescribed treatment or prophylaxis to its residents, employees and employees' household members.

3. Allow its facility to be visited by GMPHN to assist with the development and maintenance of a site dispensing plan. These scheduled visits would occur with reasonable advance notice.

4. Designate the following emergency contacts (which shall be updated annually):
   - An **Administrator** who will serve as the primary point of contact.
   - **A Clinical Director** point of contact.
   - **A Security/ Physical Plant** point of contact that will interact with GMPHN and local law enforcement in making security plans.

5. Facility agrees to indemnify and hold harmless GMPHN from any and all claims and liabilities caused by the negligent acts or omissions of Facility arising under this agreement.

6. Facility represents and warrants that it has liability insurance to cover the use of the facility specified in this agreement.

As part of this agreement, GMPHN agrees to the following:

1. Provide the prescribed treatment or prophylaxis from the Strategic National Stockpile as directed by the State Medical Director

2. Provide a point of contact to answer Facility's questions regarding the above-referenced arrangements.

3. Provide assistance to Facility in development and maintenance of a site dispensing plan

4. The GMPHN agrees to indemnify and hold harmless Facility and its directors, trustees, officers and/or employees from any and all claims and liabilities caused by the negligent acts or omissions of GMPHN arising under this agreement.

5. The GMPHN represents and warrants that it has liability insurance to cover the provision of services specified in this agreement.

GREATER MONADNOCK PUBLIC HEALTH NETWORK

By: Cathy Gray 10/26/15
Signature Date

Cathy Gray President/CEO
Print Name Title

Cedarcrest Inc. dba Cedarcrest Center for Children with Disabilities (FACILITY)

By: [signature] 11-19-15
Signature Date

[illegible] 11-5-15
Print Name Title

Created on 10/16/2012 Reviewed 10/20/2015

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GREATER MONADNOCK PUBLIC HEALTH NETWORK
Facility Registration*

Facility Name & Address		
Name: Cedarcrest Center for Children with Disabilities		
Street: 91 Maple Avenue		
City: Keene, NH	Zip: 03431	County: Cheshire

Persons/Positions authorized to sign Pickup Authorization Form:

Primary Name	Title	Work Phone / Home/Cell Phone	E-Mail
Cathy Gray	President/CEO	Work Phone: 358-3384 Home/Cell Phone: [redacted]	CGray@cedarcrest4kids.org
Secondary Name: Sheila Carrier	Title: Clinical Nurse Manager	Work Phone: 358-3384 Home/Cell: [redacted]	scarrier@cedarcrest4kids.org
Third Name: Lori Myers	Title: Nurse Manager	Work Phone: 358-3384 Home/Cell Phone: [redacted]	lmyers@cedarcrest4kids.org

Number of Residents/Patients, Employees and Household Members

Residents/Clients/Patients:	Employees	Hou[redacted]	Other:
30	110-115		

List Additional Information:

All residents are children - ranging from infants to age 21.

Completed by: Cathy Gray	Title: President/CEO
Signature: Cathy Gray	Date: 1/2/2020

*To be completed by the facility in advance and forwarded to GMPHN

Update October 15, 2012 Reviewed October 20, 2015 Updated March 8, 2019

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MEMORANDUM OF UNDERSTANDING
Long Term Care Facility Emergency Preparedness
STOP OVER POINT SHELTER FACILITY

New Hampshire licensed long term care facilities (Nursing Homes and Residential Care facilities), like others across the country, are susceptible to disasters that could exceed the resources of any single center or organization. A disaster could result in the need to immediately evacuate residents out of a licensed facility in a catastrophic event such as a fire. As part of emergency preparedness plans Nursing Homes and Residential Care facilities have adopted agreements with other licensed health care facilities to accept residents for care until a disaster affected facility can return to service.

It is anticipated that in a disaster event where significant numbers of residents must be immediately evacuated from a health care facility that the residents will most likely need to be assigned to multiple licensed health care facilities which may take a few to several hours to coordinate and implement.

This Memorandum of Understanding (MOU) is a voluntary agreement between the licensed Health Care Facility designated below and the Shelter Facility designated below whereby the Shelter Facility agrees to serve as a short term "stop over point" shelter where residents of the licensed Health Care Facility can be safely sheltered for a few to several hours while transportation and coordination of transfers to other licensed Health Care providers are implemented. The "stop over point" shelter, hereinafter the Shelter Facility, is not a licensed health care facility and is not expected to provide any health care services.

Licensed Health Care Facility:

Cedarcrest Center for Children with Disabilities
91 Maple Avenue
Keene, NH 03431

Shelter Facility:

First Baptist Church
105 Maple Avenue
Keene, NH 03431

I. Scope and Applicability

The Participants agree that, in the event of a disaster which precipitates an evacuation of the Health Care Facility (hereinafter "Event"), the Health Care Facility may request assistance from the Shelter Facility in allowing the Health Care Facility to convert a part of the Shelter Facility into a temporary shelter location in order to provide safe refuge during the Event. This MOU outlines the terms of the agreement and mutual responsibilities of the Parties.

It is anticipated that an activation of the MOU for a Health Care Facility specific disaster should not entail use of the Shelter Facility for more than 24 hours and typically would be for a period be of 2 to 12 hours. In the event of a regional disaster local authorities may designate the Shelter Facility for longer term use as a shelter for the Health Care Facility and/or other individuals.

Each Participant agrees to take all appropriate actions without regard to race, color, creed, national origin, age, sex, gender orientation, religion, or handicap to assist the Health Care Facility as necessary, and agrees to follow the guidelines set forth herein to the extent possible. No participant shall assert any cause of action for breach of this MOU by either Participant against the other Participant.

Each Participant shall incorporate this MOU into its disaster plan consistent with the provisions agreed to herein.

II. Operational Understandings

A. FACILITIES, SUPPLIES AND EQUIPMENT

The Shelter Facility shall provide habitable space for evacuated individuals and access to other requested support areas, use of existing infrastructure and equipment as described below. It is recognized that the Licensed Health Care Facility intends to provide or request from other Health Care Facilities some of the necessary specialty supplies and equipment to support its temporary occupancy of the Shelter Facility in a disaster situation.

The Shelter Facility will permit the Health Care Facility to use and operate its physical facilities and equipment, including but not necessarily limited to:

Designated areas of the Shelter Facility (list):

1) One or more assembly area(s) including Fellowship Hall to temporarily house up to 30 evacuated individuals and up to 30 accompanying staff.
2) Rest room facilities
3) Access to a food serving or staging area including a sink, oven and/or microwave where a basic meal can be prepared.
4) Access to supplies stored in Room #2

Equipment:

1) Office equipment including telephones, copy machines, fax machine
2) Internet access via Wi-Fi.
3) Tables, chairs, desks, cots, blankets
4) Refrigerators suitable for temporary storage of medications
5) Other resources and materials as mutually agreed upon by Participants

B. POINTS OF CONTACT

The Shelter Facility will designate two points of contact:

- An administrator of the Shelter Facility who will serve as the primary point of contact and who has authority to open the building and authorize occupancy in a disaster.
- A building maintenance/facilities and systems point of contact.

The Health Care Facility will provide a point of contact to be responsible for coordinating activities of its staff as well as the evacuees and answer any questions that the Shelter Facility may have. See Attachment A for contact information.

C. OTHER AGREEMENTS

The Shelter Facility will allow occasional visits, in advance of any such disaster, to the Facility by members of the Licensed Health Care Facility, the local Fire and Health department, local and/or state law enforcement and other emergency preparedness officials for the purpose of development and maintenance of emergency preparedness plans. The Shelter Facility understands that these visits may take place before a disaster for advance planning purposes including drills, and/or while the Shelter Facility is activated in an actual disaster.

It is understood that the Shelter Facility maintains and does not relinquish its flexibility to make arrangements for use or modification of its space and facilities that may adversely impact or limit the availability of its facility in any disaster. It is understood that the Health Care Facility is responsible for maintaining more than one arrangement for a "Stop Over Point" and holds the Shelter Facility harmless in the event that the Shelter Facility is not available in a disaster.

D. COST OF SERVICES, EQUIPMENT, AND PERSONNEL

The Health Care Facility and Shelter Facility shall not be responsible to pay for any resources or supplies voluntarily provided by a public, governmental or private entity to assist or run the Shelter Facility in a disaster, pursuant to an understanding that such resources and supplies are freely given. In the event of a disaster the Shelter Facility will encourage its personnel to volunteer to work at the site to assist in other response activities. The Health Care Facility and the Shelter Facility shall mutually determine if any costs incurred by the Shelter Facility associated with a disaster activation will be reimbursed by the Licensed Health Care Facility.

Both Participants agree to help each other in providing documentation that may be necessary in seeking reimbursement for expenses from any governmental payer programs such as Emergency Management & Homeland Security, the Federal Emergency Management Agency, or any other public or private entity. Both Participants recognize that this MOU is executed without knowing if any reimbursements may be available in any particular situation.

III. Effective Date, Future Amendment, and Construction

This MOU shall become effective on the date written below as the Effective Date. This MOU shall be reviewed periodically to ensure that it meets the requirements of the Participants and may be amended from time to time in writing by mutual consent of the Participants. This MOU shall automatically renew annually on the first day of each calendar year unless either Participant informs the other in writing at least 90 days prior to the renewal date.

Either Participant may terminate its participation in this MOU at any time by giving 90 days written notice to the other Participant of its intentions to terminate.

This MOU shall be deemed to be an agreement between two New Hampshire organizations subject to New Hampshire law.

The signatories below assert that they are authorized by their respective organizations and their governing body to sign this MOU on behalf of their respective organizations.

Effective Date of the MOU 12/6/2018

For the Shelter Facility

Chris Bennett 12/6/2018

First Baptist Church of Keene — Date

For the Health Care Facility

Cathy Gray 12/5/2018

Cedarcrest Center, Chief Executive Officer/Administrator — Date

CONTACT INFORMATION for Stop Over Point Shelter Facility MOU

CONTACT INFORMATION:

Cedarcrest Center	First Baptist Church of Keene
Contact: Cathy Gray	Linda Overall
Title: Administrator	Pastor
Phone: 603-358-3384	603-352-0340
Alternate: 603-313-9137	

Licensure status with New Hampshire: ICF/IID with 26 beds
Administrator: Cathy Gray
Director of Nursing Services: Thomas Connelly
Facility Manager: Mark Whipple

TRANSFER AGREEMENT

This Transfer Agreement is entered into between Applewood and Cedarcrest("facilities"). To facilitate continuity of care and the timely transfer of any patient who requests or requires [emergency] transfer, the facilities agree as follows:

I. TRANSFERRING FACILITY RESPONSIBILITIES

A. Responsibility for Transfer and Patient. The facility transferring the patient ("Transferring Facility") is responsible for effecting the transfer of the patient and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations.

B. Transfer of Medical Records. Transferring Facility will send with each patient at the time of transfer any medical and administrative information necessary to provide continuing care to the patient.

C. Transfer of Personal Effects. Transferring Facility is responsible for the transfer or other appropriate disposition of the patient's personal effects, particularly money and valuables, and information related to these items.

II. RECEIVING FACILITY RESPONSIBILITIES

A. Patient Acceptance. The facility receiving the patient ("Receiving Facility") agrees to accept any patient transferred from Transferring Facility [requiring nursing services], provided that Receiving Facility has the capacity and capability to provide continued care to the patient. Receiving Facility agrees to promptly determine its capacity and capability to accept the patient and respond to Transferring Facility's transfer request. In determining its capability, Receiving Facility agrees to utilize all available resources, including without limitation, on call physician services.

B. Responsibility for Patient. Receiving Facility's responsibility for the patient's care begins when the patient arrives at Receiving Facility.

III. RESPONSIBILITIES FOR BOTH FACILITIES

A. Contact Person. Each facility agrees to designate and provide the other facility with written contact information for a person or department that has the authority to accept and coordinate a patient transfer and resolve transfer disputes. If a facility believes that a transfer has been mishandled or inappropriately rejected, it agrees to raise the issue with the other facility's designated contact person or department. The facilities agree to attempt to resolve any transfer disputes in good faith.

B. Non-Discrimination. Neither the decision to transfer a patient nor the decision to accept a patient may be predicated upon arbitrary, capricious, or unreasonable discrimination or the patient's insurance status or ability to pay for services rendered by either facility.

C. Facility Charges. The facility rendering services to the patient is responsible for billing and collecting all charges related to such services directly from the patient, third party payor, or other sources normally billed by the facility. Neither facility shall have any liability to the other for any such charges. Transferring Facility, not Receiving Facility, is responsible for any and all transfer costs, to the extent applicable.

D. Exchange of Billing Information. Each facility agrees to provide information in its possession, including the patient's coverage or eligibility under any third party payor or medical assistance plan, to the other facility as necessary to enable it to bill and collect its charges.

E. Limitation of Liability. Each facility will have exclusive control of policies, management, assets, and affairs of its respective facility. Neither facility will assume any liability by virtue of this agreement for any debt, obligation, expense, or liability incurred by the other facility related to the quality of care provided in the other facility.

F. Non-Exclusivity. This agreement does not limit the rights of either facility to enter into a contract or transfer agreement with any other facility.

G. Term and Termination. The initial term of this agreement is one year, beginning 9/20/20. Either facility may terminate this agreement with 30 days notice to the other facility. This agreement automatically renews for successive one year terms unless either facility provides a written objection to a renewal no fewer than 30 days before the beginning of a new term.

H. Amendment. This agreement, including this provision, may be amended only by a written agreement signed by both facilities.

I. Compliance with Laws. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, laws and regulations governing the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act, the confidentiality and maintenance of medical record information, as well as any laws or standards promulgated by any applicable government or accrediting agency.

J. Governing Law; Venue. This agreement is governed by and construed in accordance with the laws of the State of New Hampshire, without giving effect to any choice or conflict of law provision that would cause the application of the laws of any other jurisdiction. Any action, suit, or proceeding arising out of or related to this agreement must be prosecuted in [state] court and both parties irrevocably submit to the jurisdiction of that court.

9/21/2020
DATE

ADMINISTRATOR'S SIGNATURE

305065

FACILITY: *Applewood Center*
FACILITY'S PROVIDER Number:
FACILITY ADDRESS:
8 Snow Rd Winchester NH 03470

10/7/2020
DATE

ADMINISTRATOR'S SIGNATURE

Cedarcrest

FACILITY: *Cedarcrest*
FACILITY'S PROVIDER Number:
FACILITY ADDRESS:
91 Maple Ave, Keene NH 03431

MUTUAL AID AGREEMENT FOR TEMPORARY SHELTER

This agreement, made in October, 2018, establishes that in the event of a disaster that necessitates the evacuation of Cedarcrest Center for Children staff and residents, the undersigned facility will accept both into their building.

Langdon Place of Keene could offer common space, bathroom facilities, and utilities as available, for residents until more appropriate shelter could be found.

The evacuated facility will send their qualified staff to care for the transferred residents.

The recipient facility will reimburse the donor facility for any food or supplies used during this period. The reimbursement will be made with ninety days following receipt of the invoice.

This agreement will be forever in force and will be reviewed/update as needed annually.

This agreement can be nullified by either of the undersigned with a thirty day written notification.

Signed	[signature]	[signature]
Date	October 31, 2018	Oct 30 2018
Title	President/CEO	Administrator
Facility	Cedarcrest Inc.	Langdon Place of Keene

MEMORANDUM OF UNDERSTANDING
Long Term Care Emergency Preparedness
Inter-Facility Assistance and Resident Transfer

I. Introduction and Background

New Hampshire nursing centers, like others across the country, are susceptible to disasters that could exceed the resources of any single center or organization. A disaster could result in the need to evacuate residents out of a facility or even an entire region. It is also possible for the disaster to result in the need for assistance with transportation of residents and/or the loan of equipment and supplies from other healthcare facilities and vendors in or out of a region.

II. Purpose of Memorandum of Understanding

The purpose of this Inter Facility Memorandum of Understanding is to aid facilities in their emergency management by establishing an outline of how a Disaster Affected Facility may be assisted by one or more Assisting Health Care Facilities. The assistance anticipated could include helping with transportation or the loaning of equipment and supplies (including pharmaceuticals) but may also include accepting and caring for residents evacuated from a Disaster Affected Facility.

This Memorandum of Understanding (MOU) is a voluntary agreement among the individual licensed Nursing Facilities and/or licensed Residential Care and Supported Residential Care signatories for the purpose of providing assistance at the time of a disaster. **For purposes of this MOU, a disaster is defined as an overwhelming incident that exceeds the effective response capability of the impacted health care facility.**

The following plan is designed for those disasters where an unpredictable event requires the immediate, short term evacuation of residents or the need of equipment and supplies to continue operations. It is NOT designed as part of a contingency plan for evacuation of long term care resident due to a labor dispute or closure of a health care facility.

It is anticipated that any event causing a facility to request activation of the MOU would involve local Emergency Management Officials and notification of the New Hampshire DHHS. The disaster may be an "external" or "internal" event for the Disaster Affected Facility and assumes that each affected facility's internal emergency management plans have been fully implemented.

By signing this MOU, the signatories are evidencing their intent to abide by the terms of the MOU in the event of a disaster as described above and to provide support, including the potential acceptance of evacuated residents from a disaster affected facility that has activated their Emergency Operations Plan. The terms of this MOU are to be incorporated into each participating facility's Emergency Management Plans and Emergency Operations Plans.

Should any changes occur during the term of the MOU that would prevent a facility from further honoring or participating in the Agreement, or if changes in contact persons or phone numbers should become necessary, the facility is to immediately notify any and all reciprocating

participating facilities. In the event this MOU is activated in an emergency and the parties desire to amend or clarify terms of the MOU to reflect the specific needs of the situation they may do so by attaching a signed mutually agreed addendum.

III. Definition of Terms

Incident Command Center (facility command post)	A location from which Facility Incident Command oversees all incident operations. It will be the Disaster Affected Facility's primary point of administrative authority in a disaster incident.
Disaster (within a facility)	An overwhelming incident that exceeds a facility's effective response capability or cannot appropriately be resolved solely by using its own resources. Such disasters will likely involve the local emergency management agency, first responders, New Hampshire DHHS and may involve loan of transportation or equipment and supplies from another facility or the emergent evacuation of residents.
Disaster (community-wide)	An overwhelming incident that is more wide spread and affects several health care facilities at or about the same time. Since the community is also affected, local vendors could be caught in the same disaster incident. This disaster could overwhelm several facilities in their ability to place numerous evacuated residents or provide equipment, supplies and transportation.
Disaster Affected Facility	A Disaster-Affected Facility is a long term care facility where an incident of disaster proportions has occurred. Transportation, staff, equipment or supplies may be requested, or the evacuation and transportation of residents may be required.
Assisting Health Care Facility	A licensed Health Care Facility that receives transferred residents or provides transportation, equipment or supplies to a Disaster Affected Facility.
Stop Over Point / Alternative Care Facility	A facility where residents can be held pending return to their original facility or distribution to an Assisting Health Care Facility. This building will normally be pre-assessed by local authorities and the Disaster Affected Facility for its capability to provide this service. This building is typically NOT a Health Care Facility and is intended for short term use, usually hours in duration. The facility should be reviewed from a vulnerability and suitability standpoint to ensure that movement to the facility will not endanger evacuated residents or staff at the time of the disaster.
Fast Out Evacuation	An evacuation triggered by an incident such as a fire or tornado where patients need immediate evacuation from the Disaster Affected Facility. Such evacuation may involve temporary movement of residents to a Stop Over Point where they can be safely held while arrangements are made for transport to one or more Assisting Health Care Facilities. A Fast Out Evacuation may also be made to an Assisting Health Care Facility and in such case

	residents may be temporarily housed in a common area such as dining area until further arrangements can be made
Slow Out Evacuation	An evacuation triggered by an incident such as loss of heat or power or local condition that is clearly deteriorating but where a few or several hours may be available to arrange transfers in a more orderly manner to one or more Assisting Health Care Facilities.
Authority Having Jurisdiction	The local fire department, building inspector or other municipal or state authority that has the legal authority to evaluate an emergency situation and order an evacuation of a facility.
Resident Evacuation Tag	A permanent or temporary bracelet affixed to a resident identifying at minimum, resident name, DOB and facility name.

IV. General Principles of Understanding

Each participating facility will commit to the following:

1. General Resources Commitments
   a. Each participant agrees to honor the terms of the MOU to the extent possible in any emergency situation.
   b. Participate annually in one or more educational/planning meetings and/or an emergency preparedness drill as will be agreed to by other participating facilities.
   c. Maintain and distribute up to date Emergency Contact lists to other participating facilities.
   d. Incorporate into the facility specific Emergency Preparedness plan contingencies to accept a surge of evacuated residents into the facility up to 10% of the facilities licensed bed compliment.
   e. Participate in the MOU and respond to any requests for assistance in a non-discriminatory manner, without regard to race, color, national origin, age, sex religion or handicap of any individual involved.
   f. **Agree not to assert any cause of action for breach of this MOU by any participant against any other participant. There shall be no expectation that any participant be prepared to provide any additional level of care or stockpile additional supplies or maintain additional staff solely for the purpose of being a party to this MOU.**

2. Communications

The Disaster Affected Facility is responsible for informing emergency authorities and the New Hampshire DHHS of its disaster situation and defining needs that cannot be accommodated by the facility itself. The senior Administrator (or designee) in the Disaster Affected Facility Command Center is responsible for requesting equipment, supplies or authorizing the evacuation of resident in conjunction with Emergency Agencies. Formal requests for disaster assistance should be initiated by the senior Administrator (or designee) of the Disaster Affected Facility to the senior Administrator of any or all potential Assisting Health Care Facilities with coordination support from DHHS.

3. Initiating Evacuations and Accepting Residents to be Evacuated
When a signatory of this MOU contacts another signatory to activate a request for assistance in a disaster situation it shall be the responsibility of the Disaster Affected Facility to inform the requested assisting facility of the nature and scope of the disaster as well as the circumstances of any order to evacuate issued by the local Authority Having Jurisdiction (AHJ). In the event that situation allows a Slow Out evacuation the Disaster Affected Facility shall confirm that the local AHJ is in agreement with any decision to evacuate.
When a signatory is requested to accept evacuated residents they agree to promptly determine their capacity and capability and respond to the Disaster Affected Facility transfer request. The signatories agree that neither the decision to transfer or accept a resident may be predicated upon arbitrary or unreasonable discrimination including the resident's insurance status or ability to pay for services.
If an evacuation is initiated the Disaster Affected Facility will use all reasonable efforts to use a Resident Evacuation Tag (Disaster Tag) and wrist bands or another acceptable level of marking for tracking and identifying residents. The Active Resident Record/Chart (Current Service Plan and Med List for Assisted Living residents) will be sent with the resident with the only exception being the need for a Fast Out Evacuation from the Disaster Affected Facility with the inability to gather the resident information. Resident Evacuation Tags will still be used in a Fast Out Evacuation although such tags may be completed at a Stop Over Point before further transportation of the residents.

4. Responsibility to Care for Residents
Once transported and admitted to an Assisting Health Care Facility, an evacuated resident shall be under the care of the Assisting Health Care Facility until discharge, transfer or reassignment. To the extent possible and needed, the staff of the Disaster Affected Facility will be available to ensure a smooth transition of care and, if determined necessary, to provide care.
At end of disaster, residents should be returned and accepted back at original facility, unless agreement is reached between administrators or based on the decision by the family/resident. The Assisting Health Care Facility is to make every effort to facilitate a smooth transition back to the original facility. NOTE: It is expected that no marketing efforts will be made by the Assisting Health Care Facility toward any residents or family members.

5. Loans of Equipment and Supplies
Use of equipment, such as vehicles, tools, and reusable materials and supplies including pharmaceuticals, are subject to the following terms:
   a. The communication of all requests shall be made by the Incident Commander of the Disaster Affected Facility.
   b. Loaned equipment may be loaned with an operator and this would follow Supervision and Financial and Legal Liability elements of this Agreement.
   c. All loaned equipment and supplies will be provided by the Assisting Health Care Facility "as is", with no representation or warranties as to fitness for a particular

purpose. The Assisting Health Care Facility does have the duty of using reasonable care when providing equipment and supplies to a Disaster Affected Facility so as not to provide knowingly defective material.

d. Loaned equipment or supplies shall be returned to the lending Assisting Health Care Facility as soon as practically possible by the Disaster Affected Facility or immediately upon receipt of an oral or written notice from the lender for the return of the equipment or supplies. The intent would be to have loaned items returned to the Assisting Health Care facility within 7-10 days.

e. If the loaned equipment or supplies are damaged, consumed or rendered unusable while at the Disaster Affected Facility, the lender will be reimbursed by the Disaster Affected Facility for reasonable costs of repair or replacement of such equipment or supplies. Any determinations of what constitutes "equal condition and capability" shall be at the discretion of the Assisting Health Care Facility.

6. Loans of Staff and Staff Supervision

In the event that a disaster triggers a situation where one or more Assisting Health Care Facilities would provide direct care or support staff to a Disaster Affected Facility the Disaster Affected Facility will assume supervisory direction over the Assisting Health Care Facility's staff while they are on assignment at the Disaster Affected Facility.

In the event that residents are evacuated from a Disaster Affected Facility it is expected that the Disaster Affected Facility will, at the request of any Assisting Health Care Facility(s), make every reasonable effort to equitably assign and arrange for the Disaster Affected Facility staff to provide assistance in caring for evacuated residents at the Assisting Health Care Facility(s). While assigned to the Assisting Health Care Facility the staff shall be under the supervision and direction of the Assisting Health Care Facility.

7. Financial and Legal Liability

a) **The participating facilities agree that they will assert no cause of action for breach of this MOU by any participant against any other participant. A Disaster Affected Facility shall hold harmless and indemnify any Assisting Health Care Facility for acts of negligence or omissions on the part of the Assisting Health Care Facility in their good faith response to provide assistance during a disaster event.**

b) Neither facility will assume any liability by virtue of this MOU for any debt, obligation, expense or liability incurred by the other facility related to the quality of care provided in the other facility.

c) Any personnel provided by an Assisting Health Care Facility to a Disaster Affected Facility shall be under the supervisory direction and are the legal responsibility of the Disaster Affected Facility where they may be working during a disaster. If they are paid for this time, it will be by the Assisting Facility which will then invoice the Disaster Affected Facility. If a Disaster Affected Facility sends its personnel to an Assisting Health Care Facility that has accepted its evacuated residents then those staff shall be under the supervisory direction of the Assisting Health Care Facility while continuing to be compensated by their own employer, the Disaster Affected Facility.

Revised	10.31.2017	9/12/18	1/23/19	4/29/19		

d) This MOU shall not be interpreted to create an association, joint venture or partnership among participating facilities. Nothing in this MOU shall be construed to give any participating facility any right of ownership, possession or control over the facilities or assets of other participating facilities.

8. Reimbursement and Payment for Service and Supplies
A Disaster Affected Facility shall reimburse and/or make timely payment or replacement of supplies within 30 days to any Assisting Healthcare Facilities for reimbursement for the care of the Disaster Affected Facilities residents or use of transportation, supplies, equipment and/or staff that may be loaned or provided to the Disaster Affected Facility. The participating facilities will work with the appropriate payor, Medicare, Medicaid or other third party to determine the appropriate mechanism to bill for services provided to any evacuated residents. The participating facilities agree that billing for the care of any evacuated resident will be done only after the mutual agreement of the Disaster Affected Facility and Assisting Health Care Facility in consultation with NH DHHS and or CMS.
In the event that an evacuated resident does not have a payment source it is the intent of this agreement that the Assisting Health Care Facility be compensated by the D saster Affected Facility at a rate at least equivalent to the Medicaid rate.

9. Effective Date, Termination and Renewal of the MOU
This MOU shall be effective between any two participating facilities upon signature of both parties designated authorized signatory. The term of the agreement shall be the calendar year.
The MOU will automatically renew each year unless either party provides 60 days' notice of intent not to renew.
A participating facility may terminate its participation in the MOU at any time by providing 60 days' written notice to any or all other participating facilities.

	Facility 1	Facility 2	Facility 3	Facility 4
Facility Name	Cedarcrest, Inc. dba Cedarcrest Center for Children with Disabilities	Rose Meadow Acres Adults with brain & spinal cord injuries	Rose Meadow Farm Adults with brain & spinal cord injuries	Rose Meadow Garden, Adults with brain & spinal cord injuries
Parent Corporation (if applicable)	N/A	N/A	N/A	N/A
Facility Licensure Level (SNF/RC/SRC)	ICF/IID	He P 805	He-P 805	He-P 805
Facility Administrator	Cathy Gray	Jamie Skinner	Nancy Quinn	April MacNe l
Date of Signature	Cathy Gray	Jamie Skinner	Nancy Quinn	
MOU Effective Date (if different)	4/29/19	5/2/19	5/1/19	5/1/2019

Revised	10 31 2017	9/12/18	1/23/19	4/29/19		

Cedarcrest Center *for* Children with Disabilities

EMERGENCY COMMUNICATIONS PLAN

Policy: Transparent and accurate communications with stakeholders, especially the media, during *and after* a crisis contributes to a successful resolution of the incident, including influencing a positive evaluation by stakeholders and the public.

Definition: The Communications Plan is the primary tool to ensure employees follow communication protocols during an emergency in contacting stakeholders, the media, and others. The Communications Plan is the primary responsibility of the CEO and the Public Information Officer (PIO), who is typically the Director of Development and Communications. The media outreach plan is an essential part of the Communications Plan.

Procedure: During an emergency (or "incident"), the Communications plan should govern all communications within an organization and with external stakeholders, including the media. Communications are the responsibility of the Public Information Officer. The plan needs flexibility; an organization's management may only need a portion of the incident command structure, depending on the scope and severity of the emergency. Irrespective of the emergency's intensity, the organization's emergency response team remains in a communications mode, appropriate to the situation, for the duration of the incident, as well as after, to ensure transparency throughout the process.

The Public Information Officer may form an Emergency Communications Team (ECT) as needed as part of a broader Incident Management Team. Typically, The Emergency Communications Team will consist of the organization's leadership; with the CEO in the lead and designated "Commander." As with Incident Command Systems, any staff can fill any position on the Emergency Communications Team. The first goal of the Emergency Communications Team is to evaluate the scope and severity of the event, gather accurate information about it, and report back to the Commander and other Emergency Communications Team members. The Public Information Officer provides leadership and training to the Emergency Communications Team (to avoid limited or conflicting information about the event or its impact). "Facts" matter and may change several times as new information is available.

Limited or conflicting information about an event or its impact make training and practice in evaluation and communicating accurate details about the emergency critical for the Emergency Communications Team. Planning and practice should include different scenarios and a variety of magnitudes of events. When an emergency strikes, the organization's staff responders and spokesperson should know instinctively what to do and how to report "up the chain of command."

With the Emergency Communications Team in place, the Incident Commander and the Public Information Officer should quickly begin to develop communications, like a press statement or interview notes, that accurately address anticipated (or specific) questions from stakeholder groups, including the news media. In planning for emergencies, an important role for The Emergency Communication Team is to develop templates of materials to make outreach more efficient in the early stages of a crisis.

The purpose of this plan is to provide procedural directions to the Public Information Officer in the event of an emergency at or relating to Cedarcrest Center.

The Public Information Officer is the designee of the Unified Command (UC) and once authorized to do so, is responsible for the development and communication of information to the public, media and other agencies as determined.

The key functions of the Public Information Officer include but are not limited to:

- Communicating appropriate information for the media
- Communicating appropriate information to key internal and external stakeholders (listed below) and other key interested parties
- Advising UC of information dissemination plans, actions and status of media relations. Decides with UC times for media update statements
- Uploading information to social media and/or the Cedarcrest website as needed

THIS PLAN ENCOMPASSES TWO SECTIONS-POLICY/PROCEDURES AND APPENDICES:

- Step by step communications process for response to an emergency
- Appendices: Media outlet information and contact (appendix)
- Appendices: Resources for response (forms, press release template and language, media call log and media kit, check list)

TOOLS FOR COMMUNICATION: Internet access (laptop, mobile phone), email addresses, Media kit hard copy and electronic file

Management should not rely exclusively on one way to communicate (e.g. telephone) their statements and messages. There should always be options in a plan for using alternate communications channels, such as text, wired telephone, cell phone, Internet, etc.

The Emergency Communications Team must be cognizant of HIPPA compliance and employment law to ensure confidentiality of covered information. Staff are not to speculate or discuss an event, especially with the media.

CONSTITUENTS/AUDIENCE

- Staff
- Family Members
- Board and Advisory Council Members
- General Public
- Media
- Vendors/Company partners

Command
Control
Consistency
Collaboration
Coordination
Communication

COMMUNICATIONS PROCEDURES DURING INCIDENT:

- Situational Assessment: Scope and type of emergency at the time of occurrence and any updates of the status of the situation
- Determine status of those contacted at stage 1. Leadership Managers briefing by UC
- Create an incident description report. Include actions taken during the incident
- Establish key messages: Create a brief written overview of the situation, impact on the children, staff, facility, organization. Review this statement with UC and Senior leadership
- Establish schedule of communication with key stakeholders
- Communicate the facts through the statement to each stakeholder group using email or other communication tools. (phone calls, emails, media release, social media, website)
- Leadership managers disseminate information to staff teams, assigned stakeholder groups
- Set up media center
- Begin media log, documentation
- Leadership Managers assure clear and concise records of who has been reached with the Incident 1 report messaging
- Monitor Social Media and Media (web and T.V.)
- Media Conference as necessary (part of schedule; clearly communicated via announcements

MEDIA MANAGEMENT

- Direct media to location to convene. (identify on/off site-nearby-) Requires access to power, briefing area and work tables.
- Record all inquiries and responses
- Prepare the spokesperson for media interaction
- Determine timely media update/statements

COMMUNICATIONS PERFORMANCE EVALUATION

- Meet with Unified Command and Leadership Managers to discuss process, quality and timeliness of information, areas for improvement.

Communication Groups

Stakeholder Name	Role	Communication Tool
Employees	Human Resources (or Supervisor Designee)	When to Work Email-work or home Text (?)
Resident Families/Guardians Including Emergency contacts	Director of Social Services and designees	Phone
Board of Trustees	President/CEO	Phone, Email
Advisory Council	Director of Development & Communications	Email
Vendors (as needed)		
Public	Director of Development & Communications	Website, Facebook Media
City of Keene	President/CEO	Phone, Email
Insurance Company	Director of Finance	Phone, Email
State Licensing Agency	President/CEO	Phone, Email

Sample Operations Plan-communications

Activity	Hour 1	Hour 2	Hour 3	Hour 4
Unified Command team meeting	✓		✓	
Stakeholder-Employees	1.5 ✓			
Family Members/ Guardians/Emergency Contacts	1.5✓			
City of Keene	✓			
Board/AC		✓		
Public/Media		2.5✓		
Insurance Company		✓		
State licensing agency		✓		

To do's:

- Determine way to quickly record outgoing phone message and post
- Access to portable pc's
- Create media log
- Create Press kits (both hard copy and electronic)
- Create master reporting logs
- Acquire lap top and back up battery
- Create media banner backdrop
- Conduct communication drill(s)

Updated 08/28/20

Emergency Plan Distribution

Master Copy: S: Facilities/Safety

Electronic Copy (Pdf) S: 1-POLICY MANUALS

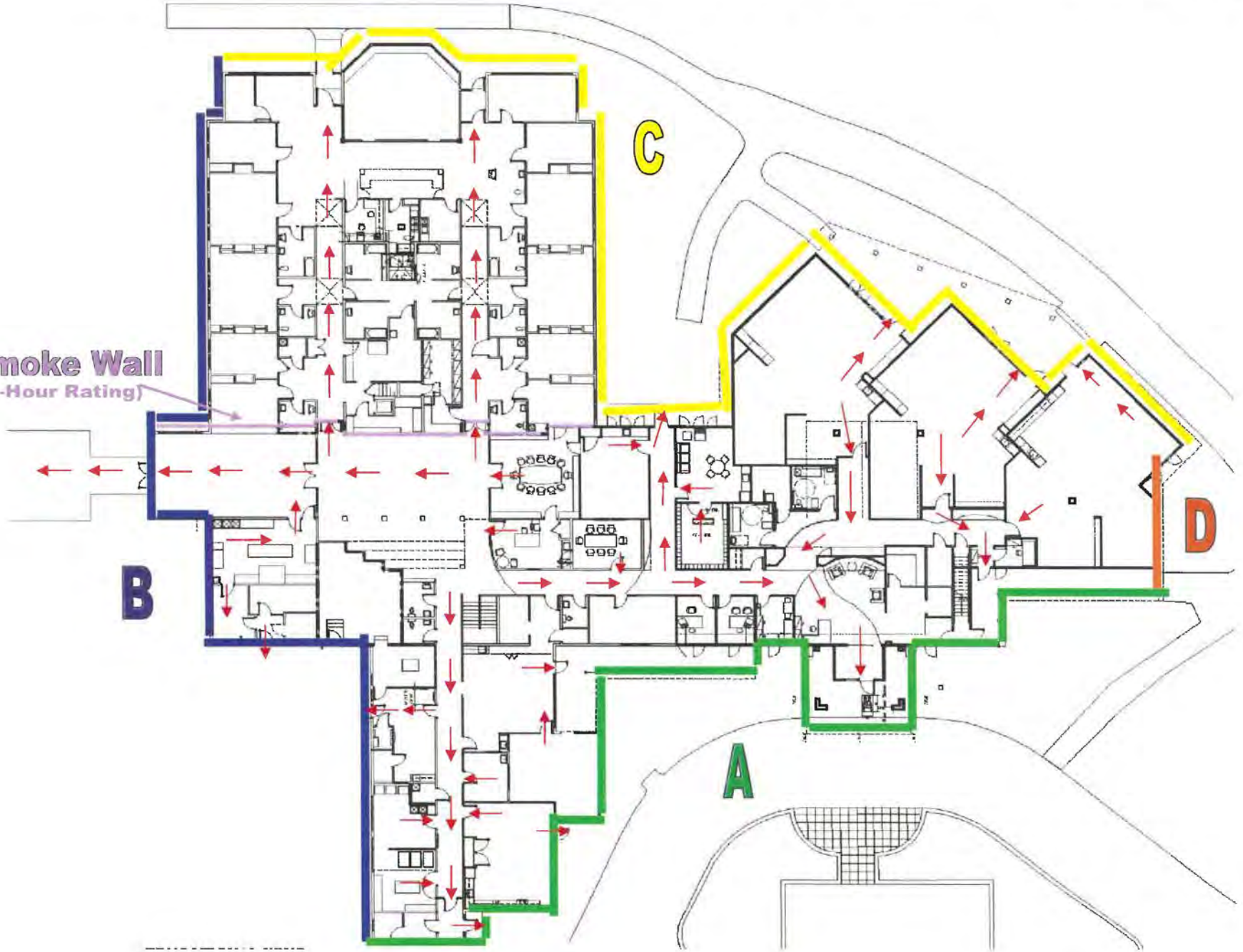
Orange Binders with Appendices:
- CEO
- Director of Finance
- Director of Nursing
- Facility Manager
- Nurses Station
- Reception
- Suitcase
- Sr. Director of Programs and Operations

Non appendices
- Library
- Staff Lounge
- Kitchen

Addendums in Emergency Suitcase

- Staff Phone List
- Family Contact List

Evacuation Routes from building



Cedarcrest Center
for Children with Disabilities
Emergency Preparedness Planning Policy

POLICY: As required by Federal regulations, Cedarcrest Center has "detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing clients" (CFR§ 483.470 (h) W Tag 438). The Safety Committee is charged with review and oversight of the plan, procedures and drills.

PROCEDURE:
Preparedness is a continuous cycle of planning, organizing, training, equipping, exercising, evaluation and improvement activities to ensure effective coordination and the enhancement of capabilities to prevent, protect against, respond to, recover from, and mitigate against natural disasters, acts of terrorism, and other man-made disasters.

Cedarcrest Center has in effect and available to all ~~key~~ personnel written copies of a plan for protecting all persons in the event of a fire or other hazard. The plan is based on an "All Hazards" approach and includes procedures for keeping persons in place, for evacuating persons to areas of refuge, and, when necessary, for evacuating persons from the building. The plan also includes procedures in response to system failure(s) or weather events. The procedures needed to ensure the safety of all individuals are outlined for each type of hazard and are amended or revised whenever necessary. All employees participate in drills and provide feedback on the effectiveness of said procedures. The Safety Committee reviews feedback from drills or events and suggests modification to the plan. A copy of the plan is readily available at all times within the facility.

The Cedarcrest Center plan was developed and revised with the advice and assistance of local emergency authorities in Cheshire County and emergency authorities in the City of Keene. The plan is reviewed and updated on a regular basis. It is submitted to NH Homeland Security annually as required of schools.

Staff members are trained both initially through orientation and then on an ongoing basis around the elements of the plan including the various types of situations that may occur, Incident Command, and staff response to the different scenarios, 'Emergency Preparedness and Response' as well as the local response system of Keene. Staff receive periodic updates and are kept informed with respect to their duties and responsibilities under the plan.

Drills are carried out monthly and two disaster drills (one tabletop and one a live drill) are conducted annually. Fire drills are conducted quarterly for each shift and monthly to meet department of Education guidelines. Each staff person must participate in a fire drill at least once in a 3-month period under various conditions. Drills are held at different times of the day and night, from different areas in the facility and use different escape routes. All residents are evacuated during at least one drill per year on each shift. The dates and responses to the drills are documented and are retained for review by the Safety Committee and administrative staff.

Approved: _____ 12/15/2022
Jay Hayston, President and CEO — Date

_____ 12-14-22
John Hamler, Facilities Manager — Date

Life Safety Plan

Cedarcrest Center
Emergency Light Annual Testing **2022**

#	Room	Type	Location	Circuit
1	**Maintenance Room**	Exit sign	Exterior Door	LS-04
2	**Maint Rm Main Electric**	Wall Emerg	Near Door	P5-02
3	**Maint Rm Life Safety Elec**	Wall Emerg	Near Door	P8-08
4	**Laundry Hall**	Exit Sign	Laundry	LS-04
5	**Laundry Hall**	Exit Sign	Atrium	LS-04
6	**Multi-Purpose**	Exit Sign	Exterior Door	LS-04
7	**Multi-Purpose**	Wall Emerg	Near Door	LP1-02
8	**Laundry**	T8	Dryer	LP1-05
9	**Laundry**	T8	Washer	LP1-05
10	**Oxygen Exit Door**	Exit Sign	Exterior Door	LS-04
11	**Observation Room**	Wall Emerg	Near Door	LP1-01
12	**Rehab Gym**	Wall Emerg	Sink	LP1-02
13	**Rehab Gym**	Exit Sign	Exterior Door	LS-04
14	**Rehab Gym**	Wall Emerg	Exterior Door	LP1-02
15	**Rehab Office**	Wall Emerg	Near Door	LP1-03
16	**Dining Room**	Exit Sign	Exterior Door	LS-04
17	**Kitchen**	Wall Emerg	Range	LS-17
18	**Kitchen**	Exit Sign	Door to Office	LS-04
19	**Kitchen**	Exit Sign	Exterior Door	LS-04
20	**Home End East Hall**	Exit Sign	Atrium	LS-04
21	**Home End East Hall**	Exit Sign	Exterior Door	LS-04
22	**Home End West Hall**	Exit Sign	Atrium	LS-04
23	**Home End West Hall**	Exit Sign	Exterior Door	LS-04
24	**Attic**	Wall Emerg	Top of Stairs	PP6-03
25	**Cedar Closet**	Wall Emerg	Near Door	PP6-01
26	**Medical Supplies**	T8	Middle Fixture	LP2-10
27	**Medical Records**	T8	Door Fixture	LP2-10
28	**Hall, Recep to Atrium**	Exit Sign	Atrium	LS-04
29	**Hall, Recep to Atrium**	Exit Sign	Hall to Staff Lounge	PP4-29
30	**Hall, Recep to Atrium**	Can	Hall to Staff Lounge	PP4-29
31	**Hall, Staff Lounge**	Exit Sign	Exterior Door	PP4-29
32	**Hall, Staff Lounge**	Can	Near staff lounge	PP4-29
33	**Staff Lounge**	T8	Near Sink	PP4-37
34	**Staff Locker Room**	T8	Doorway	PP4-37
35	**Sensory Room**	Wall Emerg	Above door	PP4-29
36	**Reception**	Exit Sign	Exterior Door	PP4-29
37	**Reception**	Exit Sign	Elevator	PP4-29
38	**Reception**	Can	Desk	PP4-34
39	**Reception**	Can	Stairwell door	PP4-34
40	**Foyer**	Chandelier	Foyer	PP4-12
41	**School Rest Room East**	T8	Inside Rest Room	PP4-37
42	**School Rest Room West**	T8	Inside Rest Room	PP4-37
43	**Hall, School**	Exit Sign	Reception	PP4-29

44	**Hall, School**	Exit Sign	Green Classroom	PP4-29
45	**Hall, School**	Exit Sign	Exterior Door	PP4-29
46	**Hall, School**	Wall Emerg	Yellow Classroom	PP4-37
47	**Hall, School**	Can	Bathroom	PP4-40
48	**Hall, School**	Can	Exterior Door	PP4-29
49	**House Keeping Closet, School**	Wall Emerg	Closet	PP4-41
50	**House Keeping Closet, School**	Wall Emerg	Front door	PP4-41
51	**House Keeping Closet, School**	Wall Emerg	School Emerg Exit	PP4-41
52	**House Keeping Closet, School**	Wall Emerg	Green Classroom	PP4-41
53	**House Keeping Closet, School**	Wall Emerg	Yellow Classroom	PP4-41
54	**House Keeping Closet, School**	Wall Emerg	Staff Lounge	PP4-41
55	**Yellow Classroom**	Exit Sign	Exterior Door	PP4-30
56	**Yellow Classroom**	Can	Soffit	PP4-30
57	**Yellow Classroom**	T8	In Front of Desk	PP4-38
58	**Yellow Classroom**	T8	Up Light by Ext Door	PP4-30
59	**Peach Classroom**	Exit Sign	Exterior Door	PP4-30
60	**Peach Classroom**	Can	Soffit	PP4-30
61	**Peach Classroom**	T8	Behind Desk	PP4-14
62	**Peach Classroom**	T8	Up Light by Ext Door	PP4-30
63	**Green Classroom**	Exit Sign	Exterior Door	PP4-32
64	**Green Classroom**	Can	Soffit	PP4-32
65	**Green Classroom**	T8	Near Column	PP4-32
66	**Green Classroom**	T8	Up Light by Sink	PP4-32
67	**Stairwell Reception**	Exit Sign	Exterior Door	PP4-29
68	**Stairwell Reception**	Exit Sign	Top	PP5-11
69	**Stairwell Reception**	Wall Emerg	Middle of Stairs	PP4-34
70	**Restroom, 2nd Fl Conf**	Can	Inside Rest room	PP5-11
71	**Mechanical Rm 2nd Floor**	Wall Emerg	Inside Mech Rm	PP5-34
72	**Hall, 2nd Floor**	Exit Sign	Door to Recpt Stairs	PP5-11
73	**Hall, 2nd Floor**	T8	Outside Conf Rm	PP5-11
74	**Hall, 2nd Floor**	Exit Sign	Mechanical Room	PP5-34
75	**Hall, 2nd Floor**	Can	Mechanical Room	PP5-34
76	**Hall, 2nd Floor**	Exit Sign	Office Supplies	PP5-34
77	**Hall, 2nd Floor**	Exit Sign	Copier Room	PP5-36
78	**Hall, 2nd Floor**	Wall Emerg	CEO Office	PP5-36
79	**Hall, 2nd Floor**	Wall Emerg	Server Room	PP5-36
80	**Stairwell Atrium**	Exit	Top of Stairs	PP5-36
81	**Stairwell Atrium**	Wall Emerg	Landing	PP5-36

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2022 Cedarcrest Center Emergency Drills

Month	Shift	School/ Residential Fire Drill- Days	Residential Fire Drill Evenings	Residential Fire Drill Overnight	Other Drills or Events
January	*second*	1/6/22@9:32am	1/26/22@4:05pm		
February	*third*	2/23/22@9:46am		2/2/22@5:00am	
March	*first*	3/31/22@8:50am			3/30/22 Code Purple/ Surge Capacity drill with Genesis Keene Center and Langdon Place
April	*second*	4/20/22@1:37pm	4/12/22@6:30pm		4/27/22 Loss of building power for an hour
May	*third*	5/26/22@10:40am		5/5/22@5:00am	
June	*first*	6-29-22@1:20pm			
July	*second*	7-28-22@2:15pm	7-29-22@5:35pm Evacuation Drill		7/18/22 Tornado Warning – shelter in place, central bathing
August	*third*	8-29-22@2:10pm		8-30-22@5:35am Evacuation Drill	
September	*first*	9-27-22@2:00pm Evacuation Drill			
October	*second*	10-25-22@2:10pm	10-31-22@5:10pm		
November	*third*	11-29-22@2:10pm		11-30-22@5:07pm	
December	*first*				

Swanzey

HAMPSHIRE FIRE PROTECTION CO., LLC

CEDx30 1
F 074853

ALL TYPES OF FIRE PROTECTION — WATER — CO_2 — FOAM
8 No. Wentworth Ave. • Londonderry, NH 03053 • (603) 432-8221 • Fax: (603) 434-3194
55 Harvey Road • Londonderry, NH 03053 • (603) 432-8221 • Fax: (603) 432-8128
1 Commercial Drive • West Lebanon, NH 03784 • (603) 448-5461 • Fax: (603) 448-7334
277 Old Homestead Highway • Swanzey, NH 03446 • (603) 358-6736 • Fax: (603) 358-6832
www.hampshirefire.com

BILL TO: Cedarcrest Center
91 Maple Ave
Keene NH 03431

DATE: 2/23/22
TECHNICIAN: Tim
TOTAL # EXT: 37
EXTS. IN SHOP: 2
SPARES: 0

JOB LOCATION: Same

CONTACT: Mark / Phill
TELEPHONE #:
P.O. #:
FAX #:

COMMENTS: 5-10lb + 1-K-Class + 1-Water Mist + 1-5lb Due in 2023

QTY	UNIT $	TOTAL	DESCRIPTION	QTY	UNIT $	TOTAL	DESCRIPTION
35	3.00	105.00	VISUAL INSPECTION				2 1/2# ____ RECHARGE
			CART. EXT. SVC	2	20.00	40.00	5# ____ RECHARGE
			EXT. SIGN				10# ____ RECHARGE
			P.W. HANGER				20# DC ____ RECHARGE
			5 LB. HANGER				30# DC ____ RECHARGE
			15 LB. HANGER	1	15.00	15.00	DRY CHEM HYDRO TEST
			CARTRIDGE ASSEMBLY	1	10.00	10.00	DRY CHEM 6 YR. MAINT
			GAUGE				5# CO2 RECHARGE
			LOCKING PIN				10# CO2 RECHARGE
			HOSE				15# CO2 RECHARGE
			HORN				20# CO2 RECHARGE
			BAND				5-20# CO2 HYDRO TEST
			GRIP				P.W. HYDRO TEST
			STEM				P.W. RECHARGE
			V.R. SEAL	1 1/2	76.00	114.00	SITE LABOR HOURS
			HANDLE REPAIR				~~MILEAGE~~

QTY	PART NUMBER	DESCRIPTION	UNIT PRICE	TOTAL

TAX EXEMPT: YES NO #
TAX:
Payment terms: Net 14 days Automatic inspection the following year
TOTAL: $284.00

CUSTOMER SIGNATURE: [signature]
DATE: 2/25/22

Fire Hydrant Flow Test/ Inspection

INSPECTION CONTRACT | Hydrant

Hampshire FIRE PROTECTION
8 NO. WENTWORTH AVENUE
LONDONDERRY, N.H. 03053
TEL. (603) 432-8221
FAX. (603) 434-3194

104 Etna Rd
Lebanon, NH 03766
TEL. (603) 448-5461
FAX. (603) 448-7334

Name of Property	Ceder Crest	Location	Right Side of Building
Street	91 Maple Street	Inspector	John Squiers
City & State	Keene, NH 03431	Date	5/17/2022

INSPECTION

Location of Hydrant: Right Side of Building

Manufacturer: M. H. Allston, Alabama Model: 454759, 5¼", 1847

	Yes	No
Accessible?	☑	☐
Is Hydrant Self Draining?	☑	☐
Any cracks in barrel?	☐	☑
Were outlet nipples tight?	☑	☐
Are outlet threads lubricated?	☑	☐
Outlet Cap gaskets good	☑	☑
Hydrant operating nut good	☑	☐

If No was Hydrant pumped out: Yes ☐ No ☑

Are threads worn? Yes ☐ No ☑

Repairs Made: None

Repairs Recommended: None

ABOVE INSPECTION CERTIFIED BY: John Squiers
Inspector

FLOW TEST

Static Pressure Reading	80	psi	Outlet diameter	2.5
Residual Pressure reading	61	psi	Booster pump on	☐ Yes ☐ No
Pitot Tube Reading	50	psi		
Flow from chart	740	gpm		
Nozzle inlet coefficient	2.5	(multiplier)		
Calculated flow	630	gpm		

ABOVE INSPECTION CERTIFIED BY: John Squiers
Inspector

Fire Hydrant Flow Test/ Inspection

INSPECTION CONTRACT | Hydrant

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AFSA American Fire Sprinkler Association

NFPA

Name of Property	Cedercrest	Location	Front of Building
Street	91 Maple Ave	Inspector	John Squiers
City & State	Keene, NH	Date	5/17/2022

INSPECTION

Location of Hydrant: Front of Building

Manufacturer: American Darling Model: B5F GHA 1986

	Yes	No
Accessible?	☑	☐
Is Hydrant Self Draining?	☑	☐
Any cracks in barrel?	☐	☑
Were outlet nipples tight?	☑	☐
Are outlet threads lubricated?	☑	☐
Outlet Cap gaskets good	☑	☑
Hydrant operating nut good	☑	☐

	Yes	No
If No was Hydrant pumped out	☐	☑
Are threads worn?	☐	☑

Repairs Made: None

Repairs Recommended: None

ABOVE INSPECTION CERTIFIED BY: John Squiers
Inspector

FLOW TEST

Static Pressure Reading	78	psi	Outlet diameter	2.5
Residual Pressure reading	51	psi	Booster pump on	☐ Yes ☐ No
Pitot Tube Reading	33	psi		
Flow from chart	601	gpm		
Nozzle inlet coefficient	2.5	(multiplier)		
Calculated flow	511	gpm		

ABOVE INSPECTION CERTIFIED BY: John Squiers
Inspector

INSPECTION AND TESTING FORM

Date: 12/28/21 Time: 8:30 am

SERVICE ORGANIZATION

Name: James Lawrence Electric, Inc.

Address: 160 Emerald St., Unit #10, Keene, NH 03431

Representative: James Lawrence

License No.: 8108M

Telephone: 603-355-8222

MONITORING ENTITY

Contact: Keene Fire Dept.

Telephone: 603-757-1863

Monitoring Account Ref. No.:

TYPE TRANSMISSION

☐ McCulloh ☐ Multiplex ☐ Digital

☒ Reverse Priority ☐ RF

☐ Other (Specify)

Control Unit Manufacturer:

Model No.:

Circuit Styles:

Number of Circuits:

Software Rev.:

Last Date System Had Any Service Performed:

Last Date That Any Software or Configuration Was Revised:

PROPERTY NAME (USER)

Name: Cedarcrest

Address: 91 Maple Ave, Keene, NH 03431

Owner Contact: Mark

Telephone: 603-358-3384

APPROVING AGENCY

Contact:

Telephone:

SERVICE

☐ Weekly ☐ Monthly ☒ Quarterly

☐ Semiannually ☐ Annually

☐ Other (Specify)

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested	
			Manual Fire Alarm Boxes
			Ion Detectors
			Photo Detectors
			Duct Detectors
			Heat Detectors
			Waterflow Switches
			Supervisory Switches
			Other (Specify):

Alarm verification feature is ☐ disabled ☒ enabled

NFPA 72, Figure 10.6.2.3(b), 1 of 5

ALARM NOTIFICATION APPLIANCES AND CIRCUIT INFORMATION

Quantity of Appliances Installed	Circuit Style	Quantity of Appliances Tested	
		All	Bells
			Horns
			Chimes
			Strobes
			Speakers
			Other (Specify):

No. of alarm notification appliance circuits:

Are circuits monitored for integrity? ☒ Yes ☐ No

SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested	
			Building Temp.
			Site Water Temp.
			Site Water Level
			Fire Pump Power
			Fire Pump Running
			Fire Pump Auto Position
			Fire Pump or Pump Controller Trouble
			Fire Pump Running
			Generator in Auto Position
			Generator or Controller Trouble
			Switch Transfer
			Generator Engine Running
			Other (Specify):

SIGNALING LINE CIRCUITS

Quantity and style of signaling line circuits connected to system *(see NFPA 72®, Table 6.6.1)*:

Quantity Style(s)

SYSTEM POWER SUPPLIES

(a) Primary (Main): Nominal Voltage 120v Amps 20

Overcurrent Protection: Type Amps

Location (of Primary Supply Panelboard):

Disconnecting Means Location: same room

(b) Secondary (Standby):

Storage Battery: Amp-Hr Rating 60

Calculated capacity in Amp-Hrs to operate system for hours

Engine-driven generator dedicated to fire alarm system:

Location of fuel storage:

TYPE BATTERY

☐ Dry Cell ☐ Lead-Acid

☒ Nickel-Cadmium ☐ Other (Specify):

☐ Sealed Lead Acid

(c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

Emergency system described in *NFPA 70®*, Article 700

Legally required standby described in *NFPA 70®*, Article 701

Optional standby system described in *NFPA 70®*, Article 702, which also meets the performance requirements of Article 700 or 701

PRIOR TO ANY TESTING

NOTIFICATIONS ARE MADE	Yes	No	Who	Time
Monitoring Entity	☒	☐		
Building Occupants	☒	☐		
Building Management	☒	☐		
Other (Specify)	☐	☐		
AHJ Notified of Any Impairments	☐	☐		

SYSTEM TESTS AND INSPECTIONS

TYPE	Visual	Functional	Comments
Control Unit	☐	☒	
Interface Equipment	☒	☐	
Lamps/LEDs	☐	☒	
Fuses	☐	☒	
Primary Power Supply	☐	☒	
Trouble Signals	☐	☒	
Disconnect Switches	☐	☒	
Ground-Fault Monitoring	☐	☒	

SECONDARY POWER

TYPE	Visual	Functional	Comments
Battery Condition	☒		
Load Voltage		☐	
Discharge Test		☐	
Charger Test		☐	
Specific Gravity		☐	
TRANSIENT SUPPRESSORS	☐		
REMOTE ANNUNCIATORS	☒	☐	
NOTIFICATION APPLIANCES			
Audible	☒	☒	
Visible	☐	☒	
Speakers	☐	☒	
Voice Clarity		☒	

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Measured Setting	Pass	Fail
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

Comments:

EMERGENCY COMMUNICATIONS EQUIPMENT	Visual	Functional	Comments
Phone Set	☐	☒	
Phone Jacks	☐	☐	
Off-Hook Indicator	☐	☒	
Amplifier(s)	☐	☐	
Tone Generator(s)	☐	☐	
Call-in Signal	☐	☒	
System Performance	☐	☐	

	Visual	Device Operation	Simulated Operation
COMBINATION SYSTEMS			
Fire Extinguisher Monitoring Device/System	☐	☐	☐
Carbon Monoxide Detector/System	☐	☐	☐
(Specify)	☐	☐	☐
INTERFACE EQUIPMENT			
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
SPECIAL HAZARD SYSTEMS			
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐

Special Procedures:

Comments:

SUPERVISING STATION MONITORING	**Yes**	**No**	**Time**	**Comments**
Alarm Signal	☐	☐		
Alarm Restoration	☐	☐		
Trouble Signal	☐	☐		
Trouble Signal Restoration	☐	☐		
Supervisory Signal	☐	☐		
Supervisory Restoration	☐	☐		

NOTIFICATIONS THAT TESTING IS COMPLETE	**Yes**	**No**	**Who**	**Time**
Building Management	☒	☐	Mark	
Monitoring Agency	☒	☐	Fire Dept Mutual Aid	
Building Occupants	☐	☐		
Other (Specify)	☐	☐		

The following did not operate correctly:

System restored to normal operation: Date: Time:

NFPA 72, Figure 10.6.2.3 (b) ...

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS

Name of Inspector: James Lawrence Date: 12/28/21 Time:

Signature:

Name of Owner or Representative: Date: Time:

Signature:

Health and Safety Plan

Cedarcrest Center
for Children with Disabilities
Standard and Transmission Precautions

POLICY: Cedarcrest Center maintains a standard of care to prevent and control the spread of infection by disrupting the mode of transmission and limiting contact with bloodborne pathogens.

PROCEDURE: Staff is to follow Standard and Transmission based precautions and the specific protective measures outlined in order to minimize the spread of infection. Infectious material includes microorganisms that can produce infection. Contamination occurs when infectious organisms are on normally clean or sterile objects.

Standard Precautions
Standard Precautions represent the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. Standard Precautions include: 1) hand hygiene, 2)use of personal protective equipment such as gloves, gowns, face mask/shield depending on the anticipated exposure, 3)respiratory hygiene and cough etiquette, 4) safe injection practices, and, 5) safe handling of potentially contaminated equipment or surfaces in the patient environment.

Hand Hygiene:
Hand hygiene includes hand washing with soap and water and use of alcohol-based hand sanitizers. Recommended techniques for hand washing include:

1. Turn water on to a comfortable temperature (warm water)
2. Apply soap to hands
3. Vigorously rub hands together for 15 seconds (20 seconds for dietary staff), covering all surfaces of the hands and fingers
4. Rinse hands from wrist to fingertips
5. Dry hands thoroughly with a disposable paper towel
6. Turn off faucet with the disposable paper towel

Use of alcohol based hand rub (ABHR) is appropriate in most situations, unless hands are visibly soiled, in which case, hands must be washed with soap and water. Recommended technique for use of ABHR includes:

1. Apply product to the palm of one hand
2. Rub hands together vigorously, covering all the surfaces of hands and fingers until hands are dry

The following situations require hand hygiene:

- When coming on duty
- When hands are visibly soiled (washed with soap and water)
- Before and after direct resident contact
- Before and after performing any invasive procedure
- Before and after eating or handling food (hand washing with soap and water)

- Before and after assisting a resident with personal care or toileting
- Before and after handling any invasive device such as tracheostomy or g-tube
- Before and after inserting an indwelling catheter
- Before and after any dressing change
- After personal use of toilet (hand washing with soap and water)
- After blowing or wiping nose
- After contact with a resident's mucous membranes, body fluids or secretions
- After handling soiled or used linens, dressings, or catheters
- After removing gloves
- After completing your shift

All staff involved in direct patient care will maintain fingernails that are clean and trimmed.

ABHR CANNOT be used in place of proper hand washing technique in a food service setting.

Dietary staff is to wear hairnets while in the kitchen area to protect hair from contacting exposed food. The FDA recommends that all dietary staff keep wearing of jewelry to a minimum, as jewelry can harbor microorganism.

Glove Use:

- Wear gloves when touching blood, body fluids, secretions, excretions and contaminated items.
- Wear gloves when touching mucous membranes and non-intact skin
- Change gloves between tasks and procedures on the same resident
- Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident
- Change gloves if they become contaminated with potentially infectious material
- Change gloves if they become punctured or soiled
- Remove gloves before leaving the work area
- Wash hands after removing gloves

Gowns, face mask, eye protection

- Wear a mask and eye protection or face shield to protect mucous membranes of the eyes, nose, and mouth during any procedure that is likely to generate splashes or sprays of blood, body fluids, secretions and excretions.
- Change gown or mask if either becomes wet. Face masks will become damp from breathing within 20-30 minutes

Patient care Equipment and Sharps handling

- Handle all patient care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents transfer of microorganisms to other residents, staff or the environment
- "Sharps" are needles, razor blades, orange wood sticks, broken glass, or anything that can puncture the skin.
- Never bend, break or recap used needles

- Dispose of all sharps in a puncture resistant, leak proof, *Bio-hazard* container as close to the area of use as is practical

- Sharps containers that are ¾ full will be sealed closed, and sent to the storage area for pick up by a medical waste disposal vendor
- Use tongs, forceps or dust pan to clean up broken glass or sharps
- Collect all specimens using Standard Precautions. Label container and place specimen in a leak-proof biohazard bag for transport to the lab
- If a sharps injury occurs, and incident report must be filled out, supervisor notified immediately, and the employee should go to Occupational Health during daytime hours, or Urgent care after-hours to be evaluated.
- All sharps injuries must be put on the OSHA mandated "Sharps Injury Log" and reported to the Workers Compensation Insurance carrier

Environmental Control and Linen Handling

- Blood spills should be handled with a blood-spill kit. If one is not available, use appropriate PPE (gloves, gown) and wipe the blood with disposable towels, then clean the area with an appropriate disinfectant or a 4:1 ratio water to bleach solution. Place disposable towels in a biohazard bag, as well as the PPE used to clean up the spill. Dispose of bag in storage area designated for biohazard waste. Wash hands immediately
- Blood on equipment: if disposable equipment, discard in a biohazard bag. If not disposable, clean as you would for a blood spill.
- Contaminated or soiled linen is handled with a minimum of agitation to avoid contamination of air, surfaces or persons
- Contaminated or soiled linen should be bagged at the point of use.
- No special precautions (i.e. double bagging) is needed for laundry originating from an isolation room

Occupational Health and Bloodborne Pathogens

Specific procedure for accidental exposure:

- Wash the exposed area immediately with soap and running water. If this is not available, use an antiseptic towelette or hand cleanser and wash hands as soon as possible with soap and water.
- Report the incident to your supervisor immediately and complete an incident report form. If the injury was from a sharp, try to save the sharp for testing.

Hazardous material on skin or mucous membrane:

- Rinse the hazardous material off under running water for the length of time specified on the Safety Data Sheet (SDS) and follow instructions for exposure on SDS sheet

Blood or hazardous material in the eye:

- Go to the nearest eye wash station and rinse the contaminated eye/eyes with cool running water for the length of time specified on the SDS sheet. Turn water to desired temperature and remove eye wash covers before placing **opened** eye/eyes under the running water. If only one eye is affected, have that eye closest to the bottom of the sink to avoid contaminating the second eye. Follow instructions on the SDS sheet.

Transmission-Based Precautions

Transmission-based Precautions should be used for residents who are infected, or suspected of being infected with infectious agents, including pathogens that require additional precautions beyond Standard Precautions.

Transmission-based Precautions are always used in addition to Standard Precautions!

Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being.

- **Airborne Precautions:**

  Airborne Precautions are used for residents known or suspected to be infected with microorganisms transmitted by the airborne route. Airborne organisms are defined as; less than 5 microns in size and can remain suspended in the air and widely dispersed by air currents within a room over a long distance.

  Examples include Tuberculosis, Measles, Varicella (chicken pox) and disseminated Herpes Zoster (disseminated Shingles)

- **Droplet Precautions:**

  Droplet Precautions are used for residents known or suspected to be infected with microorganisms transmitted by droplets. (Droplets larger than 5 microns in size that can be generated by sneezing, coughing and talking but drop from the air after a distance of 3 feet.)

  Examples include: bacterial infections such as H. Influenza, Neisseria meningitis, Mycoplasma pneumonia, Streptococcus infection, and some viral infections including Adenovirus, Influenza, Mumps or Rubella

- **Contact Precautions:**

  Contact Precautions are used for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact such as handling environmental surfaces or resident care items.

  Examples include: MRSA, VRE, Clostridium difficile, Herpes (simplex or zoster), Impetigo, Pediculosis, Scabies, and conditions such as rash of unknown origin, conjunctivitis, draining wounds, etc.

  Inform Staff of the need and type of Precautions required. Notify housekeeping so that appropriate daily and terminal cleaning is completed and other departments as necessary.

Precaution Procedures

Airborne Precautions:

The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR). This includes:

- A private room is required that has monitored negative air pressure. As there is no negative pressure room at Cedarcrest Center, the patient would have to be transferred to an appropriate hospital with an AIIR.
- An N95 respirator mask
- Keep the door closed and the resident in the room

- If a private room is not available you may cohort the resident in a room with another resident infected with the same microorganism, but no other infection.
- The resident should wear a mask for any transport from the roomResidents with Varicella (chicken pox) or Rubella (Measles) are cared for only by those individuals who have known immunity. Employees with known immunity do not have to wear respiratory protection.

Droplet Precautions:

- A private room is desirable. The door may remain open
- If a private room is not available, you may cohort residents infected with the same organism.
- When cohorting is not possible, maintain a separation of at least 3 feet between the infected resident and all others. Cubicle curtains may be used to prevent droplet transmission as well.
- Wear a mask (a respirator is not necessary) for close contact with the infectious patient (within 3 feet); the mask should be donned upon room entry.
- Limit movement of the resident. If transport is necessary, have the resident wear a surgical mask
- Follow respiratory hygiene/cough etiquette

Contact Precautions:

- A private room is preferred.
- If a private room is not available, you may cohort residents with the same microorganism or; if necessary, may be placed with a non-compromised individual
- When cohorting is not possible, maintain a separation of at least 3 feet between the infected resident and all others.
- Wear clean gloves and gown when entering the room
- Wear gloves and gown for all interactions that may involve contact with the resident or potentially contaminated areas in the resident environment.
- Change gloves after each contact with infective material (fecal material or wound drainage may contain high concentrations of organisms).
- Remove gloves and gown and wash hands before leaving the resident area
- If transport is necessary, ensure that precautions are maintained and that infective material is contained
- When possible, dedicate equipment to single or cohorted residents

Discontinuing Precautions:
The Infection Preventionist (IP) or Infection Control Nurse and the physician will determine that a resident is either free from infection or colonized before discontinuing or altering precautions. The decision to discontinue precautions is based on laboratory results and resident symptoms.

If it is determined that a resident is colonized, the MD and/or IP will write a note stating that the resident is now colonized and is to be removed from precautions based on our guidelines.

Approved by:

Cathy Gray, CEO, Nursing Home Administrator	Date
Sheila Carrier, Director of Nursing Services Infection Prevention Nurse	Date
Kathleen Collins, MD, Medical Director	Date

Cedarcrest Center
for Children with Disabilities
Abuse Prevention Policy

POLICY: Cedarcrest Center provides its residents, students, outpatients and their families or legally responsible representatives with an environment free from abuse, neglect, mistreatment and misappropriation of property and does not tolerate actions that might be construed as such.

PROCEDURE: Cedarcrest Center provides an environment that is supportive of the needs of the children served and their parent and/or guardian. The organization's policies and practices reflect this commitment. Each child is encouraged to actively participate in his/her program at a level commensurate with his/her abilities and is offered choices and adaptations that promote self-determination and functional independence. Parents and/or guardians are encouraged to be partners in program planning.

Abuse and neglect in any form are prohibited and every effort is made to prevent abuse, neglect and exploitations of residents and misappropriation of resident property. The language, actions and interactions of staff with children must reflect this standard. Alleged violations involving abuse, mistreatment, neglect, or misappropriation of resident property are defined as follows:

- **Mistreatment** – Includes behavior or facility practices that result in any type of client exploitation such as financial, physical, sexual, or criminal. Mistreatment refers to the use of behavioral management techniques outside of their use as approved by the specially constituted committee and facility policies and procedures.
- **Neglect** – Failure of the facility, its employees or service providers to provide goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Staff failure to implement facility safeguards, once client-to-client aggression has been identified, may constitute neglect.
- **Abuse**- The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being.
  - **"Physical abuse"-** the misuse of physical force which results in or could result in physical injury of residents.
  - **"Verbal abuse"** - Use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client.
  - **"Sexual abuse"** – inappropriate contact or interaction of a sexual nature involving resident(s)
  - **"Psychological/Emotional Abuse"** - the misuse of power, authority, or both, verbal harassment, or unreasonable confinement which results in or could result in the mental anguish or emotional distress of residents;
  - **"Willful"** means the individual acted deliberately and intended to inflict injury or harm.
- **Misappropriation of a resident's property** – The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent (42 C.F.R. § 488.301).
- **Injuries of unknown source** – An injury should be classified as an "injury of unknown source" when **both** of the following conditions are met:
  - The source of the injury was not witnessed by any person **and** the source of the injury could not be explained by the caregiver or family; **and**
  - The injury raises suspicions of possible abuse or neglect because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to

trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time.

Potential abuse and injuries of unknown source are to be reported immediately and will be investigated. The Social Worker, Director of Nursing Services and Administrator are alert to concerns raised by a child, family, guardian or staff member and will initiate an investigation upon receipt of a concern. Any unusual occurrences are to be reported and investigated according to Cedarcrest Center's Incident Reporting Policy. Families also may report their concerns in accordance with the facility's "Complaint Procedure". All allegations of abuse and/or neglect or injuries of unknown origin must be reported to the President/CEO immediately, regardless of the time of day or day of the week. An internal investigation is initiated immediately and the alleged offender may be relieved of his/her responsibilities during the investigation. The President/CEO or designee reports any significant incident to DCYF, Health Facilities Administration and/or the licensing board of the individual involved. The internal investigation must be concluded within five working days, with a follow-up report to DCYF, Health Facilities Administration and licensing board as appropriate. Where indicated and advised, a report to the Police Department will also be made. Mistreatment of a resident is grounds for disciplinary action up to and including termination. Appropriate disciplinary action will be taken as a result of the investigation when warranted.

Injuries of unknown origin are also reported through Cedarcrest Center's incident reporting process. Reporting to the administrator must be immediate. Investigations into possible causes of injuries are completed by the Director of Nursing Services or his/her designee. Significant injuries of unknown origin will be reported to Health Facilities Administration, as appropriate. Potential patterns of unusual incidents are identified through the incident report tracking process as a part of the Quality Assurance/Performance Improvement Program. The CEO and Director of Nursing Services will complete a review of any and all incidents where a pattern of potentially inappropriate behavior is noted. Additionally, if one or more residents experiences unexplained functional regression or signs that might indicate potential abuse, an investigation will be initiated. Cedarcrest Center will not tolerate any improper treatment of residents and will initiate an investigation at any point that concerns are raised, directly or indirectly.

To prevent the employment of individuals with convictions or prior history of child abuse, neglect or mistreatment, all potential employees are screened prior to the first day of employment. Each prospective employee must have a criminal background check through the NH Department of Safety and be checked against the Abuse Registry maintained by CMS and that maintained by Elderly and Adult Services. All volunteers who will have direct contact with children are also subject to a criminal background check. Staff orientation includes a section on Resident Rights, abuse prevention and professional boundaries. Department managers establish parameters for each position, integrating the elements of resident rights, avoidance of restraints, abuse prevention, appropriate behavioral interventions and the specifics of the department programming. All staff are then required to attend an annual inservice on Residents' Rights to increase their awareness of the rights of residents, students and their guardians, to promote respect for the needs of each individual and to review the organization's Abuse Prevention Policy. In addition, they are required to sign an annual affidavit regarding any criminal history. Ongoing education around the need for all staff to report any and all concerns around patient rights and/or care is maintained.
Efforts to assure prevention of abuse are reviewed at QAPI Meetings.

Approved: _____ _____
Jay Hayston, President/CEO Date

_____ _____
Kristin Targett, Sr. Director of Programs & Operations Date

Building Maintenance Procedures

CEDARCREST CENTER

Weekly Boiler Room Check List

Month	Week 1	Week 2	Week 3	Week 4	Week 5
Date					
Outside Temp (X1)					
Boilers	-----	-----	-----	-----	-----
Supply - Header Water Temp					
Return - Header Water Temp					
Pump 1 - Discharge Pressure					
Pump 2 - Discharge Pressure					
Boiler 1 On/Off					
Boiler 1 Pressure					
Boiler 1 Temperature					
Boiler 2 On/Off					
Boiler 2 Pressure					
Boiler 2 Temperature					
Expansion Tank Level					
Fuel Oil	-----	-----	-----	-----	-----
Oil Pump Vacuum					
Oil Level - Gallons					
Oil Delivered - Gallons					
Oil Average Daily Usage					
Oil Level - Inches					
Domestic Hot Water Meters	-----	-----	-----	-----	-----
#1 Main Hot Water (gal)					
Main Hot Water - Avg Daily Usage					
#2 Kitchen Sinks Water (gal)					
Kitchen Sinks Water - Avg Daily Usage					
#3 Dishwasher/ Laundry Water (gal)					
Dishwasher/ Laundry - Avg Daily Usage					
Domestic Hot Water Temperature	-----	-----	-----	-----	-----
#1 Central Bathing/ Restrooms 100-120°F					
#2 Kitchen Sinks 100-130°F					
#3 Dishwasher/ Laundry 140-150°F					
Fire Sprinkler System	-----	-----	-----	-----	-----
Air Compressor Run Hours (xxxx.xx hrs.)					
Air Compressor Run Hours - Avg Daily Hours					
Visual Check					
Air Compressor Oil Level					
Check/ Drain					
Air Pressure					
Water Pressure					
City Domestic Water	-----	-----	-----	-----	-----
City Water Pressure					
Building Water Pressure					
Main Cold Water Meter (x,xxx,xxx ft^3)					
Main Cold Water Meter - Avg Daily Usage ft^3					
Chlorine Level (once per month)					

Maintenance Weekly Facility Check List

Month & Year _____

	Week 1	Week 2	Week 3	Week 4	Week 5
Date					
Initials					
Temp-Maintenance Room					
Temp-Atrium					
Temp-West Hall Home					
Check Night Lights					
Fire Alarm Panel Power On yes/no					
Fire Alarm Panel Trouble yes/no					
Temp-East Hall Home					
Temp-Attic					
Humidity-Attic					
AHU4 Return Fan Hz					
AHU4 Supply Fan Hz					
AHU4 Discharge Air Temp					
Temp-Dining Room					
Temp-Kitchen					
Kitchen Storage Area Visual Check					
Education Hallway Visual Check					
Temp-Yellow Classroom					
Temp-Peach Classroom					
Temp-Green Classroom					
Entry/Reception Area Visual Check					
Surge Protector Readings					
Electrical Room Visual Check					
Generator Xfer Switch Normal yes/no					
Battery Charger DC Volts					
Outside Facility Visual Check					
Interior Lights Visual Check					
Exterior Lights Visual Check					
Fire Exit Lights Visual Check					
Attics Visual Check					
Domestic Hot Water Temp					

Preventative Maintenance Program

2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly Procedures																
Roof rake roofs after each snow storm (10x per yr)	2	5	10.0	50	1/17/22	2/7/22	3/19/22								N/A	12/12/22
Clean Kitchen Grease Trap every two weeks	2	0.75	1.6	20	1/12,17/22	2/9,23/22	3/9,23/22	4/6,20/22	5/4,18/22	6/1,15,29/22	7/13,27/22	8/10,24/22	9/6,21/22	10/5,19/22	11,2,16,23/22	12,14,28/22
Check Play structures in day rooms	4	0.5	2.0	24	1/5/22	2/2/22	3/3/22	4/5/22	5/2/22	6/3/22	7/7/22	8/2/22	9/6/22	10/5/19/20/22	11/3/22	12/2/22
Check Beds for Safety	27	1	27.0	324	1/18/21	2/9/22	3/7/22	4/8/22	5/4/22	6/3/22	7/12/22	8/17/22	9/13/22	10/14/22	11/18/22	12/5/22
Clean Company Vehicles 3 per month	6	2	12.0	144	1/21/22	2/10/22	3/4/22	4/22/22	5/4/22	6/9, 23	7/21/22	8/16/22	9/20/22	10/21/22	11/30/22	
Check Nurse Call System	10	0.05	0.5	6	1/27/22	2/23/22	3/30/22	4/27/22	5/26/22	6/29/22	7/27/22	8/30/22	9/30/22	10/31/22	11/30/22	
Test Exterior Door Alarms	1	1	1.0	12	1/27/22	2/23/22	3/30/22	4/27/22	5/26/22	6/29/22	7/27/22	8/30/22	9/30/22	10/31/22	11/30/22	
Eye Wash Stations Flushed Weekly	10	0.1	1.0	12	1/3,11,18,22	2/1,10,15,21	3/2,11,15	4/1,5,11	5/3,10,18	8/3,10,23,28	7/7,19,29	8/2,11,16,29	9/1/22	10/7/22	11/3/22	12,2,5
Generator #9	1	0.5	0.5	6	1/4,11,18,25	2/1,8,15,22	3/1,8,15,22,29	4/5,12,19,26	5/3,10,17,24,31	6/7,14,21,28	7/5,12,19,26	8/2,9,16,23,30	9-6,15/22	10/3	11/1,29/22	12/2,5
Checking Oxygen System	1	0.33	0.3	4	1/3/22	2/1/22	3/1/22	4/1/22	5/1/22	6/1/22	7/6/22	8/1/22	9/1/22	10/3/22	11/1/22	12/1/22
Checking Stretchers	4	0.25	1.0	12	1/24/22	2/21/22	3/11,22	4/19/22	5/4/22	6/8/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Standers	4	0.1	0.4	5	1/24/22	2/21/22	3/11/22	4/14/22	5/4/22	6/6/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Walkers/Gait Trainers	6	0.1	0.6	7	1/24/22	2/21/22	3/15/22	4/13/22	5/4/22	6/6/22	7/8/22	8/29/22	9/19/22	10/25/22	11/23/22	
Checking Bikes	3	0.33	1.0	12	1/6/22	2/2/22	3/15/22	4/18/22	5/19/22	6/6/22	7/7/22	8/17/22	9/13/22	9/7/22	11/4/22	12/9/22
Check Patient Lifts - Added 4/20/22					N/A	N/A	N/A	4/22/22	5/19/22	6/9/22	7/12/22	8/17/22	9/13/22	10/14/22	11/18/22	12/9/22
Glider Rockers	2	0.1	0.2	2	1/3/22	2/10/22	3/4/22	4/8/22	5/4/22	6/6/22	7/8/22	8/17/22	9/13/22	10/11/22	11/18/22	12/5/22
Test emergency lights and exit signs	1	1	1.0	12	1/3/22	2/1/22	3/1/22	4/1/22	5/1/22	6/2/22	7/6/22	8/2/22	9/1/22	10/3/22	11/1/22	12/1/22
Fire Extinguishers #4 & AED's	1	1	1.0	12	1/10/22	2/1/22	3/1/22	4/1/22	5/1/22	6/2/22	7/6/22	8/2/22	9/1/22	10/3/22	11/1/22	12/1/22
Vehicle Oil Levels	6	0.15	0.9	11	1/10/22	2/11/22	3/7/22	4/8/22	5/18/22	6/3/22	7/5/22	8/5/22	9/13/22	10/13/22	11/3/22	12/8/22
Vehicle Safety check (including tire pressure	6	0.3	1.8	22	1/6/22	2/11/22	3/7/22	4/8/22	5/18/22	6/6, 23	7/5/22	8/17/22	9/13/22	10/13/22	11/3/22	12/8/22
School Fire Drill	1	1	1.0	12	1/6/22	2/23/22	3/30/22	4/20/22	5/26/22	6/29/22	7/28/22	8/29/22	9/27/22	10/25/22	11/29/22	
Fire Drill evening/ overnight	1	1	1.0	8	1/26/22	2/2/22		4/12/22	5/5/22		7/28/22	8/30/22		10/31/22	11/30/22	
Check attics for ice damming (winter months)	1	0.5	0.5	3	1/25/22	2/2/22	3/3/22								N/A	12/14/22
Winter months check for frozen fire sprinklers	1	0.5	0.5	3	1/25/22	2/2/22	3/3/22								11/28/22	
Nutrition & Med Room Drain - pour 5 gal of hot water down	2	0.25	0.5	6	1/7/22	2/2/22	3/1/22	4/11/22	5/3/22	6/28/22	7/29/22	N/A	9/19/22	10/17/22	11/3/22	
Bathroom Sink Drains - Pour 5 gal of hot water	21	0.25	5.3	63	1/8/22	2/10/22	3/1/22	4/12/22	5/3/22	6/28/22	7/29/22	N/A	9/19/22	10/17/22	11/7/22	
Classroom Sink Drains - Pour 5 gal of hot water	6	0.25	1.5	18	1/8/22	2/10/22	3/2/22	4/13/22	5/3/22	6/28/22	7/29/22	N/A	9/7/22	10/11/22	11/7/22	
Oil Tank DES Monthly Checksheet	1	0.5	0.5	6	1/18/22	2/14/22	3/21/22	4/12/22	5/16/22	6/15/22	7/14/22	8/18/22	9/15/22	10/20/22	11/22/22	12/16/22
Sub-total			41.5	498												

Preventative Maintenance Program 2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Quarterly Procedures																
Check Toilet Seats, Hopper, Shower Heads	38	0.15	5.7	23	1/12/22			3/30/22			7/8/22			10/7/22		
Dinning room chairs	30	0.25	7.5	30	1/5/22			4/13/22			7/8/22			10/14/22		
Check all doors for proper gaps& latching	1	1	1.0	4	1/25/21			4/14/22			7/12/22			9/30/22		
Service hot water mixing valves	2	1.5	3.0	12	1/4/22			N/A			7/13/22			N/A		
GFI Receptacle Testing	29	0.1	2.9	12		1/26/21			5/2/22			7/8/22			11/2/22	
Check Electric High/Low Tables	3	0.2	0.6	2		1/26/21			5/4/22			8/18/22			11/11/22	
Replace water filters for building	3	0.2	0.6	2		2/2/22			5/4/22			8/31/22			11/22/22	
Check storage rooms for 18" sprinkler clearance	1	0.6	0.6	2		1/26/21			5/4/22			8/18/22			11/1/22	
Sprinkler system Quaterly Due			0.0	0		1/28/22			5/17/22			8/19/22			11/2/22	
Heat pump water heaters - clean filters	2	0.3	0.6	2		N/A			4/26/22			8/17/22			11/1/22	
Refrigerators - Clean coils & inspect gaskets	7	0.75	5.3	21			3/2/22			6/30/22			9/13/22			
Air Handlers AHU 1	1	1	1.0	4			2/28/22			6/1/22			9/6/22			12/6/22
Air Handlers AHU 2	1	1	1.0	4			2/28/22			6/1/22			9/6/22			12/6/22
Air Handlers AHU 3	1	1	1.0	4			3/2/22			6/6/22			9/8/22			12/8/22
Air Handlers AHU 4	1	1	1.0	4			3/14/22			6/6/22			9/8/22			12/7/22
Air Handlers AHU Kitchen	1	1	1.0	4			2/23/22			6/24/22			9/13/22			12/9/22
Fire Alarm System Quaterly			0.0	0			3/28/22			6/9/22			9/28/22			12/21/22
Inspect CyberMedix panel/components	1	1	1.0	4			3/28/22			6/28/22			9/15/22			
Fertilize lawns April, June, Sept	1	3	3.0	12				4/7/22		N/a			9/13/22			
Sub-total			20.1	80												

Preventative Maintenance Program

2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Semi-Annual Procedures																
Clean Floor Drains	19	0.5	9.5	19	1/7/22						7/18/22					
Clean multipurpose room range hood	1	0.5	0.5	1	1/4/22					6/28/22						
Clean Bathroom and all Other Exhaust Vents	65	0.5	32.5	65		1/27/21						N/A				
Kitchen Range Hood Fire Suppression			0.0	0		2/23/22						8/29/22				
Clean sediment trap Gym sink	1	1	1.0	2		1/26/22						8/15/22				
Clean sediment trap rehab maintenance sink	1	1	1.0	2		1/26/22						8/15/22				
Heat pump in Shop - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump in Server Room - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump 2nd Fl Office - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Heat pump in Family Overnight Rm - clean filters	1	1	0.5	1			3/3/22					8/17/22				
Washer/Dryers	6	1.5	9.0	18			3/31/22						9/26/22			
Checking and Cleaning Door Hardware	134	0.1	13.4	27			3/22/22						9/13/22			
CK sprinkler heads in/ext corrosion/ alinment	1	1	1.0	2			3/18/22						9/19/22			
Vehicle Lift Check/and tie down maintenance	3	1	3.0	6			3/7/22						9/14/22			
Check playground equipment for safety	1	2	2.0	4			3/31/22				7/7/22				11/2/22	
Clock login for battery life	1	0.5	0.5	1					5/2/22							12/8/22
Check, Clean, Lube Conf Rm Chairs	24	0.1	2.4	5				4/13/22						10/13/22		
Weeding of Mulch Areas and Playground	1	24	24.0	48				4/25/22	5/11/22	6/20/22	7/6/22	8/12/22	9/12/22			
Roof top Exaust ventilators	8	0.5	4.0	8				4/12/22						10/11/22		
Check Emergency supplies at church	1	1	1.0	2				4/12/22						10/11/22		
Replace/check batteries in flash lights & emergency tote	1	0.75	0.8	2				4/25/22						10/3/22		
Clean out play ground drain	1	0.75	0.8	2				4/4/21						10/7/22		
Clean dryer Vents - vendor			0.0	0				4/14/22						11/3/22		
Kitchen range hood cleaning			0.0	0				4/14/22						11/3/22		
Sub-total			45.5	91												

Preventative Maintenance Program

2022

Item Description	Units	Hr per Unit	Total Hr per Item	Annual Hours	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Annual Procedures																
Hire out Christmas tree light removal			0.0	0	N/A											
Service Patient lifts in Bedrooms & Bathrooms	20	0.5	10.0	10	1/25/21											
Test 25 percent of fire dampers yearly	1	20	20.0	20		2/30/21										
Fire Exttinguisher Annual Inspection			0.0	0		2/23/22										
Generator Minor Service			0.0	0				4/4/22								
Mulch all flower gardens	1	40	40.0	40				5/11/22	5/11/22							
Spring Yard clean up/ reseeding bare spots	1	80	80.0	80				4/4/5,7,11,12,13,14,15								
Inspection and testing of oxygen system			0.0	0					5/9/22							
Clean VFD's cooling fins (AHU1,2,3,4 & Boiler Pumps)	10	0.3	3.0	3					5/9/22							
Unwinterize play ground water supply	1	1.5	1.5	2					4/26/22							
Grub prevention	1	3	3.0	3						6/8						
Wash Condenser Coils AHU 1&2	2	2	4.0	4						8/2/22						
Wash Condenser Coils Chilled Water	1	2	2.0	2						8/24/22						
Wash Condenser Coils Kitchen MUA	1	1	1.0	1						8/24/22						
Wash Condenser Coils Kitchen Freezer	1	1	1.0	1						8/24/22						
Wash Condenser Coils Split systems/ Heat pumps	4	1	4.0	4						8/24/22						
Flush Water Heaters	4	1	4.0	4						8/24/22						
Generator Annual Load Test	1	1.5	1.5	2							7/5/22					
Emergency Light 90 minute test(July School Break)	79	0.08	6.3	6							7/8/22					
Clean and seal all cement patios and cement walks	1	12	12.0	12							N/A					
Trim Shrubs and Trees	1	60	60.0	60								8/11				
Clean Wall Heater Units	32	0.75	24.0	24								N/A				
Generator Major Service			0.0	0										10/14/22		
Clean Boiler #1	1	8	8.0	8									9/30/22			
Clean Boiler #2	1	8	8.0	8									9/22/22			
Change heating oil filters	4	0.25	1.0	1									9/1/22			
Fire Door Inspection	20	0.5	10.0	10									9/30/22			
Clean ceiling hung heaters	4	0.5	2.0	2									9/30/22			
Fall Yard Clean up	1	100	100.0	100									9/30/22	10/17/22	11/11/22	
Clean fin tube baseboard heaters	42	2	84.0	84										10/31/22		
Winterize play ground water supply	1	3	3.0	3										10/13/22		
Hire out Christmas tree light installation 14 strings			0.0	0											11/23/22	
Service Sprinkler Compressor (oil & air filter)	1	0.75	0.8	1												
Sub-total			127.5	128												

Cedarcrest Center
for Children with Disabilities
Facility Maintenance and Housekeeping Policy

POLICY: Cedarcrest Center for Children with Disabilities is committed to providing a safe and clean environment for the children served as well as their families, the staff, volunteers and visitors.

PROCEDURE:
Cedarcrest Center provides a team of environmental services and maintenance staff who are responsible to maintain the facility. A housekeeper is available through the majority of the children's waking hours. Housekeepers are assigned to clean specific parts of the building. Each staff member's schedule and work assignment is based on the children's schedule in the different program areas. The classrooms and entry areas are cleaned each morning, prior to the start of the school day and/or in the evening after the close of the school day. The residential area is cleaned after the children have gone to school and in the late evening. As rooms are cleaned, equipment in the room and area are also cleaned – including cribs, beds, stretchers and mechanical lifts. Wheelchairs are cleaned on a weekly schedule during the period when not in use. Support areas are cleaned when not in use. A specific protocol is in place for cleaning specific rooms and areas. Infection control procedures are integrated into all cleaning protocols. Staff are responsible to assure the children's safety at all times.

Specific members of the environmental services staff are also assigned to laundry, covering seven days a week. A system of gathering soiled linen and distributing clean linen has been established in keeping with infection control protocols.

Facility/maintenance staff are responsible for preventative maintenance and ongoing repairs. A routine maintenance program exists ensuring that preventative maintenance is completed on a regular schedule. In addition, all staff are responsible for reporting items in need of repair on forms designated for this purpose. Ongoing service contracts exist with vendors who are responsible for testing fire prevention and safety equipment, pest control, trash and recycling and medical waste. Inspections have proven that there is no lead paint or asbestos in the facility though if any were found, a vendor would be brought in to assure abatement. Facility/maintenance staff are responsible for maintaining the grounds including the lawns and gardens and for completing snow removal. A system of on-call coverage during winter months is in place. Any materials that may be considered hazardous are kept in secure areas including the garage. The attic, electrical rooms and mechanical rooms have secure keypad locks to assure safety. Medications are secured in locked rooms and/or a med cart with access only by nursing staff.

Outside contractors provide services for larger projects. They work under the guidance of the Facility Manager and must comply with the facility's "Contractor Rules".

The Director of Nursing Services and CEO are to be alerted to any significant facility concern that has not been resolved.

Approved: _____ 12/15/2022
Jay Hayston, President and CEO — Date

_____ 12-14-22
John Hamler, Facility Manager — Date

S:\Home Administration\POLICIES & PROCEDURES\Facility Maintenance Policy.doc 8/20/09; 11/09; 3/2011; 11/11; 11/12; 8/13; 6/17; 11/17; 8/2020

Neighborhood Relations Plan

Cedarcrest Center *for* Children with Disabilities

EMERGENCY COMMUNICATIONS PLAN

Policy: Transparent and accurate communications with stakeholders, especially the media, during *and after* a crisis contributes to a successful resolution of the incident, including influencing a positive evaluation by stakeholders and the public.

Definition: The Communications Plan is the primary tool to ensure employees follow communication protocols during an emergency in contacting stakeholders, the media, and others. The Communications Plan is the primary responsibility of the CEO and the Public Information Officer (PIO), who is typically the Director of Development and Communications. The media outreach plan is an essential part of the Communications Plan.

Procedure: During an emergency (or "incident"), the Communications plan should govern all communications within an organization and with external stakeholders, including the media. Communications are the responsibility of the Public Information Officer. The plan needs flexibility; an organization's management may only need a portion of the incident command structure, depending on the scope and severity of the emergency. Irrespective of the emergency's intensity, the organization's emergency response team remains in a communications mode, appropriate to the situation, for the duration of the incident, as well as after, to ensure transparency throughout the process.

The Public Information Officer may form an Emergency Communications Team (ECT) as needed as part of a broader Incident Management Team. Typically, The Emergency Communications Team will consist of the organization's leadership; with the CEO in the lead and designated "Commander." As with Incident Command Systems, any staff can fill any position on the Emergency Communications Team. The first goal of the Emergency Communications Team is to evaluate the scope and severity of the event, gather accurate information about it, and report back to the Commander and other Emergency Communications Team members. The Public Information Officer provides leadership and training to the Emergency Communications Team (to avoid limited or conflicting information about the event or its impact). "Facts" matter and may change several times as new information is available.

Limited or conflicting information about an event or its impact make training and practice in evaluation and communicating accurate details about the emergency critical for the Emergency Communications Team. Planning and practice should include different scenarios and a variety of magnitudes of events. When an emergency strikes, the organization's staff responders and spokesperson should know instinctively what to do and how to report "up the chain of command."

With the Emergency Communications Team in place, the Incident Commander and the Public Information Officer should quickly begin to develop communications, like a press statement or interview notes, that accurately address anticipated (or specific) questions from stakeholder groups, including the news media. In planning for emergencies, an important role for The Emergency Communication Team is to develop templates of materials to make outreach more efficient in the early stages of a crisis.

The purpose of this plan is to provide procedural directions to the Public Information Officer in the event of an emergency at or relating to Cedarcrest Center.

The Public Information Officer is the designee of the Unified Command (UC) and once authorized to do so, is responsible for the development and communication of information to the public, media and other agencies as determined.

The key functions of the Public Information Officer include but are not limited to:

- Communicating appropriate information for the media
- Communicating appropriate information to key internal and external stakeholders (listed below) and other key interested parties
- Advising UC of information dissemination plans, actions and status of media relations. Decides with UC times for media update statements
- Uploading information to social media and/or the Cedarcrest website as needed

THIS PLAN ENCOMPASSES TWO SECTIONS-POLICY/PROCEDURES AND APPENDICES:

- Step by step communications process for response to an emergency
- Appendices: Media outlet information and contact (appendix)
- Appendices: Resources for response (forms, press release template and language, media call log and media kit, check list)

TOOLS FOR COMMUNICATION: Internet access (laptop, mobile phone), email addresses, Media kit hard copy and electronic file

Management should not rely exclusively on one way to communicate (e.g. telephone) their statements and messages. There should always be options in a plan for using alternate communications channels, such as text, wired telephone, cell phone, Internet, etc.

The Emergency Communications Team must be cognizant of HIPPA compliance and employment law to ensure confidentiality of covered information. Staff are not to speculate or discuss an event, especially with the media.

CONSTITUENTS/AUDIENCE

- Staff
- Family Members
- Board and Advisory Council Members
- General Public
- Media
- Vendors/Company partners

Command
Control
Consistency
Collaboration
Coordination
Communication

COMMUNICATIONS PROCEDURES DURING INCIDENT:

- Situational Assessment: Scope and type of emergency at the time of occurrence and any updates of the status of the situation
- Determine status of those contacted at stage 1. Leadership Managers briefing by UC
- Create an incident description report. Include actions taken during the incident
- Establish key messages: Create a brief written overview of the situation, impact on the children, staff, facility, organization. Review this statement with UC and Senior leadership
- Establish schedule of communication with key stakeholders
- Communicate the facts through the statement to each stakeholder group using email or other communication tools. (phone calls, emails, media release, social media, website)
- Leadership managers disseminate information to staff teams, assigned stakeholder groups
- Set up media center
- Begin media log, documentation
- Leadership Managers assure clear and concise records of who has been reached with the Incident 1 report messaging
- Monitor Social Media and Media (web and T.V.)
- Media Conference as necessary (part of schedule; clearly communicated via announcements

MEDIA MANAGEMENT

- Direct media to location to convene. (identify on/off site-nearby-) Requires access to power, briefing area and work tables.
- Record all inquiries and responses
- Prepare the spokesperson for media interaction
- Determine timely media update/statements

COMMUNICATIONS PERFORMANCE EVALUATION

- Meet with Unified Command and Leadership Managers to discuss process, quality and timeliness of information, areas for improvement.

Communication Groups

Stakeholder Name	Role	Communication Tool
Employees	Human Resources (or Supervisor Designee)	When to Work Email-work or home Text (?)
Resident Families/Guardians Including Emergency contacts	Director of Social Services and designees	Phone
Board of Trustees	President/CEO	Phone, Email
Advisory Council	Director of Development & Communications	Email
Vendors (as needed)		
Public	Director of Development & Communications	Website, Facebook Media
City of Keene	President/CEO	Phone, Email
Insurance Company	Director of Finance	Phone, Email
State Licensing Agency	President/CEO	Phone, Email

Sample Operations Plan-communications

Activity	Hour 1	Hour 2	Hour 3	Hour 4
Unified Command team meeting	✓		✓	
Stakeholder-Employees	1.5 ✓			
Family Members/ Guardians/Emergency Contacts	1.5✓			
City of Keene	✓			
Board/AC		✓		
Public/Media		2.5✓		
Insurance Company		✓		
State licensing agency		✓		

To do's:

- Determine way to quickly record outgoing phone message and post
- Access to portable pc's
- Create media log
- Create Press kits (both hard copy and electronic)
- Create master reporting logs
- Acquire lap top and back up battery
- Create media banner backdrop
- Conduct communication drill(s)

Updated
08/28/20

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: KEENE CENTER GENESIS HEALTHCARE
Located at: 677 COURT STREET
KEENE NH 03431

To Operate: Nursing Home

This annual license certificate is effective under the conditions and for the period stated below:

License#: 03706
Effective Date: 06/01/2022 Expiration Date: 05/31/2023
Administrator: PATRICK LYONS
Medical Director: LESLIE PITTS,MD

Total Number of Beds: 106

EFFECTIVE 10/11/2022 PATRICK LYONS IS THE NEW ADMINISTRATOR

Chief Legal Officer

State of New Hampshire

Board of Examiners of Nursing Home Administrators

Authorized as

Nursing Home Administrator

Issued To

PATRICK WALTER LYONS, NHA

License Number: 3829
Current

Issue Date: 04/22/2019

Expiration Date: 12/31/2023

CERTIFICATE OF LIABILITY INSURANCE

7/31/2022 | DATE (MM/DD/YYYY) 07/23/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Lockton Companies 3280 Peachtree Road NE, Suite #250 Atlanta GA 30305 (404) 460-3600	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Lloyd's	
INSURED Trident Topco, LLC 1475385 and its subsidiaries See attached for Additional Insureds Names 930 Ridgebrook Road Sparks Glencoe MD 21152	INSURER B : Zurich American Insurance Company	16535
	INSURER C : Coverys Specialty Insurance Company	15686
	INSURER D : American Zurich Insurance Company	40142
	INSURER E :	
	INSURER F :	

COVERAGES MAIN **CERTIFICATE NUMBER:** 16852582 **REVISION NUMBER:** XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR [X] Deductible: $100,000 GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [ ] LOC OTHER:	N	N	W2FA31210101	07/31/2021	07/31/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$ 1,000,000 $ 200,000 $ 5,000 $ 1,000,000 $ 3,000,000 $ 3,000,000 $
B	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY	N	N	BAP 1861365-04	07/31/2021	07/31/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX $ XXXXXXX
C	[X] UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [X] CLAIMS-MADE DED RETENTION $	N	N	005MD000027078	07/31/2021	07/31/2022	EACH OCCURRENCE AGGREGATE $	$ 15,000,000 $ 15,000,000 $
D B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	N	WC 1861364 04 WC 0614814 04	07/31/2021 07/31/2021	07/31/2022 07/31/2022	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
A	Professional Liability	N	N	W2FA31210101	07/31/2021	07/31/2022	Per Claim $1,000,000 Per Aggregate $3,000,000 Deductible $100,000	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
For Providers in PA that participates in MCare, primary limits of $500K/$1.5M. MCare limits of $500K/$1.5K apply excess of primary limits. All VA providers subject to $2,500,000/$7,500,000 limits effective 7/1/21.

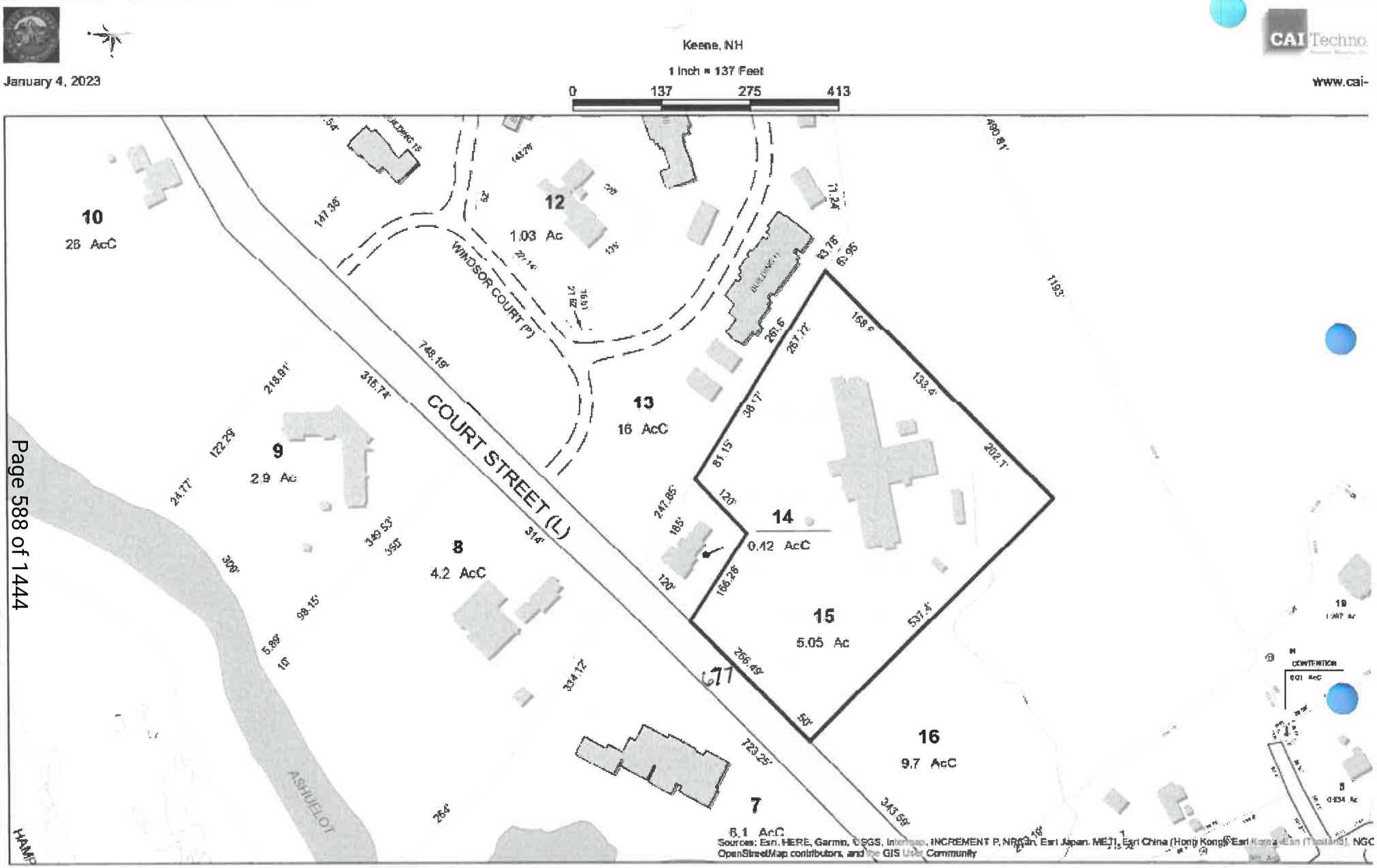
CERTIFICATE HOLDER

852582
KEENE CENTER
677 COURT STREET
KEENE NH 34311702

CANCELLATION See Attachments

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



Data shown on this map is provided for planning and informational purposes only. The municipality and CAI Technologies are not responsible for any use for other purposes or misuse or misrepresentation of this map.

677 COURT ST.

Location 677 COURT ST.

Acct# 228015000000000

Building Name

Appraisal $4,315,700

Building Count 1

Map/Lot # 228/ / 015/000 000/000

Owner CBYW KEENE PROPCO LLC

Assessment $4,315,700

PID 5666

Current Value

Appraisal			
Valuation Year	**Improvements**	**Land**	**Total**
2020	$3,910,600	$405,100	$4,315,700

Assessment			
Valuation Year	**Improvements**	**Land**	**Total**
2020	$3,910,600	$405,100	$4,315,700

Parcel Addreses

Additional Addresses
No Additional Addresses available for this parcel

Owner of Record

Owner CBYW KEENE PROPCO LLC
Co-Owner
Address 4500 DORR ST.
TOLEDO, OH 43615

Sale Price $23,029,100
Book & Page 2973/1191
Sale Date 12/23/2016

Ownership History

Ownership History			
Owner	**Sale Price**	**Book & Page**	**Sale Date**
CBYW KEENE PROPCO LLC	$23,029,100	2973/1191	12/23/2016
FC-GEN REAL ESTATE LLC	$6,000,000	2703/0424	07/22/2011
MCKERLEY HEALTH CARE	$0	0978/0806	12/01/1979

Building Information

Building 1 : Section 1

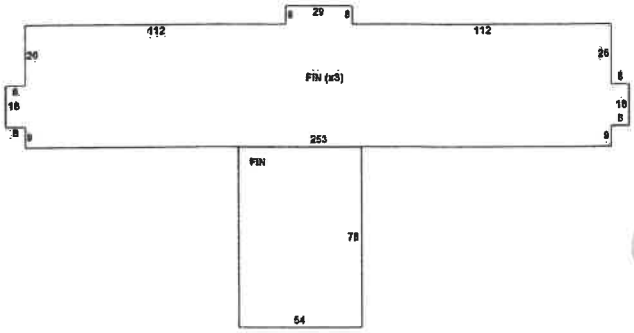
Year Built: 1980
g Area: 45,999
Replacement Cost: $5,913,171
Building Percent Good: 64
Replacement Cost Less Depreciation: $3,784,400

Building Attributes	
Field	**Description**
STYLE	Nursing Home
MODEL	Commercial
Grade	C
Stories:	3
Occupancy	1.00
Exterior Wall 1	Brick Veneer
Exterior Wall 2	
Roof Structure	Flat
Roof Cover	Membrane
Interior Wall 1	Drywall/Sheetrock
Interior Wall 2	Typical
ior Floor 1	Vinyl/Tile
Interior Floor 2	Carpet
Heating Fuel	Propane
Heating Type	Hot Water
Air Conditioning	Unit
Bldg Use	Commercial Improved
Bedrooms	
Full Baths	
Half Baths	
Extra Fixtures	
FBM Area	
Lighting	Above Normal
Frame	Fire Proof
Plumbing	Normal
Wall Height	10.00

Building Photo

(http://images.vgsi.com/photos2/KeeneNHPhotos/0007\262.0.jpg)

Building Layout



(ParcelSketch.ashx?pid=5666&bid=5666)

Building Sub-Areas (sq ft)			Legend
Code	**Description**	**Gross Area**	**Living Area**
FIN	Finished Area	45,999	45,999
		45,999	45,999

Extra Features

Extra Features				Legend
Code	**Description**	**Size**	**Assessed Value**	**Bldg #**
CNP	CANOPY	480.00 S.F.	$7,100	1

SPR1	SPRINKLERS-WET	45999.00 SF	$32,400	1
ELV1	ELEV PAS 2-3 STOPS	2.00 UNITS	$58,500	1
EE1	Enclosed Entry	88.00 S.F.	$1,100	1

La

Land Use

Use Code	201
Description	Commercial Improved
Zone	HD
Category	

Land Line Valuation

Size (Acres)	5.05
Depth	
Assessed Value	$405,100
Appraised Value	$405,100

Outbuildings

Outbuildings						Legend
Code	**Description**	**Sub Code**	**Sub Description**	**Size**	**Assessed Value**	**Bldg #**
LGT1	POLE & SINGLE LIGHT			1.00 UNITS	$300	1
FGR1	GARAGE- AVE			240.00 S.F.	$3,000	1
FN1	FENCE			480.00 S.F	$500	1
PAV1	PAVING- ASPHALT			21800.00 S.F.	$21,800	1
PAT1	PATIO- AVE			600.00 S.F.	$1,500	1

Valuation History

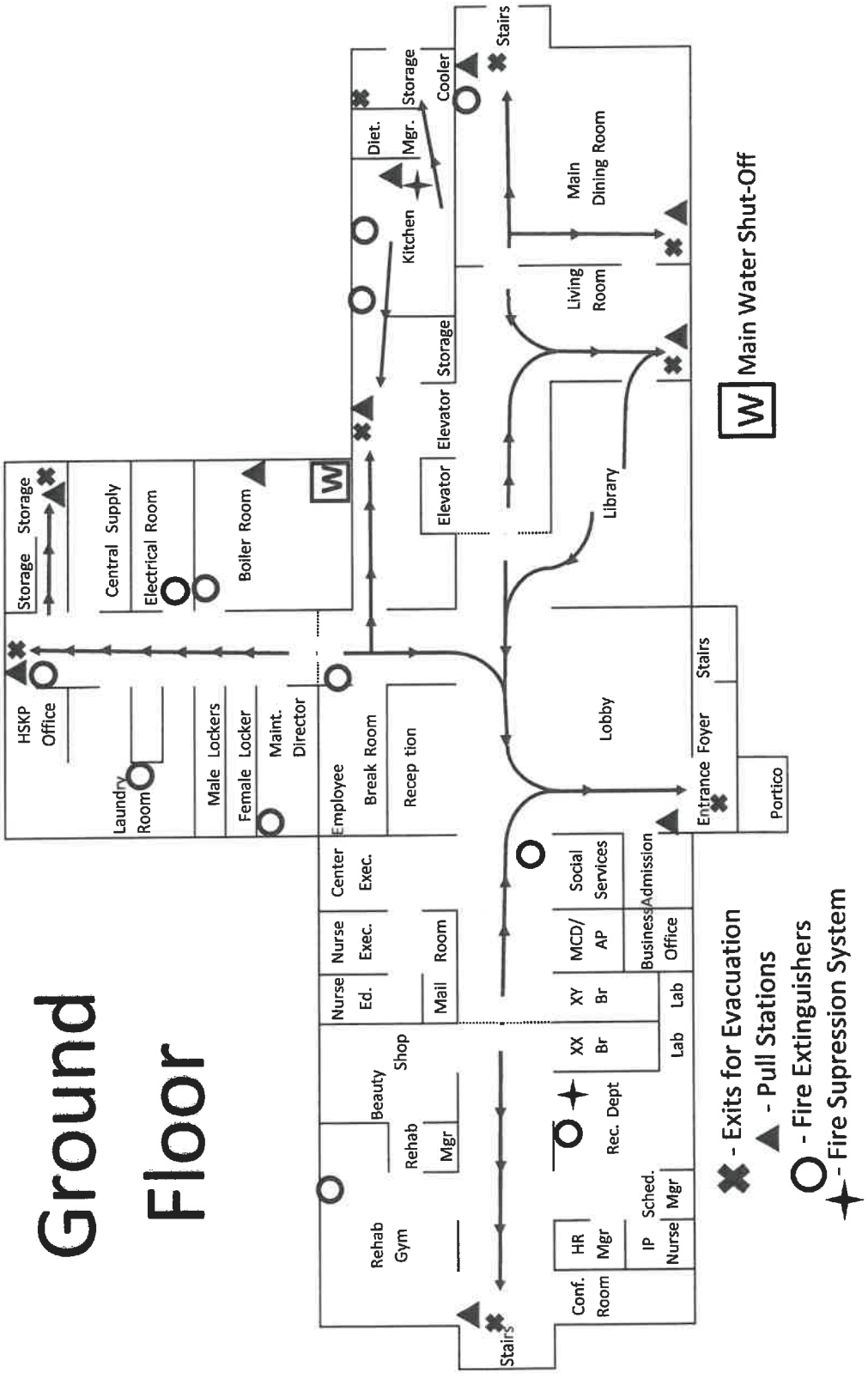
Appraisal			
Valuation Year	**Improvements**	**Land**	**Total**
2019	$3,910,600	$405,100	$4,315,700

Assessment			
Valuation Year	**Improvements**	**Land**	**Total**
2019	$3,910,600	$405,100	$4,315,700

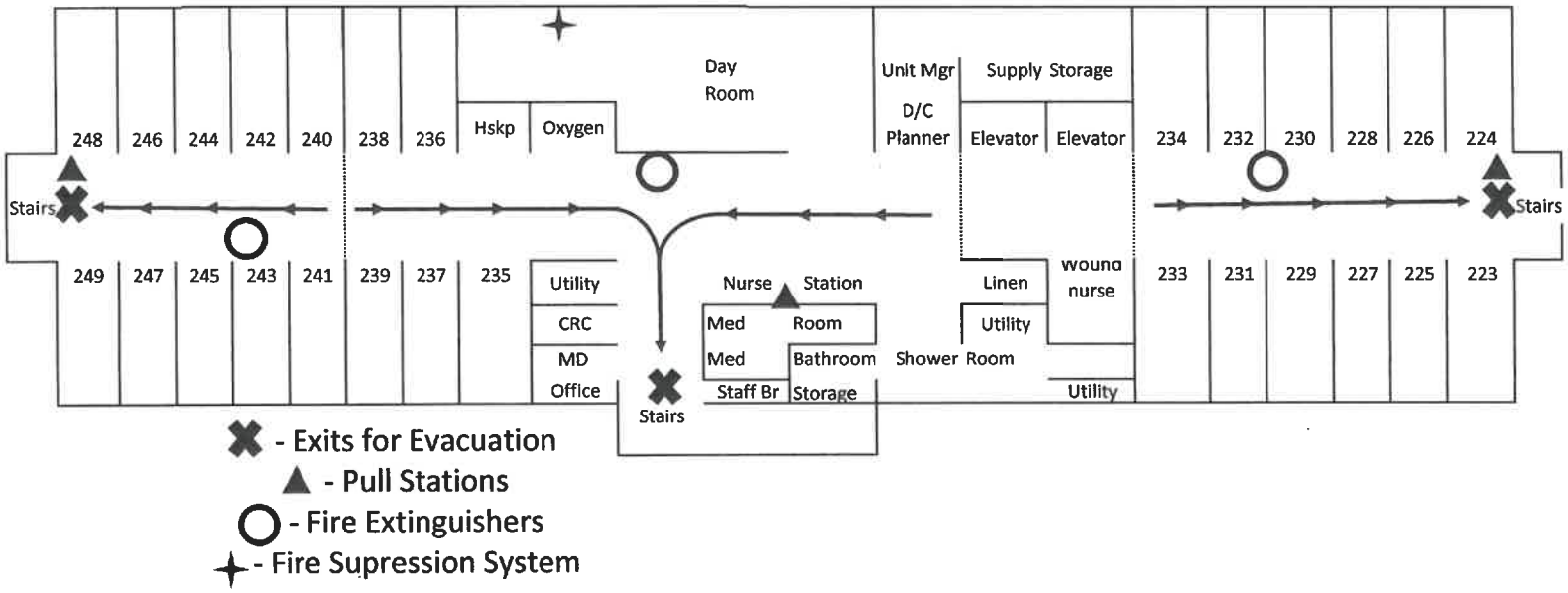
PROPERTY SITE INSPECTION

A. PROPERTY NAME:	**Genesis – Keene Center**	
Year built	1981	Acreage 9 acres
Renovations	Year: 2005-6	Cost: $400,000
:	Name: James R. Beeler, NHA	Experience: 17 yrs as NHA, 3.5 yrs. at Genesis
DON:	Name: Diana Wilson, RN	Experience: 8 yrs., 1 yr. as DON at Genesis

Occupancy	Total licensed beds: 106 Decertified beds: 0
Census	Total: 101 Mcare: 13 Mcaid: 64 Private: 20 Mgd: 2 Other: 2
Annual Survey	When: 7/27/06 Tags (G or higher) 0 Resurvey: 10/06 Cleared: 10/2/06
	If G - - description of incident
Building Condition And Composite	Exterior: Brick Interior: Drywall/steel/cement ER generator Yes Roof: Flat, tar #Floors Three FL/TX Hurricane Plan: Yes Curb appeal Good #Nurses Stations Two Sprinklers: Full coverage Signage Yes, new Parking: 52 spaces
Rates	Mcare: $395.00 Mcaid: $137.50 Private: $255.25 Semiprivate: $237.25 ALZ N.A.
Beds	Private: 2 Semi: 104 Triples: 0 Quads: 0
Special Units (care)	None Therapy: PT, OT, Speech
Amenities	Beauty: Yes Van: No Internet: Yes Cable: Yes Phones: New/yes Other:
Other	Unions: None Agency/Pool use: None Therapy (contract/inhouse)In-House Housekeeping/Laundry: (contract/inhouse) In-House
CAP EX	Physical Plant issues: Minor Kitchen: Good Laundry: Aging Boiler Good PTacs/HVacs Good, but aging Description of Work: Budgeted Work for 2007: Complete Level II renovations of resident rooms, tub room, nursing station, other areas ($600,000)
:rral System	Top 3 or 2 Hospitals and proximity: 1. Cheshire Medical Center (Keene, NH – one mile) 2. Dartmouth-Hitchcock Medical Center (Lebanon, NH – 40 miles) 3. Monadnock Community Hospital (Peterborough, NH – 25 miles)
Competitors	Top 3: 1. Harborside/Westwood (Keene, NH) WHY? Proximity Beds 85 SNF beds 2. Langdon Place/Sun Health (Keene, NH) WHY? ALF beds Beds 25 SNF, 75 ALF 3. Maplewood/Cheshire County Nursing Home WHY? County/size Beds 148 SNF, 20 ALF
Facility Demographics	Area Monadnock Region Socioeconomic Diversified
Major City	Keene, NH (pop. 15,000)


Ground Floor
HSKP Office
Storage
Storage
Central Supply
Electrical Room
Boiler Room
W
Laundry Room
Male Lockers
Female Locker
Maint. Director
Employee Break Room
Recep tion
Elevator
Elevator
Storage
Kitchen
Diet.
Mgr.
Storage
Cooler
Stairs
Main Dining Room
Living Room
Library
Lobby
Entrance Foyer
Stairs
Portico
Center Exec.
Nurse Exec.
Nurse Ed.
Mail Room
Social Services
MCD/ AP
Business Office
Admission
XY Br
XX Br
Lab
Lab
Rec. Dept
Beauty Shop
Rehab Mgr
Rehab Gym
Conf. Room
HR Mgr
IP Nurse
Sched. Mgr
Stairs
W Main Water Shut-Off
- Exits for Evacuation
- Pull Stations
- Fire Extinguishers
- Fire Supression System

2nd Floor



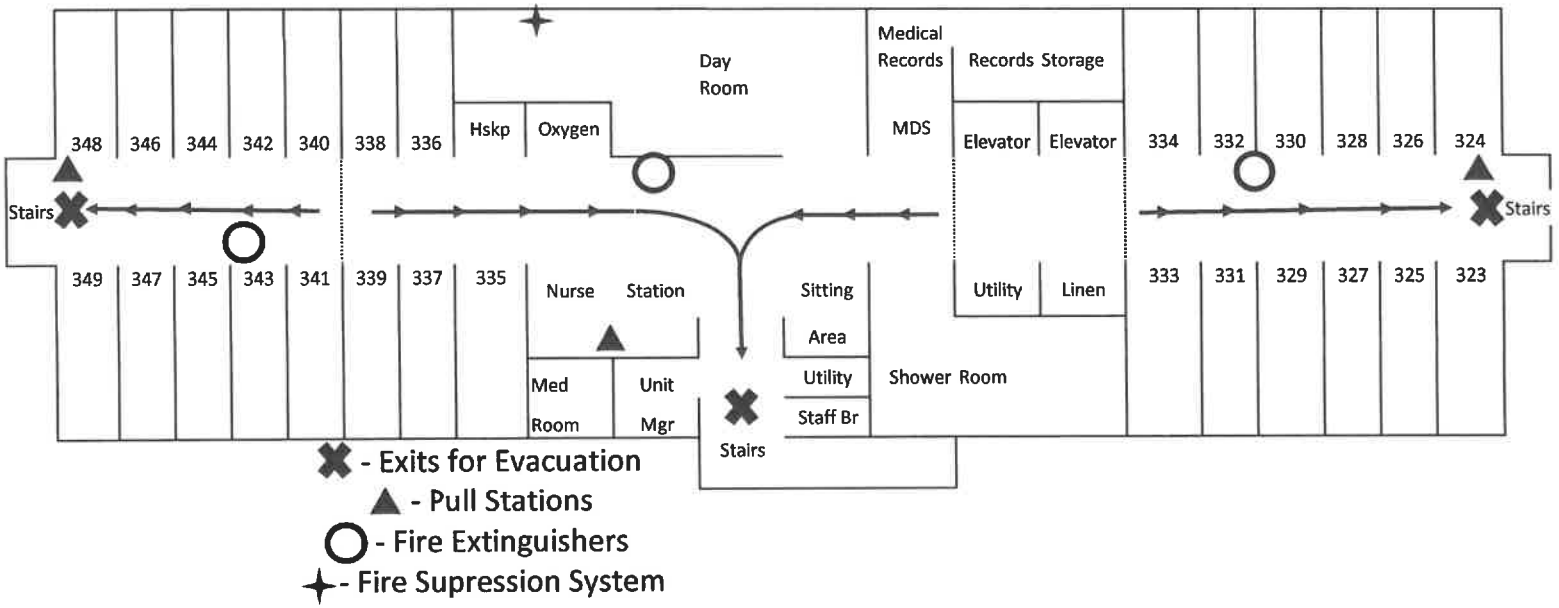
✖ - Exits for Evacuation

▲ - Pull Stations

○ - Fire Extinguishers

✦ - Fire Supression System

3rd Floor


Day Room
Medical Records
Records Storage
MDS
Hskp
Oxygen
Elevator
Elevator
348 346 344 342 340 338 336
334 332 330 328 326 324
Stairs
Stairs
349 347 345 343 341 339 337 335
333 331 329 327 325 323
Nurse Station
Sitting Area
Utility
Staff Br
Utility
Linen
Med Room
Unit Mgr
Shower Room
Stairs
- Exits for Evacuation
- Pull Stations
- Fire Extinguishers
- Fire Supression System

Genesis Keene Center Security Plan

Genesis Keene Center's security measures include lighting in all parking lots, surrounding the building, and at all entrances. We have a security camera for after hours which monitors the front door to the building and allows staff caring for residents on the second floor to monitor activity after hours. All exterior doors except the front main entrance remain locked, with the maintenance door to the rear of the building being controlled by a key code pad. The code is changed periodically as needed. The main front door to the building is locked daily at 6pm and unlocked at 6am.

All privileged patient information is kept according to HIPAA guidelines. This included both written and electronic medical records.

All staff, visitors, and vendors are screened 24/7 by an electronic device monitoring temperature, and a time stamped photo is electronically kept on file for everyone entering the facility.

All staff wear picture name badges identifying their role at all times when in the building. All staff sign agreements upon hire acknowledging weapons, drugs, or alcohol are not allowed on the property.

Keene Center employs a "Wander Guard" system. Residents who may wander and need to be kept safe are free to move around the building, however entrance into stairwells, elevators, or outside doors is prohibited and doors will lock when a Wander Guard device attached to a resident gets within 24 inches of one of these areas.

Submitted with this Security Plan is the Keene Center Emergency Preparedness Plan.

MENU

Tasks in Use

Print List

Search for

All task types

Weekly

Category	Title	Assigned To			
Generators	**Exercise generator (with no load), perform routine checks, create entry in logbook.**		Regulatory	Logs	Maintenance
Resident Wandering System	**Check operation of door monitors and patient wandering system.**		Regulatory	Logs	Maintenance
Water Systems	**Inspect eye wash stations.**		Regulatory		Maintenance
Water Temps	**Test and log the hot water temperatures.**		Regulatory	Logs	Maintenance
Laundry Inspection	**Check dryer**		Maintenance		
Oxygen Concentrators	**In-House Maintenance**		Maintenance		
Resident Lifts	**Weekly Lift Rounds/Clinical Check-In**		Maintenance		

Monthly

Category	Title	Assigned To			
Defibrillators (AED)	**In-House Maintenance**		Regulatory		Maintenance
Elevators	**Firefighters' Emergency Operation Testing**		Regulatory		Maintenance
Emergency and Exit Lighting	**Conduct a 30 second functional test.**		Regulatory	Logs	Maintenance
Fire Extinguishers	**Check and initial fire extinguishers**		Regulatory		Maintenance
Generators	**Test generator under load, perform routine checks, create entry in logbook - Diesel**		Regulatory	Logs	Maintenance
Kitchen Exhaust Hoods	**Owner's Inspection - Quick Check**		Regulatory		Maintenance
Magnetic Exit Locks	**Test operation of doors and locks.**		Regulatory	Logs	Maintenance
Resident Lifts	**Inspect mobile lifts.**		Regulatory		Maintenance
Exhaust Fans	**Inspect exhaust fans for proper operation and clean if necessary**		Maintenance		
Facility Inspection	**Inspect kitchen small appliances**		Maintenance		
Resident Scales	**Check calibration of resident scales**		Maintenance		

Every 2 Months

Category	Title	Assigned To	
Grease Traps	**Inspect grease trap** Next due: February 2023		Maintenance

Every 3 Months

Category	Title	Assigned To				
Dryer Vent	**Complete In-House System Cleaning** Next due: January 2023		Regulatory	Maintenance		
Emergency and Exit Lighting	**Conduct a 90 minute operational test** Next due: February 2023		Regulatory	Logs	Maintenance	
Fire Drills	**Perform a fire drill during 1st shift- (Upload copy of drill with signature sheet to TELS when complete)** Next due: March 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 2nd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: January 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 3rd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: February 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Sprinkler System	**Have fire sprinkler system certified/inspected.** Next due: January 2023		Regulatory	Requires Doc	Maintenance	
Ice Machines	**Check filters (if present), clean coils, sanitize interior, delime as necessary** Next due: February 2023		Maintenance			
Rooftop Inspections	**Regular maintenance and safety inspection.** Next due: January 2023		Maintenance			

Every 6 Months

Category	Title	Assigned To			
Disaster Drills	**Conduct a Facility-based exercise (Disaster Drill)** Next due: June 2023		Regulatory	Requires Doc	Maintenance
Emergency Preparedness Drills	**Conduct elopement drill (Missing Resident Drill)**		Regulatory	Requires Doc	Logs	Maintenance

	Next due: February 2023				
Facility Safety	**Life Safety Documentation Audit** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Fire Alarm Test	**Have fire alarm system inspected by a contractor** Next due: April 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have Fire Suppression System inspected by outside contractor** Next due: March 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have hood cleaned by a certified contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Nurse Call System Test	**Conduct a test of the nurse call system.** Next due: March 2023		Regulatory	Logs	Maintenance

Every 12 Months

Category	Title	Assigned To			
Beds - Electric	**Bed Safety Audit 001-040 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 041-080 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 081-120 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Electrical	**Test and Document the Electrical Receptacle Inspections** Next due: September 2023		Regulatory	Requires Doc	Maintenance
Elevators	**Schedule certification and ensure certificate in unit is up-to-date** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Complete Risk Assessment - Click Instructions for the Assessment Tool and Procedure** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Inspect all facility window openings*** Next due: April 2023		Regulatory	Logs	Maintenance
Fire Extinguishers	**Have fire extinguishers certified.** Next due: July 2023		Regulatory	Requires Doc	Maintenance
Fire and Smoke Doors	**Inspection - Latch and Gap** Next due: June 2023		Regulatory	Logs	Maintenance
Generators	**Have generator serviced by contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Water Systems	**Complete training on Water Management Plan**		Regulatory	Maintenance	

	Review – Click on instructions Next due: December 2023	
Water Systems	**Water Management Plan Review - Upload your plan to TELS** Next due: November 2023	Regulatory Requires Doc Maintenance
HVAC - Air Handlers	**Inspect air filter, verify operation** Next due: October 2023	Maintenance
HVAC: Condensing Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
HVAC: Package Units	**Clean / change air filter and verify unit operation** Next due: October 2023	Maintenance
HVAC: Package Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
Resident Lifts	**Genesis Safe Handling Center Assessment - Lift Program** Next due: August 2023	Logs Maintenance
Safety Committee	**Conduct April Safety Committee Meeting** Next due: April 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct August Safety Committee Meeting** Next due: August 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct December Safety Committee Meeting** Next due: December 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct February Safety Committee Meeting** Next due: February 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct January Safety Committee Meeting** Next due: January 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct July Safety Committee Meeting** Next due: July 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct June Safety Committee Meeting** Next due: June 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct March Safety Committee Meeting** Next due: March 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct May Safety Committee Meeting** Next due: May 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct November Safety Committee Meeting** Next due: November 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct October Safety Committee Meeting** Next due: October 2023	Loss Prevention Requires Doc Maintenance

Safety Committee	**Conduct September Safety Committee Meeting** Next due: September 2023	Loss Prevention	Requires Doc	Maintenance	
TELS Masters Training	**TELS Offers Free Trainings - See instructions for further assistance** Next due: November 2023	Maintenance			
Vital Signs Monitors	**Unit Recalibration** Next due: August 2023	Maintenance			

Every 36 Months

Category	Title	Assigned To			
Emergency Generators	**Conduct a 4 hour Load test** Next due: November 2025		Regulatory	Requires Doc	Maintenance

Every 48 Months

Category	Title	Assigned To			
Facility Safety	**Inspection and Testing - Fire Dampers and Smoke Dampers** Next due: November 2025		Regulatory	Requires Doc	Maintenance

Genesis Healthcare Annual Mandatory Training

- Module 1 - Understanding the World of Dementia: The Person and the Disease
- Module 2 - Being with a Person with Dementia: Listening and Speaking
- Module 3 - Being with a Person with Dementia: Actions and Reactions
- Active Shooter in Long Term Care
- Residents' Bill of Rights & Staffs' Responsibilities
- Electrical Safety & Work-Related Practices 1
- Electrical Safety & Work-Related Practices 2
- Hazardous Communication
- Fire Safety
- Bloodborne Pathogens - BBP & PPE
- Elopement
- Access to Exposure & Medical Records
- Tuberculosis
- Infection Prevention and Control Overview
- Musculoskeletal Disorder Prevention
- Abuse Prohibition
- Respiratory Protection Training - Training on the use of Respirators
- Welcoming Program Centers Completion
- 2022/2023 Code of Conduct - All Staff
- GHC Emergency Preparedness Plan

Nurse Aide (CNA/LNA) Orientation Checklist

Employee Name:	Orientation Start Date"
Mentor Name:	Shift:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire.
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____

Date Checklist Completed: _____

CENTER TOUR & GENERAL INFORMATION	
Office Locations:	
• Scheduler • Director of Nursing • Center Administrator	• Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) • Unit Manager, Nursing Supervisor • Human Resources
Nursing Unit(s)	
Assigned Unit Introduction/Tour	
Bed Location Identification (door/window)	
Location of AED/crash cart ***By DAY 1 Orientation***	
Telephones: • Locations • Use & Paging Demonstration • Phone Directory	
Wandering System: • Location(s) • Demonstration & Code • Location of Elopement Book • Center Elopement Protocol	
Emergency Door Alarms (Codes)	
Location of Personal Protective Equipment (PPE)	
POLICY & PROCEDURE HIGHLIGHTS	
Communication	
Nurse to CNA Shift Report STOP AND WATCH (Early Warning Tool) CNA Assignment/Tasks	VItal Signs Weights Kardex
Safe Resident Handling	

Nurse Aide (CNA/LNA) Orientation Checklist

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Demonstration; *Specific to Center Type*
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Resident with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Resident Off the Floor S/P Fall**

Bed Rail Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Nurse evaluates need for bed rail
- If the bed rail is NOT indicated, the rail will be removed or secured in the DOWN position by maintenance
- Kardex indicating the use of the bed rail
- Immediately report any bed rail incidents

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based (Isolation) Precautions
- Respirator Fit Testing
- COVID protocols

Skin Health & Pressure Injury Prevention

- **Pressure Injury (Ulcer/Bed Sore) Prevention is a PRIORITY!**
- **Prompt Identification, Reporting and Interventions are Essential!**
  - Promptly report skin changes, skin concerns, or new/worsening wounds to the nurse supervisor
  - Promptly report interventions that are not working as intended or are missing &/or need replacement (e.g., heel lift boots, specialty surfaces)
  - Seek direction before using/applying any new intervention (e.g., heel lift boot)
- Refer to Kardex for:
  - Heel positioning devices/techniques/schedules
  - Turning/Repositioning devices/techniques/schedule
  - Skin care/incontinence care products & strategies
  - Seating devices (e.g. cushions, chairs)
  - Other individualized pressure injury prevention efforts

Elopement

- Resident Leaves the Premises Without Authorization
- Wandering Device use
- Report elopement behaviors to Nurse

Falls Management

- Center Process for Communicating High Risk Residents
- **Immediately Report Any Fall**
- Licensed Nurse evaluation required prior to moving the resident who had a fall
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a patient Off the Floor after Fall**

Nurse Aide (CNA/LNA) Orientation Checklist

Nutrition/Hydration:

- Thick Liquid (Dysphagia)/NPO Status Communication
- Diet Orders/Consistency
-
- Validation of Diet Order Prior to Serving

Current Center Survey Plan of Correction

- Review, if applicable

ADL Documentation ***(**Utilize SmartZone Application within PointClickCare as indicated)***

Complete Point of Care (POC) course - ***By Day 1 SmartZone****

- Review Center's process for documentation
- Review tub/shower schedule & documentation

Restorative Nursing

- Identifying Patients with Restorative Nursing Program (Kardex)
- Review Center's process for documentation (paper or electronic)

Patient Care Needs

- Inventory of Effects
- Patient Supplies (e.g. Basin, Urinal, etc.)
- Assistive Devices (eg. Walker, Wheelchair)
- Incontinence Products
- Special Care Needs: Tracheostomy, Dialysis, Ventilator, Infusion Devices, Enteral Feeding Devices, Oxygen/Respiratory Therapy

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Licensed Nurse (RN/LPN/LVN) Orientation Checklist

Employee Name:	Orientation Start Date:
Employee Job Title:	Mentor Name/Title:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire..
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____ Date Completed: _____

CENTER TOUR & GENERAL INFORMATION

Office Locations:
- Scheduler
- Director of Nursing
- Center Administrator
- Human Resources
- Assistant Director of Nursing (ADON)/ Nurse Practice Educator (NPE)
- Unit Manager, Nursing Supervisor
- Central Supply
- Other

Nursing Unit(s) (e.g., names of units, locations, secured/unsecured, etc.)

Assigned Unit Introduction/Tour (e.g., medication room, utility rooms, kitchenette, etc.)

Bed Location Identification (door/window)

Location of AED/crash cart ***By DAY 1 Orientation***

Location of Omnicell and/or Emergency Drug Kit

Telephones:
- Phone Directory(s)
- Use & Paging Demonstration

Wandering System:
- Location(s)
- Demonstration & Entry/Reset Code
- Location of Elopement Book
- Center Elopement Protocol

Emergency Door Alarms (Codes)

Location of Personal Protective Equipment (PPE) / Clinical Supplies

POLICY & PROCEDURE HIGHLIGHTS

Cardiac &/or Respiratory Arrest – *Must Be Completed By DAY 1 Orientation*

- Location of Code Status Orders
- Center Process for Emergencies / Code

Communication

Nurse to Nurse - Nursing Shift Report
Nurse to CNA Shift Report
STOP AND WATCH/Early Warning Tool
CNA Assignment/Tasks
24 Hour Report
Kardex
Provider Notifications
Patient/Patient Representative Notifications

Incident & Accident Reporting

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

- PCC Risk Management Portal
- Event Completed for Any Patient Accident/Incident or Grievance/Concern
- Nursing Supervisor Notified of Any Accident/Incident
- Physician/Patient Representative Notification

Safe Resident Handling

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Transfer Reposition UDA
- Lift Demonstration; Specific to Center Equipment Brand
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Patient with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Patient Off the Floor S/P Fall**

Bed Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Bed Rail Evaluation (UDA): completed upon admission, readmission, quarterly, change in bed/mattress, & change in condition
- If the bed rail is NOT indicated, the rail must be removed or secured in the DOWN position by maintenance
- Requirements for bed rail use:
  - Utilize Bed Action Safety Grid to identify & minimize any zones of entrapment
  - Consent & physician order
  - Care Plan & Kardex indicating use of the bed rail

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based Precautions
- Antibiotic Stewardship
- Immunizations
- Respirator Fit Testing
- COVID Screening
- Cleaning and Disinfection
- Outbreak Management

Skin Health & Pressure Injury Prevention

- **Pressure Injury Prevention is a PRIORITY**
- **Skin Check** UDA admission & weekly
- **Braden** (or Norton Plus): admission, weekly x 4, quarterly, & with change in condition
- At Risk & Actual **CP & Kardex** initiated upon admission (no later than 24 hours after admission)
- Review **Guidelines** (Surfaces, Skin Care, Turning/positioning, Heels, Skin, Wound)
- Weekly Wound Evaluation (SWIFT)
- **Prompt Identification, Reporting & Interventions Essential**
- **Promptly** observe & respond to any reports of skin/ wound concerns by CNA or others
- **New Wound:** complete Change in Condition UDA, wound evaluation, notify provider/RP, update care plan, & obtain treatment order
- **PCC Risk Portal:** Completed for all new IHA pressure injuries

Elopement

- Patient Leaves the Premises Without Authorization
- Wandering Device Placement & Function Documentation Required
- PCC Risk Management Portal , Physician, Patient Representative, Administrator/Director of Nursing Notification, Preventive Intervention(s), Care Plan Updates

Falls Management

- Process for Communicating High Risk Patients **Immediately Report Any Fall**
- Nurse Evaluation Prior to Moving the Patient
- **Total Lift & (2) Staff Must Use Lift to upright Patient Off the Floor S/P Fall**
- Complete PCC Risk Management Portal for All Falls; Physician & Patient Representative Notification, Preventive Intervention(s), Care Plan updates
- **Neuro checks for ANY Fall Unwitnessed by Staff or Head/Facial Injury**

Neuro Checks Documented on Paper Flow Sheet

- Every 15 minutes x 2 hours, then
- Every 30 minutes x 2 hours, then
- Every 60 minutes x 4 hours, then
- Every 8 hours until least 72 hours has elapsed

Nutrition / Hydration

- Dysphagia/NPO Status communication process
- Diet Orders/Consistency
- Enteral Feeding: Administration / Pump
- *Diet Order Communication Form*
- Validation of Diet Order Prior to Serving

Controlled Substance Documentation

- New Orders for Schedule II-V Controlled Substances
- Delivery and Receipt of Controlled Substances
- Inventory of Controlled Substances
- Routine Reconciliation (e.g. Shift Count) of Controlled Substances
- Accessing Emergency Medications from eKit/Automated Medication Dispensing System (e.g. Omnicell)
- Disposal/Destruction of Expired or Discontinued Controlled Substances
- **Loss/Theft of Controlled Substances: Any Discrepancy Must Be Reported Immediately to Nursing Supervisor**

Notification of Patient Change in Condition

- eInteract Change in Condition UDA
- Print SBAR from Change in Condition UDA
- Complete PCC Risk Management Portal, if applicable
- Physician/Patient Representative Notification
- Changes in Orders or Treatment
- Transfer or Discharge
- STOP AND WATCH
- Clinical Dashboard Monitoring

Medication Administration *(**Utilize SmartZone Application within PointClickCare as indicated)*

Complete eMAR Order Supply Management course - ***By Day 1 SmartZone*****
Complete EMAR course - ***By Day 1 SmartZone*****
Complete Pharmacy Orders course - ***By Day 1 SmartZone*****

- Omnicell Access
- Medication Error Requires Physician & Patient Representative Notification
- Electronic Order Entry
- Medication Receiving
- EMAR Documentation
- 24 Hr. Chart Check
- Monthly Order Review
- Medication Not Available, Check Omnicell, Pharmacy & Physician Notification
- Medication Refusal Requires Physician Notification
- Behavior Monitoring Documentation
- Medication Disposal
- Omniview Medication Returning
- Omniview Resident Discharge
- Omniview Resident Leave of Absence

PointClickCare (PCC) *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Assessments Management course - ***By Day 1 SmartZone*****
- Assessment and Progress Notes
- Document Manager
- UDA Schedule
- Dashboard
- Care Plan(s)
- Lab and Radiology

Admissions / Discharges *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Resident Entry course - ***By Day 1 SmartZone*****
- Nursing Documentation UDA Upon Admission
- Bed Rail Evaluation UDA
- Skin Check UDA
- Discharge Documentation UDA and Discharge Transition Plan
- Omniview Patient Discharge
- Baseline Care Plan

Point of Care Testing

- Finger Stick Glucose, Fecal Occult Blood, Hemoglobin, INR, Influenza, SARS antigen testing performed according to manufacturer instructions.

Infusion Therapy

- **Nurses Who Lack Infusion Experience Must Complete an Approved Infusion Education Program Prior to Caring for Patient with Infusion Devices**
- **RN ONLY UPON HIRE:** May perform assessment and management of Short Peripheral Catheters and Midline/PICCs
- IV Pumps

Respiratory Management

- Oxygen Administration.
- Location of Oxygen/Respiratory Equipment.
- CPAP / BiPAP / Tracheostomy Care
- Respiratory Equipment: Supply Cleaning, Disinfection, Labeling/Replacement
- Aerosol Generating Procedures

Current Center Survey Plan of Correction

Review, if applicable

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Keene Center Health and Safety Plan

Please see attached Infection Control Policies and Procedures

1. Patient Placement in Transmission Based Precautions
2. Discontinuing Transmission Based Precautions
3. Droplet Precautions
4. Special Droplet and Contact Precautions
5. Standard Precautions
6. Respiratory and Hygiene/Cough Etiquette
7. Contact Precautions

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC306 Patient Placement in Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 2

POLICY

Transmission Based Precautions (Airborne Infection Isolation (AII), Contact, Droplet) will be implemented when indicated. The precautions should be the least restrictive possible for the patient. Personal Protective Equipment (PPE) will be readily available near the entrance to the patient's room.

Transmission Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission, more than one Transmission Based Precautions category may be required. Whether used singly or in combination, they must always be used in addition to Standard Precautions. The type of PPE and precautions used depends on the potential for exposure, route of transmission, and infectious organism/pathogen (or clinical syndrome if an organism is not yet identified).

PURPOSE

To prevent the transmission of infectious disease.

PROCESS

1. Notify the attending physician or Medical Director (in the absence of the attending physician) and the Infection Preventionist if there is reason to believe that an individual has an infectious disease.

2. Initiate Precautions (Standard plus Airborne Infection Isolation, Contact, or Droplet) as indicated. May utilize *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions* to guide choice of precautions. Post "STOP. Please see nurse before entering room." sign on door.

    2.1 Empirically initiate Transmission Based Precautions based on signs and symptoms that are consistent with a communicable disease.

        2.1.1 If laboratory tests confirm diagnosis, continue with precautions indicated.

        2.1.2 If test(s) results are negative, adjust or discontinue precautions as indicated.

3. Notify patient, family/health care decision maker, and all departments of precautions.

4. Instruct patient and visitors regarding Precautions and use of personal protective equipment (PPE) as indicated.

4.1 Patients on Transmission Based Precautions should remain in room except for medically necessary care.

5. Document in medical record:

5.1 Notification of physician;

5.2 Initiation of Precautions;

5.3 Notification of patient, family/health care decision maker, and departments;

5.4 Instructions to patient and visitors.

Refer to:

- *Airborne Infection Isolation Precautions policy*
- *Contact Precautions policy*
- *Droplet Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC302 Discontinuing Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 1

POLICY

Transmission Based Precautions will be discontinued when it has been determined that the risk of transmission of disease is over.

PURPOSE

To discontinue precautions when indicated.

PROCESS

1. Refer to *"Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions"* to evaluate the appropriateness of discontinuing Precautions.

2. When appropriate duration criteria has been met, consult with Infection Preventionist or Director of Nursing to consider the discontinuation of Precautions.

3. When discontinuation of Transmission Based Precautions is appropriate:

   3.1 Notify all departments;

   3.2 Instruct patient and visitors that Precautions are no longer needed;

   3.3 Return patient to his/her room if a move to a separate room occurred, if indicated;

   3.4 Inform the Environmental Services Department to perform discharge/turnover cleaning;

   3.5 Remove "STOP" signs once discharge/turnover cleaning is complete.

4. Document:

   4.1 Discontinuation of Precautions;

   4.2 Instruction of patient and visitors;

   4.3 Room change, if indicated.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC303 Droplet Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 3

POLICY

Droplet Precautions will be followed in addition to Standard Precautions when caring for a patient who has known or suspected infection by microorganisms that are transmitted by droplets (large particle droplets, larger than 5 µm in size); for example, influenza. State regulations will be followed when applicable.

PURPOSE

To prevent transmission of infectious agents by droplets.

PROCESS

1. Place patient in private room, if possible.

    1.1 Patient may cohort with an individual who has the same organism.

        1.1.1 Avoid placing immunocompromised patients with patients who are on Droplet Precautions.

    1.2 When neither private room nor cohorting is possible, patient may share a room with a roommate with limited risk factors. Maintain spatial separation of at least three feet between the infected individual and others, including other patients and visitors.

    1.3 Draw curtain between patient beds.

    1.4 Special air handling is not necessary.

    1.5 May keep door to room open.

2. Post a "STOP. Please see nurse before entering room." sign on door.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and use of personal protective equipment (PPE).

4. Staff will put on surgical mask upon entry to room of infected individual. Handle items contaminated with respiratory secretions (e.g., tissues) with gloves.

    4.1 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles/face shield should be worn.

4.2 Change personal protective equipment and perform hand hygiene between contact with patients in the same room.

4.3 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.

4.4 Before exiting room, remove and bag PPE and wash hands.

4.4.1 Remove bagged PPE from room and discard in soiled utility.

5. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/containment of infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

5.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

5.2 For patients being transported outside of the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

6. Dedicate personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

6.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *COVID-19 policy*

- *Respiratory Hygiene/Cough Etiquette procedure*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC310 Special Droplet and Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	12/07/22
REVIEW DATE:	
REVISION DATE:	
PAGE:	1 of 2

POLICY

Special Droplet and Contact Precautions will be used to prevent transmission of infectious organisms that can be spread via pathogens that spread through the air or by direct person-to-person respiratory transmission. An example of a disease requiring special droplet and contact precautions is SARS-CoV-2. State regulations will be followed, when applicable.

PURPOSE

To prevent the spread of infectious agents.

PROCESS

1. Display Special Droplet/Contact Precautions sign outside the patient/resident (hereinafter "patient") room on the door.

2. Keep the patient's door to the room closed unless doing so would endanger the patient.

3. Instruct patients and visitors regarding the precautions in use and the required personal protective equipment (PPE).

    3.1 Have the patient wear a surgical mask anytime staff is in the room.

4. Wear proper PPE including respiratory protection (N95 respirator), eye protection, gown, and gloves prior to entering the room of those who require Special Droplet and Contact Precautions.

    4.1 Before exiting the room, remove gown and gloves and bag PPE and perform hand hygiene. Once outside of the room, remove and clean eye protection. Discard N95, perform hand hygiene, and don a new mask.

    4.2 Remove bagged PPE from the room and discard it in the soiled utility.

5. Limit transport of patients to essential medical purposes. If transport out of the room is necessary:

    5.1 Place a surgical mask on the patient and instruct them to observe respiratory hygiene and cough etiquette;

    5.2 Transport personnel need to wear a surgical facemask during transport if the patient is masked.

5.2.1 If the patient is not masked, transport personnel need to wear an N-95 respirator;

5.3 Notify the receiving location of precautions.

6. Dedicate use of personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment, when available.

7. If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7.1 Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. The duration of these transmission-based precautions will be determined per Centers for Disease Prevention & Control (CDC) guidance for discontinuing precautions for persons with COVID.

Refer to:

- *COVID-19 policy*
- *Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *Safety and Health Policies and Procedures:*
  - *Personal Protective Equipment policy*
  - *Respiratory Protection Program policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC307 Standard Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/21
PAGE:	1 of 4

POLICY

All blood and body fluids are considered potentially infectious and, therefore, Standard Precautions are always used when providing patient/resident (hereinafter "patient") care.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Perform hand hygiene per *Hand Hygiene* policy.
2. Wear gloves whenever exposure to any of the following is planned or anticipated:
   - 2.1 Blood, blood products, and other potentially infectious materials (all body fluids including urine, feces, saliva) except sweat;
   - 2.2 Mucous membranes;
   - 2.3 Wound drainage;
   - 2.4 Drainage tubes;
   - 2.5 Non-intact skin;
   - 2.6 Potentially contaminated intact skin (i.e., patient incontinent of stool or urine).
3. Change gloves:
   - 3.1 Between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms;
   - 3.2 After contact with patient and/or surrounding environment (including medical equipment);
   - 3.3 During patient care if hands move from contaminated body site to clean body site.
4. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.

5. Wear mask, eye protection, and face shield during procedures/care that are likely to generate droplets/splashing/spraying of blood/body fluids/secretions or excretions.

    5.1 During aerosol generating procedures (i.e., suctioning of respiratory tract) if patients not suspected of being infected with an organism for which respiratory protection is otherwise recommended (i.e., TB, influenza).

    5.2 Wear face mask if in contact (i.e., within three feet) with a patient with a new, acute cough or symptoms of a respiratory infection (i.e., influenza-like illness).

6. Wear gowns:

    6.1 During procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

    6.2 Remove gown and perform hand hygiene before leaving the patient's environment..

7. Prevent transmission of microorganisms from used equipment.

    7.1 Wear gloves and PPE as needed when handling used equipment soiled with blood and/or body fluids.

    7.2 Do not use reusable equipment for the care of another individual until it has been cleaned and disinfected appropriately.

        7.2.1 Disposable equipment may be used when available.

    7.3 Discard single use items promptly.

8. Before exiting room, remove and bag PPE and perform hand hygiene.

    8.1 Remove bagged PPE from room and discard.

9. Provide routine cleaning and disinfection of environmental surfaces, beds, bed rails, bedside equipment, and other frequently touched surfaces.

10. Handle, transport, and process used linen soiled with blood and/or body fluid in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other individuals and the environment.

11. Follow Sharps safety (refer to *Safety and Health Policies and Procedures, Needle Handling and Sharps Injury Prevention* policy).

12. Follow respiratory hygiene/cough etiquette.

13. Use protective mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is possible.

14. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions, or wound drainage in a single patient room, when available).

15. **Safe Injection Practices:**

    15.1 Use aseptic technique to avoid contamination of sterile injection equipment.

    15.2 Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single use items. They should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

    15.3 Use fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion or administration set.

    15.4 Use single dose vials for parenteral medications whenever possible.

    15.5 Do not administer medications from single dose vials or ampules to multiple patients or combine leftover contents for later use.

    15.6 If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.

    15.7 Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

    15.8 Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

Refer to:

- *Hand Hygiene policy*
- *Linen Handling policy*
- *Cleaning and Disinfecting policy*
- *Respiratory Hygiene/Cough Etiquette procedure*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures:*
  - *Needle Handling and Sharps Injury Prevention policy*
  - *Personal Protective Equipment policy*

Genesis

PROCEDURE:

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Post signs at entrances instructing patients/residents (hereinafter "patients") who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection and to practice Respiratory Hygiene/Cough Etiquette. Refer to CDC for examples of signage.

2. **Respiratory Hygiene/Cough Etiquette**:

   2.1 Individuals who have signs and symptoms of a respiratory infection (cough, congestion, runny nose, or increased production of respiratory secretions) should:

      2.1.1 Cover the nose and mouth with a tissue when coughing or sneezing.

      2.1.2 Use tissues to contain respiratory secretions. Dispose of used tissues in a waste receptacle.

      2.1.3 Perform hand hygiene after contact with mucus and contaminated objects. Hand hygiene consists of:

         2.1.3.1. Hand washing with plain soap and water, OR

         2.1.3.2. Using alcohol based hand rub.

3. **Masking and Separation of Persons who have Respiratory Symptoms:**

   3.1 Offer masks to persons who are coughing, when tolerated and appropriate. Masks with ear loops or with ties may be used to contain respiratory secretions.

   3.2 Encourage persons with a respiratory infection to maintain separation of least three feet away from others.

4. **Droplet Precautions:**

   4.1 Health care personnel should observe Droplet Precautions when examining or caring for a patient who has symptoms of a respiratory infection.

      4.1.1 These Precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

   4.2 Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a surgical mask must be worn while providing patient care.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC301 Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 3

POLICY

In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the resident/patient (hereinafter "patient") or the patient's environment (e.g., C. *difficile*, norovirus, scabies). State regulations will be followed when applicable.

Contact Precautions should also be used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. For patients colonized with multi-drug resistant organisms, refer to *Modified Enhanced Barrier Precautions* policy.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Place patient in private room, if possible.
    - 1.1 Patient may cohort with an individual who has the same organism.
    - 1.2 Do **not** place colonized or infected patient with another patient who has:
        - 1.2.1 A different multi-drug resistant organism;
        - 1.2.2 An invasive device such as a port, IV line, track, or indwelling bladder catheter;
        - 1.2.3 A recent post-operative wound;
        - 1.2.4 Open wound(s) (including pressure injury);
        - 1.2.5 Severe immunosuppression (e.g., cancer, HIV, etc.).
2. Place a "STOP. Please see nurse before entering room." sign on door.
    - 2.1 Print Precautions sign in color or order from Smartworks.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and the use of personal protective equipment (PPE).

4. Staff must use barrier precautions before or upon entering the room. PPE must be worn before contact with the patient or the patient's environment

   4.1 Wear gown and gloves.

   4.2 Wear eye protection if splashing of infectious material is likely.

   4.3 Change gloves and gowns during care if gloves/gowns come in direct contact with infectious material.

   4.4 Change gown and gloves, and perform hand hygiene before providing care to other patient in the room.

   4.5 Before exiting room, remove and bag gown and gloves and wash hands upon exiting room.

      4.5.1 Remove bagged PPE from room and discard in soiled utility.

      4.5.2 Wash hands.

5. Dedicate personal care equipment (e.g., thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

   5.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

6. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/ containment of .infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

   6.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

   6.2 For patients being transported outside the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Multi-Drug Resistant Organisms (MDROs) policy*
- *Modified Enhanced Barrier Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

Center Emergency Preparedness Plan (EPP) 2022/2023

Center Name: Keene Center
Address: 677 Court Street, Keene, NH 03431
Phone Number: 603-357-3800

This document outlines the center's integrated approach to emergency preparedness. When appropriate, the center team contacts local emergency response services officials and other healthcare providers, to participate in collaborative and cooperative planning efforts. This Emergency Preparedness Plan is reviewed and updated annually, and on an as-needed basis.

IMPORTANT NOTE: After this document has been reviewed completed by the center Emergency Preparedness Leadership Team, it must be saved electronically on Central and printed and stored in multiple, unlocked locations that may be accessed by center staff.

SAFETY PHILOSOPHY

This center is committed to operating in a manner that promotes the safety, health, and well-being of our staff while providing the quality care to all of our customers. We strive to continually develop, promote, and enforce safe work practices and provide a healthful working environment consistent with established federal, state, and accreditation requirements. This center encourages team cooperation and collaboration with local, tribal, regional, state and/or federal emergency preparedness officials to participate in an integrated response during disaster and emergency situations.

Information contained in the Emergency Preparedness Plan (the "Plan") is based on available best practices. The Plan has been prepared as guidance for emergency response and crisis management. It cannot be assumed that the Plan takes into consideration all potential events, scenarios, and/or circumstances. As a result, the Plan is designed to be flexible based on the specific and unique circumstances, conditions, and/or events related to any emergency situation. Notably, while the Plan has been developed consistent with legal authority, the experiences and judgments of those responsible for local leadership and implementation of the Plan will determine how best to utilize it in an emergency situation. This center does not make any guarantees or representations related to the absolute sufficiency and comprehensiveness of the Plan, and notes that additional information/steps may be required in the event of an actual emergency.

Throughout this document, the terms "disaster" and "emergency" are used. Emergency is defined as a serious, unexpected, and often dangerous situation requiring immediate action; disaster is a sudden event, such as an accident or a natural catastrophe, that may cause great damage or loss of life. This Plan is written to address both types of events. The term "staff" is also used, to reference center employees, contract personnel, regularly scheduled volunteers and medical professionals that provide service to center residents and patients.

In the event of a public health crisis such as the coronavirus ("COVID-19") outbreak, policies and procedures may be temporarily modified or adjusted to align with Company and facility needs and/or directives issued by federal, state, local health care, and/or regulatory authorities. These modifications may be communicated either through Company notices or other communications

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EPP GENERAL STATEMENT/PURPOSE

THE PURPOSE OF THIS PLAN IS TO PROVIDE GUIDELINES FOR THE CENTER TO:

1. Respond effectively during disasters/emergencies;
2. Reduce human vulnerability to adverse effects of the disaster or emergency;
3. Reduce environmental and structural vulnerability to adverse effects of the disaster/emergency;
4. Provide care and services to the center's residents/patients during an emergency and/or an evacuation;
5. Identify staff responsibilities during an emergency;
6. Provide timely and effective communication;
7. Provide for recovery after the emergency.
8. Comply with relevant legal authority and guidance including but not limited to: Life Safety Codes, OSHA's Employee Emergency Action Plans (29 CFR 1910.38), CMS guidelines, elements of the Nursing Home Incident Command System (NHICS), and any pertinent state/local requirements.

SCOPE OF PLAN

THIS CENTER HAS THE POTENTIAL OF BEING AFFECTED BY, BUT NOT LIMITED TO, THE FOLLOWING EMERGENCIES:

1. Threats to security;
2. Utility failures;
3. Weather conditions;
4. Structural damage from fires or explosions;
5. Chemical spills;
6. Community disasters; and
7. Community, regional, national or global infectious disease outbreaks.

THESE SITUATIONS MAY REQUIRE:

1. Suspension of routine processes (further described below);
2. Center employees performing non-routine tasks should understand the task completely.
    a. If a staff member does not know how to safely perform the task, the employee is guided to ask their department head for instructions on how to safely perform the task.
    b. If the department head is not aware of the task's safety considerations, the department head will contact the Director of Employee Safety for guidance.
3. Triage;
4. Decision-making regarding evacuations and sheltering-in-place;
5. Evacuation of residents/patients, visitors and personnel;
6. Resident elopement; and
7. Acceptance of unscheduled admissions.
    a. The Center only accepts admissions within its scope of care unless directed by a regulatory agency.

THIS PLAN IS DEVELOPED SPECIFICALLY FOR THIS CENTER BASED ON A SITE-SPECIFIC HAZARD VULNERABILITY ASSESSMENT, AND INCLUDES:

1. A developed and tested incident management process, including the center's communication plan;
2. A corresponding analysis of the resources of the center;
3. Center-specific planning and response tools for emergency management; and
4. Elements that promote collaboration, interoperability, and communication with state, local, tribal and community resources.

This center provides a copy of this completed plan to the local Emergency Management Services on an Annual Basis, and as necessary.

Refer to: Appendix 1: Hazard Vulnerability Assessment (HVA)

GENERAL GUIDELINES

WHEN POSSIBLE, THIS CENTER TAKES ADVANTAGE OF AVAILABLE LEAD-TIME BEFORE EMERGENCIES. STAFF SHOULD:

1. Immediately report all potential emergency and/or disaster situations to the Administrator or designee and the Director of Nursing (DON);
    a. Notify additional department heads or designees as instructed by the Administrator.
    b. Administrator/designee: Notify the Marketing President (MP) of any potential emergency situation. Provide a copy of this completed plan to the local EMS;
2. Keep a radio/television tuned to an emergency weather channel or other Emergency Alert System broadcaster on at all times;
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, communication plan and contact information;
4. Locate the emergency and protective action supplies. Replenish if necessary;
5. Clear corridors of obstructions;
6. Reassure residents/patients, visitors, and team members;
7. Assist in the Incident Commander (see below) determinations regarding the number and mix of employees necessary if emergency is activated;
8. Notify the Administrator, DON, or designee of the potential staffing and supply needs;
9. Conserve resources (e.g., water, linen, supplies, etc.);
10. Keep phone lines free of personal calls;
11. Ensure a supply of food and water is available for residents/patients and staff in collaboration with the Dining Services Director;
    a. The center acknowledges during a disaster visitors may be present. The center's first priority for water and food distribution is to staff and residents.
    b. Note: Water can be used indefinitely as long as container intact. Dates do not imply expiration.
12. Be sure resident census is updated and accurate;
13. Estimate the number of ambulatory and non-ambulatory residents, and identify residents on transmission-based precautions that will need cohorting or segregation from other residents;
14. Identify residents with communication impairments, limited English proficiency, and plan for interventions to provide effective communication, such as interpreter services, large print or translated materials.
15. Centers with pets or resident service animals should consider the pets/animals in any emergency situation - i.e. food, water, care needs, and handling/controlling the animal.

NOTIFICATION and INCIDENT COMMANDER

1. During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.
2. When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. Refer to Appendix 22 for the center succession plan.
3. The Incident Commander is responsible for activation, implementation, and termination of the Emergency Preparedness Plan, staff assignments, patient oversight and associated documentation.
4. The Incident Commander is responsible for contact, and collaboration with, as appropriate:

a. Department heads;
b. MP;
c. Residents and responsible parties;
d. State Licensing Board;
e. Local, tribal, regional, state or federal emergency management officials; and
f. State Ombudsman Office.

LEVELS OF EMERGENCY

1. After determining an emergency situation exists, the Incident Commander declares an emergency. The levels of emergency are:
   a. ***Alert.*** Disaster possible; increased awareness. Administrator or designee notified;
   b. ***Stand By.*** Disaster probable, ready for deployment. All department heads notified;
   c. ***Activate.*** Disaster exists, deployment. Department heads or designees report to Center; and
   d. ***Stand Down.*** Disaster contained, resumption of normal activities.

NOTIFICATION OF PLAN

1. Residents are notified of the EPP via a statement in the Admission Kit and a posting in the Center.
2. The Administrator requests time to review the EPP during Resident Council meetings.

Refer to Posting GHC 5408 in SmartWorks and the Emergency Preparedness Compliance Guide.

COMMAND AND CONTROL

1. The Incident Commander coordinates activities in the center;
2. All staff are generally considered to be essential for the duration of a declared emergency; and
3. Emergencies are typically managed from a central location, identified as the Emergency Operations Center.

Refer to:
Appendix 2: Building Construction and Life Safety
Appendix 3: Center Administrative Staff Contact List
Appendix 4: Emergency Operation Center Designation

COMMUNICATION PLAN

1. During emergencies, this center uses primary and alternate means of communication;
    a. Landline telephone, cell phones, and the Regroup Mass communication platform are primary means of emergency communication. Email, and text messaging are alternate means for communication efforts; and
    b. Two-way radio communications are used where required to communicate with the local EMS during a regional emergency.
2. Internal Communication
    a. The Incident Commander is responsible for communicating the initial and ongoing situation status with the center's department heads and MP or designee.
    b. The MP or designee is responsible for communicating the status of any emergency to area/division leadership and appropriate corporate staff.
    c. Center staff attempt to use simple, precise language when communicating during an emergency. Codes are not used.
3. External Communication
    a. The Incident Commander is the key spokesperson for the center and:
        i. Notifies and communicates with regulatory and community agencies and resources regarding the center's occupancy, status, needs and ability to provide assistance;
        ii. Notifies/self-reports incidents involving fire, death, and/or serious bodily injury in accordance with federal and state guidelines.
        iii. Notifies the public relations department (Lori Mayer at 610-283-4995) who will handle radio/TV or other media inquiries, press releases or statements.
            1. NOTE: Center and regional employees do NOT communicate directly with the media; rather, all communications are handled by the public relations department. (Refer to Appendix 6.)

Refer to:
Appendix 5: Area Administrative Contact List
Appendix 6: Company Contacts
Emergency Notification Announcements

CRISIS PUBLIC RELATIONS: STAFF MEMBERS, VOLUNTEERS, CONTRACTORS, PHYSICIANS, FAMILY OF RESIDENTS AND COMMUNITY (INCLUDING OTHER LONG TERM CARE FACILITIES, AS APPOPRIATE)

1. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations.

COMMUNICATION WITH RESIDENTS, FAMILY MEMBERS AND OTHERS

2. This center uses the Genesis HealthCare CareLine as the emergency contact number (866-745-2273) as alternate communication in addition to primary telephone numbers for the residents' responsible parties and family members for contact during an emergency.

3. Based on direction from the Administrator/Incident Commander, residents, responsible parties and family members are notified as soon as possible when there is an emergency declaration at the center by center staff in person, via telephone, and through use of the Genesis CareLine. This communication includes patients who are included in census but outside of the center at the time of the emergency (i.e., at external physician appointments, dialysis, etc.). If the center determines additional alternate communication methods are needed, the Incident Commander works with company resources to obtain support, equipment and services.
4. If the center determines it has additional surge capacity (see below), local EMS and other long term care providers are notified of such capacity.
    a. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts, and to assist patients in receiving the care they need. In addition, while the HIPAA Privacy Rule is not suspended during an emergency, the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the privacy rule.
    b. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices.
    c. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures, and apply administrative, physical and technical safeguards of the HIPAA Security Rule to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy if possible, and disclosures are limited to the minimum necessary to accomplish the purpose.
    d. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

Refer to:
Appendix 7: Emergency Resources and Contacts
Appendix 8: Additional Resources

INTERNAL FUNCTIONS

THE CENTER TAKES ADVANTAGE OF LEAD-TIME BEFORE EMERGENCIES:

1. Staff will notify the Administrator or designee and DON of all potential emergency situations.
2. Keep a radio/television on at all times (if possible) and tuned to an emergency weather channel or other Emergency Alert System broadcaster.
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, emergency supplies, communication plans and appropriate contact information, with staff, visitors, volunteers and onsite contractors. Staff are monitored through use of the staffing schedules (updated as needed), and volunteers, visitors and others are monitored using the visitor log (typically kept in the reception area).
    a. Locate the emergency supplies; replenish if necessary. Refer to **Appendix 12: Emergency Supplies and Location of Critical Equipment**.
        i. The following equipment is typically available at this center: wheelchairs, walkers and canes, portable/folding chairs (for Staging Area), oxygen concentrators, IV poles, feeding pumps, suction machines, bedside commodes.
        ii. The following medical supplies are typically available at this center; first aid supplies, gauze, bandages, alcohol, triple antibiotic ointment, disposable gloves, eye protection, disposable gowns, surgical masks, BioMasks, N95 respirators, saline eyewash solution, incontinence products, barrier cream, sanitizing wipes, hand sanitizer, medications, medication cups/straws, shelf-stable nutritional supplements, food thickener, bladder catheter supplies, sterile pads, first aid tape, syringes, stretch gauze, elastic bandages, glycerin swabs, normal saline, and insulin supplies.
4. Remind staff to remain calm and in control, for organized response and to reassure the residents.
5. Clear corridors of obstructions.

DEPARTMENT HEAD EMERGENCY RESPONSIBILITIES:

1. Train personnel on department responsibilities;
2. Assign on-call responsibility for emergency management;
3. Provide support as directed by the Incident Commander;
4. Assure emergency duties are assigned;
5. Assign duties to staff based on physical capabilities and competencies;
6. Maintain a current list of all employees and their phone numbers;
7. Identify staff interested in volunteering to work in receiving facilities if evacuation is initiated;
8. Determine the minimal number and mix of employees necessary if an emergency is activated.
9. Notify the Administrator, DON, or designee of the potential staffing and supply needs; and
10. Conserve resources (e.g., water, linen, and supplies).

EMERGENCY PROCEDURE: TAKE COVER

1. It is the Incident Commander's responsibility to monitor all threatening situations and determine when the **Take Cover Procedure** is initiated. Situations involving risk to

residents, staff, and visitors due to events occurring inside and outside of the center are considered in the decision to **Take Cover**.

2. Upon making the decision to **Take Cover,** an announcement is broadcast over the center intercom system stating the following message:
    a. **"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."**
    b. Staff, if it is safe to do so, assist residents to Areas of Refuge identified in Appendix 2 of this EPP. If unsafe, staff takes immediate cover.
    c. Residents who use wheelchairs and cannot get into the Take Cover position are positioned with wheelchairs facing a wall with wheels locked, and covered with linens to help protect from flying debris (time permitting).
    d. Staff, residents and visitors (as they are able to), get into the Take Cover position (see below).


3. Emergency Job Tasks – Take Cover
    a. Administrator/Incident Commander
        i. Direct all individuals to Take Cover.
        ii. Be prepared to contact authorities if injuries and damages occur.
        iii. Direct everyone to remain in the refuge area until the danger has passed.
            1. **An "All Clear, Take Cover is over" message is then paged to signal the Take Cover situation has ended.** Afterwards, the Incident Commander accounts for residents, staff, and visitors.
    b. Nursing Staff
        i. Connect oxygen concentrators/tanks to residents requiring oxygen as needed.
        ii. Take first aid supplies/medical supplies to designated Area of Refuge, time permitting.
        iii. Relocate the residents to safe refuge and stay in close proximity of the residents while **taking cover**. Maintain transmission-based precautions as best as possible.
        iv. Close drapes, blinds, doors, and windows (time permitting).
4. Upon broadcast of the Take Cover announcement, all staff immediately discontinues tasks they are working on and begin implementing their **Take Cover** responsibilities.
    a. Immediately relocate residents and visitors to bathrooms or interior hallways (refer to Areas of Refuge, Appendix 2) away from all windows and doors. Staff closes all drapes, blinds, and doors.
    IMPORTANT NOTE: If residents, visitors, and staff are directed to Take Cover in a hallway having a door or window at the end of the corridor, attempt to keep a distance of 30 feet (30') away from the door or window.

b. Staff avoid areas with large ceiling spans. Small rooms or interior hallways away from windows and doors are suitable for **taking cover**.
c. Upon relocating all residents to a safe refuge, the staff stays in proximity of the residents while **taking cover** as well.
d. **Maintenance staff and Managers on Duty** should be prepared to activate Utility Shut-Off Procedures.
e. All *other* staff members immediately secure records, close drawers and cabinets, shut down electronic appliances, and report to the nearest Area of Refuge (refer to Appendix 2).
f. If a situation allows for advanced warning, residents, staff, and visitors will be re-located a designated area providing optimum refuge.
g. Upper floor occupants are moved to the basement or lowest level within the center.
h. Priority is given to evacuating the highest floor first.
i. Census is taken to account for all residents, staff, and visitors.
j. Upon issuance of the All Clear announcement, residents are taken back to their rooms.

Administrator (OR DESIGNEE) ALL EMERGENCIES:

1. Administrators are responsible for execution of Transfer Agreements and/or Memorandums of Understanding (MOU) for patient care and transportation. Updating your center's EPP ensures Divisional and Corporate support can access the Transfer Agreements or MOU's and activate those as you coordinate center emergency response.
    a. Where possible, centers attempt to transfer residents to Genesis-affiliated centers, as this allows for usage of existing databases and continuity of care.
    b. Administrators use Transfer Agreements and/or MOUs with non-affiliated centers, which are often mutual agreements, to arrange for patient care and services and evacuation transportation. (These agreements are activated after a decision has been made to evacuate.)
    c. Administrators activate this Emergency Preparedness Plan when necessary. If applicable, the *National Criteria for Evacuation Decision-Making in Nursing Homes* is reviewed with the management team to evaluate whether to evacuate or Shelter-in-Place. The availability and duration of emergency power is considered when making such determinations.
2. The Administrator/Designee is the Incident Commander and is responsible for activating and coordinating all activities related to the emergency.
    a. Only the Incident Commander, in collaboration with the MP and/or an authority with jurisdiction, can declare an evacuation.
3. The Administrator/Designee contacts the MP and directs internal and external communication as described above.
4. The Administrator/Designee contacts the local EMS and collaborates on integrated response, as appropriate.
5. The Administrator/Designee contacts the Ombudsman and communicates:
    a. How the residents will be sheltered;
    b. When/If the residents will be evacuated; and
    c. Where the residents will be sheltered.
6. The Administrator/Designee contacts the state licensing board.
7. The Administrator/Designee notifies the Medical Director and department heads.

8. The Administrator/Designee instructs staff to keep all doors closed in resident rooms, stairwells and functional rooms (storage, pantry, linen, etc.).
9. The Administrator/Designee instructs staff regarding suspension of non-essential services and procedures during emergencies.
10. The Administrator/Designee tracks the incident's progress and disseminates information to respective staff.
11. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers.
12. The Administrator/Designee establishes frequent communication with staff members, residents, and resident responsible parties.
13. The Administrator/Designee contacts vendors and others who may be needed for post-incident restoration and makes arrangements for services.
14. The Administrator/Designee completes NHICS Form 251, Center System Status Report to assess the center's damage.
15. The Administrator/Designee directs additional emergency documentation completion; refer to Appendices and Exhibits in this EPP.

Refer to Appendix 9: Transfer Agreements
Appendix 10: Short-term Evacuation Plan

Administrator (OR DESIGNEE) SHELTER-IN-PLACE (SIP): During emergencies the Administrator/Designee:

1. Meets with management team to discuss preparations for SIP.
2. Activates the center's SIP Plan as directed by area/divisional, regional, or corporate Leadership; and local authorities.
3. Notifies staff members, residents, and resident responsible parties of the decision to SIP.
4. Instructs individuals in the center to remain until it is safe to leave.
5. When it is safe, allows staff, volunteers, visitors, and vendors to communicate with their family members.
6. Oversees moves of residents to Areas of Refuge as necessary.

Administrator (OR DESIGNEE) EVACUATION: During emergencies the Administrator/Designee:

1. Activates the center's Evacuation Plan as directed by area, divisional, regional, or corporate leadership; or by local authorities. (Management team then notifies supervisors and staff.)
2. Meets with management team to finalize instructions for evacuation.
3. Coordinates evacuation efforts with local Emergency Management Agencies.
4. Notifies the following of the evacuation decision:
    a. The Genesis CareLine (866-745-2273) to determine bed availability;
    b. Residents and responsible parties of decision to evacuate. Communicates emergency phone numbers including alternate care center numbers;
    c. The Medical Director; and
    d. The receiving facility(ies) of the pending arrival.
5. Designates a staff member to monitor and complete the NHICS Master Resident Evacuation Tracking Log Form 255.
6. Notifies alternate care facilities of the pending arrival. Activates Transfer Agreements/MOU as necessary.

7. Secures the center and verifies all electronics and computers have been turned off and unplugged.
8. Approves shut-down procedures for non-essential utilities and designates appropriate personnel to implement shut-down.
9. Verifies emergency supplies for transport.
10. Initiates recovery and re-entry efforts when deemed safe.

SENDING CENTER: ADMINISTRATION TASK LIST

1. Schedule additional staff to coordinate transportation; consider and determine plans for cohorting patients, when applicable.
2. Work with MP to schedule transportation.
3. Update original evacuation report to reflect any changes; i.e., residents in hospital.
4. Review return plan with staff and ensure plan is followed.
5. Schedule additional staff to coordinate transportation.
6. Send supplies to receiving center as needed. Consider need to provide beds, wheelchairs, over bed tables, oxygen, food, water, bathing materials, linens, means for privacy, medical supplies and continence supplies.
7. Communicate daily with receiving center Administrator on return status.

RECEIVING CENTER: ADMINISTRATION TASK LIST

1. Verify all local emergency services are available prior to resident transport.
2. Contact center staff and ensure adequate staff is available to meet the needs of the residents; discuss and determine plans for cohorting patients when applicable.
3. Schedule staff to prepare the building for residents and ensure adequate supplies for each department are available.
4. Verify local vendors and contractors are available i.e. food and nutrition services, housekeeping/laundry, dialysis, physicians, pharmacy, oxygen, gas stations, x-ray and lab services.
5. Coordinate the return schedule with Senior Vice President of Operations and MP.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): ALL EMERGENCIES

1. During all emergencies nursing is responsible for:
    a. Coordinating resident care;
    b. Coordinating communication with medical providers;
    c. Printing and securing the following resident-specific documents:
        i. Admission Record (face sheet).
        ii. MARs;
        iii. TARs;
        iv. Most recent monthly order sheet;
        v. Care Plan;
        vi. Weight and VS Summary;
        vii. Most recent 7 days of nursing notes;
        viii. Most recent physician progress notes;
        ix. Behavior Monitoring Form;
        x. Skin integrity report; and

xi. Patient-specific medications, treatment and feeding supplies, including adaptive equipment, special needs items and preventive devices for falls and skin breakdown.

d. Obtaining additional clinical staff in collaboration with the Administrator and Human Resources;
e. Coordinating resident needs with food and nutrition services and materials management;
f. Notifying pharmacy services of pending evacuation and alert for need to provide back-up medications;
g. Communicating the status of care and resident conditions to the Administrator;
h. Accounting for and keep track of residents and staff;
i. Maintaining effective lines of communication with nursing staff members;
j. Preparing medications (one week supply if possible) for those residents going to alternate facilities, hospitals, or home;
k. Verifying all physician orders are current and have been obtained for residents.
l. Updating and printing resident/patient census reports;
m. Estimating the number of ambulatory and non-ambulatory residents/patients for transportation and assistance purposes. Identify residents on transmission-based precautions that require cohorting or segregation from other resident; and
n. Identifying residents with communication impairments, and associated planned interventions and updating resident care plans as necessary.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): EVACUATION TASK LIST

1. Designates Phase I and Phase II Evacuation Nurse Coordinators.
    a. Nurse Coordinator Phase I works to transfer the highest acuity residents first via ambulance if possible. Considers hospital transfers as appropriate.
    b. Nurse Coordinator Phase II works to transfer lower acuity residents via the most appropriate methods available. Phase II residents may be moved to a staging area prior to evacuation. Staff members are designated to each of the vehicles to assist and care for the residents during the transport. Identifies patients that may be cared for by family/friends and arranges discharge.
2. Groups the residents according to unit, acuity, and those on transmission-based precautions and assigns staff members accordingly.
3. Prepares the lists of residents and receiving location(s) so staff can prepare clothing, supplies, medications, and any other items.
4. Completes the *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient. This tracking includes patients that are counted in the resident census even if they are off-site at the time of the emergency.
5. Designates staff members to accompany each group.
6. Assists in coordinating transfer of all residents to alternate hospitals or other locations. Use *NHICS 255 Master Resident Evacuation Tracking Form.*
7. The Evacuation Nurse Coordinators or designees:
    a. Complete *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient noting patient-specific supplies and equipment.
    b. Collect patient-specific information (see above).
    c. Collect the supplies as noted on NHICS 260 and supervise load of medications, supplies and administration records to accompany transport vehicle:

i. A licensed nurse is assigned to safeguard controlled substances.
ii. If residents needing critical medications are deemed unsafe to carry their own medications, then a licensed nurse carries the medications.
iii. When necessary and appropriate, a separate cooler is provided for temperature-controlled medications.

d. Contact the DON of receiving center to inform him/her of the status of the evacuation.
e. Transfer residents from bed and transport in accordance with care plans.
f. If possible and time-permitting, inspect the residents for:
   i. Proper attire for the weather;
   ii. Identification (ID) wristbands (if applicable);
   iii. Assistive devices including hearing aids, dentures, glasses, and prosthesis.
g. Provide a change-of-shift (hand off) report. Include information regarding patients at risk for falls and elopement.
h. Supervise resident evacuation from the building and the resident flow to transportation.

SENDING CENTER: NURSING TASK LIST

1. Provide the *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
2. Pack resident medical records, supplies, clothing, necessary personal items and medications. Inventory sheets are completed if there is ample lead-time.
3. Prepare/pack any special needs equipment or supplies as necessary. (For example: special size Foley/ostomy supplies, enteral feed formula, oxygen).
4. Load residents with assistance from transport crew.
5. Give report and narcotics/controlled medications to transport nurse/crew.
6. Provide the resident records to transport crew.
7. Provide a method for resident identification either via use of wristbands or use of photo identification.
8. Provide resident identification.
   a. The sending center nursing team reports significant resident information to receiving center in a verbal or written hand-off report, including (wristbands may be used for this purpose):
      i. Code status/Advanced Directives
      ii. Potential for Fall Risk
      iii. Potential for Elopement Risk
      iv. Diagnoses
      v. Food, Medication and Other Allergies
      vi. Thickened liquid consistency
      vii. Diet consistency
      viii. NPO Status
      ix. Seizures
9. Provide medication management
   a. Medications are checked against the MARs to ensure all meds are accounted for per physician order before the residents are transported to the receiving center.
   b. Narcotics/controlled medications are separated and provided to the transport nurse who keeps control of the medications until arrival at the receiving center.

c. The transport nurse and DON or designee include the narcotic count sheet/MAR with each medication.

10. Provide resident special needs equipment.
    a. The DON/Designee uses the *NHICS 260 Individual Resident Evacuation Tracking Form* to identify special equipment or supplies needed during transport.
    b. Pressure relief devices for residents identified with specific wound needs.
    c. When possible, special equipment or supply needs (i.e., positioning devices, oxygen (see below) and means of securing oxygen, nebulizers, gel pads, special size colostomy bags) are loaded on the transport vehicle prior to the residents.
11. Provide oxygen needs to appropriate residents.
    a. Oxygen use is documented on the *NHICS 260 Individual Resident Evacuation Tracking Form*.
    b. Residents requiring oxygen are transported by wheelchair with the oxygen tank secured to the chair. Chair wheels are locked to prevent rolling during transport.
    c. Extra oxygen tanks are secured to prevent movement.
    d. Residents requiring oxygen may be transported separately due to limited number of wheelchair spaces on transporting vehicles.
12. Provide enteral feeding supplies to appropriate residents.
    a. The DON/Designee is responsible for ensuring enteral feeding formula and supplies are packed.
    b. Formula, tubing and syringes are collected, packed for transport, and labeled with the resident name(s).
    c. If support is necessary (i.e. inadequate formula on hand), the DON/Designee contacts the Regional Manager of Food and Nutrition Services for assistance.

TRANSPORTING CREW: NURSING TASK LIST

1. Find/Load first aid kit.
2. Ensure all transported supplies are labeled.
3. Inspect oxygen to ensure it is secured for transport.
4. Ensure transport team and residents have required PPE.
5. Upon arrival at the sending center, notify Administrator and DON and obtain a copy of *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
6. Assist with loading assigned residents.
7. Check actual residents loaded against *NHICS 255 Master Resident Evacuation Tracking Form* to ensure accuracy.
8. Check for critical medications and equipment: snacks/drinks; clothing and belongings; and associated administration records (MARs and TARs).
9. Take report from evacuating center nurse and take possession of narcotics.
10. As time allows, document resident condition on departure.
11. Provide care/services as necessary during transport and document such services.
12. Contact the receiving center periodically to coordinate arrival time.
13. Report to the nursing team at the receiving center upon arrival and transfer resident medications, belongings, documentation, and supplies.

TRANSPORTING CREW NURSING POLICY AND PROCEDURE

1. Oxygen.

a. The center uses *NHICS 260 Individual Resident Evacuation Tracking Form* to identify residents that require continuous or PRN oxygen. Residents with continuous or PRN oxygen needs are transported via wheelchair so the oxygen tank can be secured to the chair. During transport, the chair wheels are locked to prevent rolling. Residents using oxygen may be transported separately due to the limited number of wheelchairs spaces on transport vehicles.
b. Extra oxygen tanks are secured to prevent movement.
c. Guidance for the Safe Transportation of Medical Oxygen for Personal Use
    i. Vehicle operators take precautions to ensure medical oxygen for passengers' personal use is handled and transported safely.
    ii. For Transportation in the Passenger Area Task List/Instructions:
        1. Only transport oxygen in a cylinder maintained in accordance with the manufacturer's instructions. The manufacturer's instructions and precautions are usually printed on a label attached to the cylinder.
        2. Before boarding, inspect each cylinder to assure that it is free of cracks or leaks, including the area around valve and pressure relief device. Listen for leaks; do not load leaking cylinders. Visually inspect the cylinders for dents, gouges or pits. A dented, gouged, or pitted cylinder should not be transported.
        3. Limit the number of cylinders to be transported on board the vehicle to the extent practicable.
        4. If transportation arrangements allow, the vehicle operator considers limiting the number of passengers requiring medical oxygen.
        5. Cylinders used for medical oxygen are susceptible to valve damage if dropped. Handle these cylinders with care during loading and unloading operations. Never drag, roll or carry a cylinder by the valve or regulator.
        6. Do not handle oxygen cylinders or apparatus with hands or gloves contaminated with oil or grease.
        7. Secure each cylinder to prevent movement and leakage. "Secured" means the cylinder is not free to move when the vehicle is in motion. Each extra cylinder should be equipped with a valve protection cap.
        8. Oxygen cylinders or other medical support equipment are not stored or secured in the aisle. Make sure the seating of the passenger requiring oxygen does not restrict access to exits or use of the aisle.
        9. Since the release of oxygen from a cylinder could accelerate a fire, secure each cylinder away from sources of heat or potential sparks.
        10. Smoking or open flames (cigarette lighter or matches) are not permitted in the vehicle when medical oxygen is present.
        11. When the destination is reached, remove all cylinders from the vehicle as soon as possible.
    iii. For Transportation in the Cargo Compartment Task List:
        1. Place each cylinder in a box or crate or load and transport in an upright or horizontal position.
        2. Protect valves from damage, except when in use.
        3. Secure each cylinder against movement.

2. Narcotics/controlled medications.

a. When necessary, narcotics/controlled medications are transported from the sending center to the evacuation center.
b. All narcotics/controlled medications should have the count sheet/MAR attached to the medication.
c. A log listing the narcotics/controlled medications/MAR for each resident is sent to the receiving center. A copy is provided to the transporting nurse.
d. A nurse completes a narcotic count with the receiving center nurse upon arrival.
e. All narcotics/controlled medications should remain in the possession of a nurse during transport.

3. Illness or death enroute.
    a. If a resident/patient has a significant change in condition or expires during transport, the transporting vehicle diverts to the closest acute care center, if possible.
    b. If this is not possible, the transport crew alerts the receiving center and manages the patient situation until arrival.
4. Documentation.
    a. During transport, the transportation nurse/crew document resident conditions and status at the time of transfer and also documents medications administered, treatments given and any other information that is deemed pertinent.

NURSING: RECEIVING CENTER TASK LIST

1. On arrival take report from the transport nurse/crew and count narcotics/controlled medications.
2. Complete triage.
3. Pull original documents from the transport nursing documentation, make copies, and return original documentation to the sending center as soon as possible, and as appropriate.
    a. Give copies of the documentation from the sending center to medical records for retention to support continuity of care during the evacuation process.
4. Review MARs and TARs against documentation received from sending center to ensure all physician order changes were posted to these documents. Review other changes to identify orders for continuation.
5. Depending on appropriateness and availability, arrange for grief counselors to counsel evacuees.

NURSING: TRIAGE EVACUATION RECEIVING CENTER TASK LIST

1. If possible, set up stations for providing care as follows:
    a. Station I: Complete the resident admission assessment including:
        i. Vital signs with pain assessment
        ii. Evaluate presence of infections
        iii. Weight
        iv. Height
        v. Provide resident belongings to receiving nurse along with resident assessment information.
    b. Station II: Provide:
        i. Hydration
        ii. Snacks
    c. Station III:
        i. Transport resident and belongings to assigned room

ii. Provide as-needed personal care

NURSING: SHELTER-IN-PLACE TASK LIST

1. Assist in moving residents to Area of Refuge (if indicated) and frequently monitor their conditions.
2. Connect oxygen concentrators/tanks to residents requiring oxygen.
3. Take first aid supplies/medical supplies to designated safe areas and initiate treatment.
4. Be prepared to assist as needed at the direction of the Incident Commander.

NURSING: EXPANSION/SURGE OF RESIDENTS

1. Coordinate triage of casualties, if necessary.

Refer to Appendix 11: Triage of Casualties

MEDICAL DIRECTOR: ALL EMERGENCIES TASK LIST

1. If possible and appropriate, report to the center;
2. Provide assistance as appropriate, via telephone, electronically or in-person, during an external or internal emergency requiring medical evaluation and /or intervention and coordinate the activities of physicians as necessary;
3. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
4. The center only accepts admissions within its scope of care unless directed by a regulatory agency.
5. Triage casualties;
6. Obtain additional medical resources in collaboration with the SVP/VP of Medical Affairs or Regional Medical Director; and
7. Assist center with transfer decisions and emergency orders if attending physician cannot be reached.

HUMAN RESOURCES AND SCHEDULING: ALL EMERGENCIES TASK LIST

1. Human Resources /Benefits Designee and Scheduler are responsible for scheduling and assembling adequate staff in consultation with the Administrator/Designee:
    a. Maintain current information all center personnel and volunteers with addresses and phone numbers for contact purposes;
    b. Coordinate with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event that staff is needed in alternate locations;
    c. Update the department heads with results of attempts to obtain staff. Confirm expected availability as well as the number of family members joining the staff members;
    d. Coordinate, if necessary, transportation of the center staff to work;
    e. Monitor the length of time each employee works during the declared emergency and provide adequate time off to rest and recover. Time worked should not exceed sixteen (16) hours over a 24 hour period if possible;
    f. Identify areas where employees can rest and recover;
    g. If necessary, work with regional Human Resources staff to contact other Genesis centers to obtain additional staff.

FOOD AND NUTRITION SERVICES: ALL EMERGENCIES TASK LIST

1. The Dining Services Director or designee:
    a. Follows the Food and Nutrition Services Policies and Procedures, Food Service Emergency Plan and associated guidelines including a plan to obtain food and water in the event of an emergency;
    b. Obtains additional staff in collaboration with Human Resources;
    c. If power outage is likely, set refrigerators and freezers to the lowest setting to preserve items for the longest possible time period;
    d. Unplugs non-essential equipment;
    e. Obtains supplies of food and water for residents/patients and staff;
    f. Creates water supply:
        i. Fill tubs, pitchers, and as many containers as possible with water;
        ii. Bags as much ice as possible and stores bags in the freezers; and
        iii. If advanced warning is provided, purchases ice and stores in freezers.
    g. Determines the numbers of residents, visitors, volunteers, and employees for whom food service may need to be provided.
    h. Provides food service as appropriate and able. Refer to Exhibit 1 for Sample Emergency Menus.

FOOD AND NUTRITION SERVICES EMERGENCY EVACUATION GUIDELINES

1. The Dining Services Director/Designee:
    a. Coordinates food service with the center Incident Commander following the EPP.
        i. Provides adequate snacks and fluids for each vehicle transporting residents;
        ii. A sample snack menu, extended for consistency modified and Gluten-Free diets, has been developed for these purposes and may be customized as needed; and
        iii. All therapeutic diets are waived during an emergency with the exception of consistency-modified and Gluten-Free diets as allowed by state regulations.
    b. Packaged snacks and fluids (including thickened water) are provided in disposable containers or bags, if possible, with labeling for consistency-modified and Gluten-free (when appropriate).
    c. Gathers relevant vital resident and department records.
        i. Enteral feedings for residents are managed by nursing staff with support from the Dining Services Director/Designee.

SENDING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director or designee sends Food and Nutrition Services staff ahead to the receiving center(s) to prepare snacks and fluids for residents **on their arrival;**
2. Consult with the Regional Manager of Food and Nutrition directly to review plans for evacuation;
3. Dining Services Director makes plans for meals to be served prior to transport. (Note: Meals may be served inconsistently with the normal center schedule to ensure residents are prepared and fed at designated departure times);
4. Create/Print diet roster for distribution to receiving facilities;
5. Create/Print 2 tray card copies for each resident;
6. Prepare a simplified shelf-stable snacks and liquids master list. Include specific-consistency diets, thickened liquids, and disposable supplies (napkins, plastic cutlery).

7. Prepare and label snacks for consistency-altered diets (Dysphagia Advanced and Puree). A snack list identifying snacks for consistency-altered diets is included for transport.

RECEIVING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director and assigned staff arrive at the center in sufficient time to allow for inventory of food items to ensure nutrition needs of the residents.
2. The Dining Services Director/Designee prepares beverages and light snacks to be provided upon evacuated residents' arrival to the center. Include meals appropriate for consistency-altered diets and thickened liquids

REHABILITATION SERVICES: ALL EMERGENCIES TASK LIST

1. The Director of Rehab or designee:
    a. Assists with triage, transfer, or evacuation of residents;
    b. Obtains additional staff in collaboration with Human Resources; and
    c. Directs rehab staff to assist on the units as required.

MAINTENANCE SUPERVISOR: ALL EMERGENCIES TASK LIST

1. Gather emergency supplies. See Appendix 12: Emergency Supplies Checklist;
2. Evaluate the safety of the physical plant;
3. Coordinate emergency repairs;
4. Communicate the status of the center environment to the Administrator.
5. Make rounds of the center and grounds;
6. Secure potential flying debris (above, below, around, and in the center);
7. Check equipment for functionality:
    a. Monitor fuel supply for generator; and
    b. Check that equipment and utilities are functioning properly.
8. Prepare all vehicles for evacuation if needed;
    a. Check fuel, oil, and water levels for each vehicle;
    b. Move vehicles away from trees;
    c. Prepare maps/obtain directions with evacuation routes and alternate routes for each vehicle. A paper map with all routes should accompany each vehicle.;
    d. Load phone or other communication devices in each vehicle;
    e. Load first aid kit in each vehicle; and
    f. Identify storage space for medical and business records, medications, and equipment in each vehicle.
        i. Identify oxygen storage area, as needed, in each vehicle. Follow the guidelines for oxygen transport in vehicles.
9. Transporting Crew/Maintenance
    a. Service van as necessary to include air conditioning, oil, gas, tires, fire extinguisher, safety belts, etc. are all in good condition by completing the Pre-trip Vehicle Safety Inspection Checklist. Check transport supplies and load them into the vehicle;
    b. Identify route with maps for travel from evacuating center to receiving center and back to original center as appropriate;
    c. Identify van driver, licensed staff transporting evacuees, and schedule departure. Staff are made familiar with the use of safety devices in the vehicle;
    d. Bring money or purchase cards in the event supplies are needed during for the trip; and

e. Load communication devices.

Refer to Appendix 12: Emergency Supplies and Location of Critical Equipment

MAINTENANCE SUPERVISOR: EVACUATION TASK LIST

1. Secure the center and verify all electronics and computers have been turned off and unplugged;
2. Designate someone to stay behind, if deemed safe, to safeguard the center;
3. Activate shut-down procedures for non-essential utilities;
4. Work with responding emergency agencies on building security, traffic control, utility control, and elevator operations;
5. Make final rounds of the center and grounds;
6. Secure windows and other building openings; and
7. Pull shades and close all drapes.

MATERIALS MANAGEMENT (CENTRAL SUPPLY): ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain medical supplies and PPE;
2. Provide supplies and linens to the nursing units; and
3. Notify medical and medication suppliers of additional needs.

SOCIAL WORK: ALL EMERGENCIES TASK LIST

1. Provide support and crisis intervention services for residents, residents' families, and staff;
2. Notify responsible parties and residents, as directed by the Administrator/Incident Commander, of decisions to Shelter-in-Place/Evacuate and resident status;
3. Review and update Advanced Directives;
4. Manage resident discharges and placement, if possible, based on resident/responsible parties' requests;
5. Follow-up within 24 hours, if possible, to confirm care and services for discharged residents.

SENDING CENTER: SOCIAL SERVICES TASK LIST

1. Contact evacuated residents' families to let them know the residents' location;
2. Assist DON in supervising certified nursing assistants as they pack and inventory residents' belongings; and
3. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment and care plan accordingly.
    a. For residents experiencing adjustment difficulty, follow up as indicated.

RECEIVING CENTER: SOCIAL SERVICES TASK LIST

1. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment, and care plan accordingly.
2. Assist DON in supervising certified nursing assistants to ensure resident's personal belongings are made available to each resident and inventoried in accordance with established procedures;
3. Notify Responsible Parties of resident arrival/admission; and
4. Assess psychological/social needs to ensure needs and preferences are communicated to the interdisciplinary team.

a. Follow up with status call to Responsible Party as soon as possible following admission.

ADMISSIONS DEPARTMENT: ALL EMERGENCIES TASK LIST

1. Maintain a current list of residents;
2. Print face sheets if evacuation is possible;
3. Coordinate admissions with the DON/Administrator;
4. Assist social services with contacting responsible parties; and
5. Report available transportation and receiving center capacities to the Incident Commander.

ADMISSIONS DEPARTMENT: EVACUATION TASK LIST

1. Notify agencies with Center Transfer Agreements of the emergency situation and potential to evacuate;
2. Communicate resident information and status to the receiving center; and
3. Maintain a list that includes each resident name and the time/place of each resident's transfer.

BUSINESS OFFICE/PAYROLL: ALL EMERGENCIES TASK LIST

1. Manage payroll; and
2. Provide means to pay for food, supplies, and/or transportation.

BUSINESS OFFICE/PAYROLL: EVACUATION TASK LIST

1. The Cash Handler secures the following items for evacuation:
    a. Center petty cash;
    b. Resident trust fund (RTF);
    c. Petty cash;
    d. Resident trust check stock;
    e. Printed copy of most recent RTF Trial balances;
    f. Imprest checkbook;
    g. Payments to be deposited; and
    h. If applicable, purchase cards.
2. Turn off and unplug all computers; and
3. Take laptop(s) if applicable.

ENVIRONMENTAL SERVICES: ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain linen in the event of an emergency;
2. Secure:
    a. Linens;
    b. Blankets;
    c. Trash can liners;
    d. Mops;
    e. Rags;
    f. Buckets;
    g. Trash cans;
    h. Cleaning and disinfecting supplies; and
    i. Toilet paper.
3. Place emergency orders for supplies;
4. Clear corridors of any obstructions such as carts, wheelchairs, etc.;

5. Check equipment (wet/dry vacuums, etc.);
6. Unplug non-essential equipment; and
7. Maintain sanitation considering best practices for infection control.

LAUNDRY: ALL EMERGENCIES TASK LIST

1. Close all laundry chutes; and
2. Unplug non-essential equipment.

MEDICAL RECORDS: EVACUATION TASK LIST

1. Prepare resident medical records transport to the appropriate receiving facilities;
2. Assist nursing to obtain charting from each nursing station and provide them to the transporting nurse; and
3. In situations of planned evacuation to affiliated centers, centers follow a process to obtain/grant access to electronic medical records. Refer to the Planned Evacuation Process on for details.

RECEIVING CENTER: MEDICAL RECORDS

1. Place the Clinical Record at the appropriate nurse's station;
2. Make copies made of documentation from sending facilities, place the copies in a manila envelope marked "CONFIDENTIAL: Do Not Destroy". Place with the clinical record in the event of discharge of the resident. Send originals back to the sending center as soon as possible, and appropriate;
3. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices;
4. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures by applying administrative, physical and technical HIPAA Security Rule safeguards to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy and disclosures are limited to the minimum necessary to accomplish the purpose; and
5. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

SURGE CAPACITY

1. External disaster expansion guidelines:
    a. In the event of an external disaster, this center may be used by local hospitals and other health care facilities to care for additional patients as space/staff permit;
    b. Unplanned admissions from an external disaster are completed in collaboration with:
        i. External agencies;
        ii. Healthcare providers;
        iii. Administrator;
        iv. DON;
        v. Medical Director;
        vi. Admissions Coordinator;
        vii. Human Resources or Staffing Coordinator; and
        viii. The CareLine.
    c. The center only accepts admissions within its scope of care unless directed by the local health authorities or a regulatory agency.
    d. If the center team determines it is experiencing a healthcare surge, the following guidelines are used to assess, prepare, and mobilize to meet the need for increased patient care capacity:
        i. Transfer patients to other institutions in the region, state, or other states;
        ii. Group like-patient types together to maximize efficient delivery of patient care;
        iii. Convert single rooms to double rooms or double rooms to triple rooms, if possible;
        iv. Designate units or areas of the facility for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients;
        v. Use cots, beds, or other sleeping surfaces in flat space areas (e.g., cafeterias, recreation areas, lounges, lobbies) for noncritical patient care;
        vi. Beds should not be placed near windows, if possible and appropriate to the emergency, so as to avoid broken glass and protect patient privacy and security; and
        vii. Determine whether additional staff, including State or Federally designated health care professionals and volunteers, may be used to address surge needs.
    e. The center identifies areas and spaces that could be opened and/or converted for use as patient treatment areas, such as activity rooms, dining rooms, rooms with unlicensed beds, or other unused center space. Areas are selected based on the intensity of the incident and the anticipated number of healthcare surge patients the center may receive. The identified areas are cleared of excess furniture and equipment as needed.
2. Roles and Responsibilities
    a. The Director of Nursing/Resident Care Director and Admissions Director determine bed availability and admission placement in collaboration with CareLine;
    b. The Medical Director is notified and is responsible for emergency physician coverage, if necessary;
    c. The DON/Resident Care Director evaluates nurse staffing needs;

d. The Administrator/Designee and department heads are responsible for assuring adequate supplies and staff;
e. The Administrator/Designee contacts area leadership, the law department and regulatory agencies, as necessary to obtain waivers for additional capacity;

f. The Social Worker is responsible for notifying the residents' responsible parties of admission;
g. Center staff coordinates admission, identification, assessment and care planning for new residents following established operational, clinical, and admissions policies and procedures. Exception would be when suspended or waived by management and/or in consideration of CMS, state agency and other regulatory guidance; and
h. The center assumes responsibility for the care and services of residents admitted as the result of an emergency.

Refer to Appendix 13: Surge Capacity

EMERGENCY PHYSICIAN COVERAGE

The Medical Director is notified of all center-related emergencies having the potential for or currently requiring medical intervention.

DEPENDING ON THE CIRMCUMSTANCES AND TYPE OF EMERGENCY, IT IS THE MEDICAL DIRECTOR'S RESPONSIBILITY TO:

1. Provide on-site and/or offsite assistance during an external or internal emergency;
2. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
3. Triage casualties; and
4. Obtain additional medical resources in collaboration with the Vice President/Senior Vice President of Medical Affairs.

INTERRUPTION OF NORMAL OPERATIONS

The Incident Commander may suspend or relax policies and procedures during an emergency. These decisions and the associated potential consequences are considered carefully. In making these decisions, the Incident Commander prioritizes essential operations that must continue to prevent compromise of resident care. All significant departures from established policy and procedures and this EPP must be approved by the Incident Commander, Regional, Divisional, and Corporate leadership.

CAPACITY FOR DECEASED RESIDENTS

1. This center plans for the potential handling and holding of deceased individuals if support from local emergency responders or other community resources is not immediately available;
2. Human remains
   a. This center considers the following information in handling, processing, and storing human remains onsite on a temporary basis:
      i. The center's normal capacity, if any, to store deceased individuals; including refrigeration capacity available to store human remains safely and separated from emergency food supply;
      ii. Suitable areas on the center's periphery to store human remains without refrigeration;
      iii. Equipment (ice-making, etc.) or materials/supplies needed (storage bags for ice, deodorizers, body bags, heavy duty plastic wrap, personal protective equipment (PPE), tarps, pallets, etc.) to provide temporary storage of human remains; and
      iv. Ways to control and isolate temporary morgue provisions away from healthy center occupants (residents, staff, and visitors).
   b. The Incident Commander makes decisions and provides direction regarding temporary storage of human remains, and contacts support services and the local EMS for assistance.
3. Documentation
   a. The center documents information about deceased individuals on **NHICS Form 259: Master Center Casualty Report**.

RECOVERY AND RESTORATION

1. Post-emergency procedure
   a. Immediately following the emergency, when it is safe to do so, the Incident Commander undertakes the following actions:
      i. Coordinate recovery and restoration operations with area, division, region and corporate representatives, the Emergency Management Services (EMS), and other agencies with jurisdiction to restore normal operations.
      ii. Provide local authorities with a master list of displaced, injured, or dead and notify next of kin/responsible party. ***Refer to NHICS Form 259 Master Facility Casualty Fatality Report.***
      iii. Advise personnel to dispose of any food/supplies suspected to be or actually contaminated or spoiled.
   b. Inspection task list:
      i. When it is safe to do so, the Incident Commander and the Maintenance Director, with support services as necessary, perform an initial damage inspection. **NOTE: If there is concern of structural damage, center staff do not enter the building. The following precautions are taken to avoid injury and damage:**
         1. Open doors carefully.
         2. Avoid the use of open flame in the event of fuel leakage, dampened electrical equipment, or flammable materials;
         3. Watch for falling objects or downed electrical wires. Do not touch downed electrical wires or objects touched by downed wires;
         4. Stay away from windows and/or glassed areas;
         5. Take pictures and document damage; and
         6. Arrange for cleaning services, including removal/clean up of spilled medications, drugs, and other potentially harmful materials following center policies and procedures. (Refer to: Safety and Health P&P SH800.)
   c. When it is safe to do so, the Incident Commander and the Maintenance Director perform a utilities inspection. **The following precautions are taken to avoid injury and damage:**
      i. If a natural gas smell is noticed, open windows and doors, shut off main gas valve, leave premises, and contact the Utility Provider **IMMEDIATELY;**
      ii. If damage to wiring is suspected, do not use any appliances and shut off electrical power. Contact the Utility Provider and the contracted Electrical Contractor; and
      iii. If damage to plumbing is suspected, check water outlets and sewage lines. Shut off the main water valve if damage is observed. Contact the Utility Provider and contracted Plumbing Contractor.
   d. The Incident Commander reports all building, equipment, or utility damage to the MP;
   e. Upon notification from the proper authorities, center support services and/or utility providers the emergency has been terminated or de-escalated, the Administrator oversees the orderly return of residents and staff;

f. Before reoccupation of the building, a safety inspection of the center and surrounding areas, including the utilities delivery systems and HVAC units, is performed by the Incident Commander, the Maintenance Director, and regulatory agency(ies);
g. Recovery and restoration is managed in consideration of best practices for infection control, including:
    i. Frequent hand washing. If local water supply contaminated, use bottled water. If hands not visibly soiled – use alcohol-based hand rub;
    ii. In response to flooding or water damage and when possible, cleaning out damaged areas within 24 to 48 hours to prevent mold growth;
    iii. Cleaning, wearing rubber gloves, with a solution of approximately 1 cup bleach to each gallon of water, with open doors and windows for air circulation. (Bleach solution is not mixed with ammonia or other cleaners);
    iv. Use of dust masks during activities that may stir up mold spores or excessive dust.
    v. If applicable, following local officials' instructions for use of bottled water. If instructed to boil water, boiling for at least a full minute before using it to cook, clean or bathe;
    vi. Discarding all perishable food items that may have become contaminated or in contact with flood water including canned food;
    vii. Treating wounds in accordance with routine infection control practices;

    Note: Adapted from Becker's Infection Control and Clinical Quality, "APIC: 6 tips for infection prevention after a hurricane" written by Brian Zimmerman, 8/29/17.
h. After center reoccupation is considered safe, the Incident Commander and department leaders work to prepare the center to resume normal operations, and coordinate transportation and re-admission of residents;
i. After re-admission, the center re-establishes all essential services; and
j. After re-admission, the Incident Commander coordinates provision of crisis counseling for residents/patients, families, and staff as needed.

LOSS OF UTILITIES

1. Loss of electrical power
    a. Back-up Power/Generators: Emergency lighting/power is provided in conformance with center policies and the state's Department of Health policies to maintain temperatures, provide emergency lighting, as well as for fire detection and extinguishing systems and sewage and waste disposal. The ability to obtain and maintain generator power is a factor in whether to evacuate or Shelter-in-Place;
    b. The center follows multiple policies and procedures regarding infection control, hazardous waste, food handling and life safety that guide the center's sewage and waste control practices. The center will seek additional resources as necessary to meet sewage and waste disposal needs in accordance with current standards;
    c. If this center has a generator, the emergency generator system will be inspected weekly by appropriate service location staff and annually by a qualified outside contractor or more frequently if required by state regulation. If this center maintains an onsite fuel source to power the emergency generator(s), the center has contracted with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency.
    d. Service Delays:
        i. In the event electrical service is disrupted, flashlights are distributed throughout the center, prioritized as needed;
    e. Extended Loss: If power is lost and expected to be disrupted for an extended period of time, assistance is requested from local agencies.
        i. Center staff should consider the content of residents' personal refrigerators and advise residents accordingly;
        ii. In the absence of power for the call bell/light system the center uses bells or other methods to alert staff to their needs.
        iii. Loss of Utilities Alert:
            1. When appropriate and possible, the following announcement is made: **"Center Alert-We are activating Loss of Utilities protocols-(Describe loss of Power and Location). Please continue your duties and listen for further instructions."**
        iv. Provide instructions as necessary for the specific circumstances.
2. Air conditioning failure
    a. Notify HVAC Company and report problem;
    b. Monitor room temperatures. When the temperature of any resident/patient area reaches 81 degrees Fahrenheit for four (4) consecutive hours:
        i. Open doors;
        ii. Operate fans;
        iii. Notify the Administrator or designee and the Medical Director;
        iv. Make arrangements for transfer of residents/patients to other areas of the Center, or other facilities if necessary;
        v. Monitor residents'/patients' temperatures every four (4) hours;
        vi. Encourage fluids, begin intake and output records as necessary;
        vii. Relocate residents/patients who are at risk of hyperpyrexia/over-heated;
        viii. Observe residents/patients for symptoms of hyperpyrexia. Document findings.

c. The center follows protocols for addressing significant changes in condition for residents with symptoms of hyperpyrexia.

3. Heating failure
   a. Notify HVAC Company;
   b. If the outside temperature goes below 30 degrees Fahrenheit, drain plumbing and put antifreeze in the toilets and sinks;
   c. Monitor room temperatures. When the temperature inside the center remains at 65 degrees Fahrenheit, for four (4) consecutive hours:
      i. Obtain and distribute blankets, covering hands, feet, and heads;
      ii. Distribute warm soups, coffee, or tea to residents/patients;
      iii. Notify the Administrator, DON, or designees;
      iv. Notify the Medical Director;
      v. Monitor and chart resident/patient temperatures every four (4) hours;
      vi. Relocate residents/patients at high risk of hypothermia; and
      vii. Observe residents/patients for symptoms of hypothermia. Document findings.
   d. The center follows protocols for addressing significant changes in condition for residents with symptoms of hypothermia.
4. Interruption of telephone service
   a. Notify the telephone company and report disruption of service (use cellular or public telephone);
   b. Evaluate all phones and fax lines in the Center to determine the extent of the disruption; and
   c. During the disruption, the Incident Commander uses a cellular phone for emergent communication. Other available cell phones are used as needed with prioritization to avoid interruption to care and services.
5. Loss of water supply
   a. Notify the water division of the public utility department of the disruption of services;
   b. If the water department advises services will be resumed promptly, all residents/patients and service areas will be informed and instructed to refrain from turning on water taps until supply is re-established. Nursing services are responsible for advising residents/patients of the situation;
   c. If necessary, a minimum of the supply in hot water tanks and the emergency supply of water may be used. Contact may be made with the potable water supplier for additional water;
   d. In the event of a disaster in the immediate area creating prolonged and/or indefinite disruption of water supply to the center, the Incident Commander attempts to obtain water for residents/patients. If adequate water is not available, the Incident Commander proceeds with evacuation; and
   e. Prepare and handle disposal of human waste using supplies for containment and specific storage locations, and with use of PPE.

Refer to Appendix 14: Emergency Water Supply
Refer to Appendix 15: Utility Shut-Off Procedures

UTILITY, ELEVATOR & GENERATOR SYSTEM FAILURE

Failure	Contact	Action
Sewer drains backing up	Maintenance	Do not flush toilets or hoppers. Do not use equipment that sends water to drain. Be sure to turn off water except for drinking. If long-term outage expected, consider: Evacuation; Bath in a Bag; Accessible Portable Showers; and Accessible Portable Toilets
Water-sinks and toilets inoperative.	Maintenance	Use distilled or sterile water for drinking.
Fire sprinklers or alarm system inoperative.	Maintenance	Begin fire watch. Minimize fire hazards. NOTIFY LOCAL FIRE DEPARTMENT by calling 911
Water non–potable (not drinkable)	Maintenance	Water cannot be used for drinking, washing or cooking. Place "Non-Potable Water-Do Not Drink" signs at all drinking fountains and sinks. If a water shut-off valve is in place, turn off the water to the sink/drinking fountain. Use emergency water supply for drinking and cooking.
Elevator(s) out of service	Maintenance	Review fire and evacuation plans: modify plans if necessary. If people are trapped inside elevator, notify them help is on the way and call fire department. Notify elevator maintenance contractor.
Telephones	Maintenance	Use pay phones, cell phones, and runners as needed. Contact the phone company.
Electrical power (emergency generators working)	Maintenance	Ensure life support systems are on emergency power (red outlets). Distribute flashlights/glow sticks. Never plug generator into wall outlet. Keep generator dry. Allow generator to cool completely before refueling. Use only approved fuel containers. Monitor the generator for overheating. Always operate generators outdoors.
Generator and all electric systems failure	Maintenance Nursing	Use battery powered lighting (flashlights, etc.). Watch battery levels on all critical medical equipment. Implement transfer agreements for residents on critical medical equipment. Prepare center for evacuation
Nurse call system or resident alarms.	Maintenance Nursing	Establish visual resident monitoring rounds or surveillance. Call in additional staff if necessary.
Natural Gas outage or natural gas odor.	Maintenance	Open windows/ventilate area. Remove residents and employees from the area. Turn off gas equipment. Contact the gas company and the fire department.

BOMB THREAT

1. Center bomb threat guidelines for staff
   a. Do not panic or act in such a way that causes panic to residents, family members, or other employees;
   b. Do not hang up;
   c. Notify other employees;
   d. Have another employee contact 911 and alert authorities to threat;
   e. The following announcement is made: "**Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions.**";
   f. **Do not evacuate** the center until instructed to do so by the Incident Commander. This decision is generally based on advice from the police and/or fire department;
   g. Restrict access to the center;
   h. Close all doors; and
   i. Escort visitors and residents to resident rooms where they remain with doors closed until an all-clear is given.
2. If the bomb's location is mentioned in the threat:
   a. Immediately remove any residents, visitors and staff from the area;
   b. If you find an object out of the ordinary or appearing to be an explosive device, do not touch it and inform authorities of the object's location;
   c. Do not attempt to disarm, remove or disturb the potential explosive device; and
   d. Report all suspicious activities to investigating authorities.
3. Potential explosives
   a. **The center maintains a list of potential explosives to report to the fire/police departments. The potential explosives list:**
      i. Identifies oxygen storage locations;
      ii. Identifies fuel storage locations; and
      iii. Identifies locations of any other potential explosives in the center.

Refer to Appendix 16: Potential Explosives List

4. After the threat is received:
   a. As soon as possible after receiving the call, the receiver of the call documents all information relating to it, including the:
      1. Possible location and type of bomb;
      2. Time of detonation;
      3. Background noises (e.g., music, voices, etc.); and
      4. Voice quality (male/female), accents, or any speech impediments.
5. If a suspicious/explosive object is found:
   a. Immediately contact the Incident Commander. The Incident Commander then contacts law enforcement to immediately report the object's location. In the absence of immediate notification, center staff calls 911;
   b. Do not touch the object; and
   c. Follow the instructions of the bomb squad or local law enforcement officials who assume authority regarding object removal.

6. Law Enforcement and/or the Incident Commander initiates a partial or total evacuation as needed.
7. If a suspicious object is found without prior notification:
    a. Call 911;
    b. Report the exact location and description of the object;
    c. Follow any instructions given to you at this time by law enforcement officers; and
    d. Call Administrator, DON, or Designees.

BIOTERRORISM

1. Reporting requirements and contact information
    a. Any employee recognizing chemical or biological exposure symptoms immediately notifies the Administrator/Designee/Incident Commander;
    b. The Incident Commander immediately contacts 911 and area leadership;
    c. Restrict building entrance and exit until cleared by authorities;
    d. The Incident Commander contacts the Centers for Disease Control Bioterrorism Emergency Response Office at (770) 488-7100;
    e. Employees promptly evacuate all persons from the affected area as instructed by the Incident Commander; and
    f. As instructed by regulatory authorities, all building occupants remain on the premises until cleared and approved to exit.
2. Mail handling
    a. The center follows general mail handling guidelines, including:
        i. Opening all mail with a letter opener or method least likely to disturb contents;
        ii. Opening letters and packages with a minimum amount of movement; and
        iii. Center staff are advised not to blow into envelopes; or shake or pour out contents, and to keep hands away from nose and mouth while opening mail; and to wash hands after handling mail.
    b. Observing for suspicious envelopes or packages such as:
        i. Envelopes/packages with discoloration, strange odors or oily stains, powder or powder-like residue;
        ii. Protruding wires, aluminum foil, excessive tape or string;
        iii. Unusual weights for size, or lopsided or oddly shaped envelopes; and
        iv. Poorly typed or written addresses, no return address, incorrect titles, misspelling of common words, a postmark not matching the return address, and restrictions such as "personal" or "confidential."
3. In Handling Suspicious Mail, staff should:
    a. Stay calm and do not shake or empty contents of any suspicious package or letter;
    b. Keep hands away from mouth, nose, and eyes;
    c. Isolate package or letter and not carry or show to others, and cover gently with clothing, paper, inverted trash can; and
    d. Not try to clean up any spills or walk through any spilled material;
    e. Alert others in area and leave area, closing all doors;
    f. Wash hands with soap and water;
    g. Notify supervisor/designated responder who in turn calls 911, local FBI Field Office, area, division, region and corporate leadership;
    h. Not allow anyone to enter the room until proper authorities arrive; and
    i. List all people who were in the room or area when the package or letter was recognized. Give the list to the health and law enforcement officials.
4. Potential agents
    a. Diseases with recognized bioterrorist potential and the agents responsible for them are described in Table 1. (Note: The Center for Disease Control does not prioritize these agents in any order of importance or likelihood of use.)

Table 1. Most Common Chemical and Biological Agent Used in Terrorist Attacks

Chemical Agents	Effects	Onset
Nerve Agents Tabun Sarin Soman GF, VX	Contraction of the pupils of eyes Watery discharge from nose Labored or difficult breathing Convulsions	Seconds to minutes
Blister Agents (Vesicants) Mustard Lewisite Phosgene Oxime	Skin redness Blisters Eye Irritation Blindness Labored or difficult breathing Coughing	Minutes to hours
Blood Agents Hydrocyanic Acid Cyanogen Chloride Arsine Methyl Isocyanate	Panting Convulsions Loss of consciousness Breathing stops - usually temporary in nature	Minutes
Choking Agents Phosgene Chlorine Ammonia	Tightness in the chest Coughing Labored or difficult breathing	Minutes to hours

Biological Agents	Effects Of Inhalation	Time From Exposure Until Symptoms Appear	Contagious?/Treatment
Anthrax	Fever Headache Fatigue Labored or difficult breathing Death if untreated	1 to 5 days	Not contagious, but spores can survive outside host for years. Treat with IV antibiotics for 30 days. Can also use vaccination which is effective only if begun before symptoms appear.
Botulism	Blurred vision Eyes sensitive to light Difficulty speaking Progressive paralysis Respiratory failure	1 to 5 days	Not contagious. Treat with supportive therapy. Antitoxin available from CDC.
Hemorrhagic Fever	High fever Low blood pressure Bleeding from mucous membranes Organ failure Death	4 to 21 days	Contagious: spread through body fluids. Treat with supportive therapy. Ribavirin for some viruses.
Plague	Fever Chills Headache Nausea Vomiting Pneumonia Septicemia/blood poisoning Death	2 to 3 days	Highly contagious by aerosol/droplet route. Medications available - Should be given within 8 to 24 hours of time symptoms begin.
Smallpox	Fever Severe fatigue Headache Backache Abdominal pain Blister-like skin lesions Death - 20 to 30% of those infected	7 to 17 days	Highly contagious by aerosol route or contact with pox scabs. Symptomatic treatment. Vaccine available through CDC.

NUCLEAR, RADIATION, OR HAZARDOUS CHEMICAL FALLOUT

1. In the event of a nuclear, radiation, or hazardous chemical fallout:
    a. Notify Administrator or designee;
    b. Contact the local health department or police if there is the belief exposure has occurred;
    c. Tune radio to the local emergency broadcast station;
    d. Alert center residents/patients, staff, and visitors and keep them informed of new developments. The following announcement is made:
        i. **"Center Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."** Provide instructions as needed.
    e. Close all doors, windows, and drapes;
    f. Move residents/patients to the hallways and close the fire doors;
    g. In the event of hazardous chemical fallout, seal all openings to the outside air and block all outside air intakes;
    h. Reassure residents/patients, visitors, and staff;
    i. Evaluate the need to restrict entrance into the center in collaboration with Area leadership, division, region, state and local authorities;
    j. Follow the direction of state and local authorities; and
    k. If directed by local authorities, evacuate residents/patients per location Evacuation Plan.

    Note: Facilities located in a Nuclear Emergency Planning Zone should follow the plan developed for their location.

FIRE EMERGENCY GUIDELINES

1. This center monitors potential fire risk. Any unsafe condition is reported to a supervisor immediately so corrective measures can be taken promptly.
2. In the event of a fire:
    a. Extinguishers: Fire extinguishers are used in accordance with instructions.
    b. Transport: Residents are transported to a safe area;
    c. Staff Assignments: One person is assigned to wait outside the building to direct the fire department personnel to the area of the fire;
    d. Evacuation: Residents are evacuated as necessary and according to the Evacuation Plan;
    e. Staff ensure the Fire Lane is clear for emergency personnel and vehicles;
    f. Staff use the census log, staff census/schedule, and visitor log to account for staff, residents and visitors;
    g. Staff relocate wheeled equipment during fire or other emergency; and
    h. Report fire incidents, death or serious bodily injury by phone to the state agency and others as required by state guidelines.
3. Fire response and announcement:
    a. Upon discovering fire or smoke, center staff:
        i. Remove residents from immediate danger according to evacuation guidelines
        ii. Make the following announcement:
            1. **"Center Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."**
        iii. Implement the R.A.C.E. program:
            1. **Rescue** Remove residents to at least 20 ft. from the threatened area, preferably on the opposite side of the closest fire door.
            2. **Alarm** Activate the closest fire alarm. Even though automatic alarms may be activated, contact the fire department by calling 911.
            3. **Confine** After removing endangered residents, close the door(s) of the threatened room or area. Close smoke/fire doors behind you as you go.
            4. **Extinguish/Evacuate** Assess the fire threat to either attempt to extinguish the fire or evacuate residents from the affected station. If the area is evacuated, check that all smoke/fire doors are properly closed. Block the bottom of the doors with sheets or towels to slow smoke penetration into the unaffected areas.
4. Fighting the fire:
    a. **Call 911 for all fires;** and
    b. If the fire is small, it may be extinguished by smothering (covering) with sheets or clothes, or by using a portable fire extinguisher.
        i. Fire extinguishers are used only if the fire is small and there is no threat of endangering the user or other individuals;
        ii. When using a portable extinguisher, staff are instructed to follow the "PASS" protocol: Pull, Aim, Squeeze, and Sweep:
            1. **Pull** the fire extinguisher pin;
            2. **Aim** the nozzle at the base of the flame;
            3. **Squeeze** the handle; and

4. **Sweep** the fire extinguisher back and forth at the base of the flame.

iii. Staff are advised to make **one** attempt to extinguish a fire with a fire extinguisher. If first attempt is unsuccessful, staff should confine the fire area and evacuate the residents and staff.

SPECIAL CARE UNIT/RESIDENTS FIRE PROCEDURE:

Vent units, dialysis units, dementia units, bariatric patients, and hospice patients are subject to special consideration during a fire emergency due to a locked unit and acuity. Due to this consideration, this center has special procedures for addressing these specific patients' safety needs, as documented in Appendix 17.

Refer to Appendix 17: Special Care Unit Fire Procedure

AUTOMATIC SPRINKLER OR ALARM SHUT-OFF

When it becomes necessary to shut off the automatic sprinkler or fire alarm system in the building for any reason, it is the duty and responsibility of the Administrator/Designee to:

Inform the Fire Department that the sprinkler or alarm system has been shut off, the reasons for system shut off, and the approximate length of time the system will be off.

Designate personnel to serve on fire watch for the period the sprinkler or alarm system is shut off.

Fire watch personnel tour the center at least every hour to check for fire or conditions that could result in fire. (The center follows local fire regulations requiring more frequent rounds to the extent that such regulations exist.)

Refer to:

Appendix 18: Fire Sprinkler Shut-Off Procedures
Appendix 19: Fire Alarm Reset Procedures

SECURITY PLAN

This center has established a security plan to help protect the safety of residents/patients, staff, and visitors.

1. Exterior building security
    a. This center has a schedule for locking/unlocking of exterior doors during nighttime hours, including persons responsible; and
    b. This center follows a schedule to inspect outdoor lighting adequacy.
2. Interior building security
    a. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection.
    b. This center's security plan includes a schedule to inspect indoor lighting adequacy.
    c. The center's plan also contemplates resident-specific security needs, including:
        i. Security measures for special units;
        ii. Risk for resident elopement;
        iii. Use of Electronic alarms systems; and
        iv. Communication call bells.
3. Administrative controls for security
    a. The center follows the communications protocols established in Section V of this plan as needed to address security issues.
    b. The center's security plan describes the check-in procedures for visitors.

Refer to Appendix 20: Security Plan

INTERNAL OR EXTERNAL DISTURBANCES

1. For disturbances within the center, staff are advised to:
    a. Approach the individual causing the disturbance (subject) and attempt to calm them down;
    b. If the individual cannot be quieted, politely ask the subject to leave the center;
    c. Call the police department for assistance if the subject does not cooperate; and
    d. If the subject attempts to leave after the call is made, do not attempt to detain him/her. Call the police back and inform them of the current situation.
2. Under the influence
    a. To protect the center, residents, visitors and personnel from being injured or offended by individuals under the influence of alcohol or narcotics, staff are advised to:
        i. Inform the individual of your intention to call them a cab and have them leave the property;
        ii. If the individual refuses to leave, call the police department; and
        iii. If the individual is an employee, immediately notify their supervisor and Administrator.
3. External disturbances
    a. Anyone detecting a civil disturbance or potential civil disturbance during normal business hours reports the situation to the Administrator and/or, after normal business hours, to the Manager on Duty (Incident Commander) who:
        i. Assesses the situation (location of the disturbance, what the disturbers are doing, how many are there, etc.);
        ii. Reports the situation to the police department immediately by dialing 911 and requesting assistance;
        iii. Instructs staff to lock all building doors and windows and close all blinds and curtains in resident rooms;
        iv. Instructs staff to move residents into their rooms and away from exterior windows and close room doors;
        v. Instructs visitors to stay in the resident room(s);
        vi. Monitors building access at all entrances to identify non-authorized persons attempting to enter the center. Unauthorized access/attempts at access to the center are immediately reported to 911;
        vii. Relinquishes control of the situation, if established, to the police department/EMS upon their arrival; and
        viii. When the disturbance has subsided or has been controlled, the Incident Commander surveys the affected areas and determine the need for additional assistance.

HOSTAGE SITUATION

1. If a hostage situation is identified, staff are advised to:
    a. Immediately call 911 and explain the situation to the police and provide specifics such as the:
        i. Subject's name or identifying information;
        ii. Victim(s);
        iii. Exact Location; and
        iv. Known or suspected weapon(s),
2. Notify Administrator or designee as soon as possible and activate the Emergency Plan;
3. The following announcement is made: "**Security Alert-We are activating Hostage protocols- We have a Hostage situation (Location). Please listen for further instructions.**" Provide further instructions as needed;
4. Evacuate the affected area per the location's Evacuation Plan, attempt to isolate the subject, and secure the perimeter;
5. Remain calm; follow the subject's directions;
6. If the subject is talking: listen; do not argue;
7. Avoid heroics: be aware not to make sudden movements; and don't crowd the subject; and
8. Be prepared to respond to law enforcement personnel regarding your observations and any additional information you may have involving the subject or victim.

ELOPEMENT: MISSING RESIDENT/PATIENT

1. If a resident/patient is discovered missing:
    a. Communicate internal notification of missing resident/patient. The following announcement is made: **"Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.**;
    b. Begin a coordinated search throughout the building; search every room in the Center;
    c. Search immediate grounds, supply flashlights and associated supplies; and
    d. If the resident/patient is not found, the charge nurse/supervisor should:
        i. Notify the Administrator and DON or designees;
        ii. Call 911 and report the missing resident/patient;
        iii. Notify responsible family member;
        iv. Notify the resident's/patient's physician;
        v. Notify the appropriate state and local agencies; and
        vi. Supply resident's/patient's picture to police, etc.

Refer to Appendix 21: Elopement Drill Documentation Form

SEVERE WEATHER/NATURAL DISASTER

1. **TORNADOES**
   a. Tornadoes are violent local storms extending to the ground with whirling winds reaching 300 mph. Spawned from powerful thunderstorms, tornadoes can uproot trees, damage buildings, and turn harmless objects into deadly missiles in a matter of seconds. Damage paths can be in excess of one mile wide and 50 miles long. Tornadoes can occur in any state but occur more frequently in the Midwest, Southeast, and Southwest, with little or no warning.
      i. Tornado Watch – Atmospheric conditions are right for tornadoes to potentially develop. Be ready to take shelter. Stay tuned to radio and television stations for additional information. NOTE: Multi-floor centers consider relocating non-ambulatory and dependent residents from the higher floors to the lowest floor.
      ii. Tornado Warning – A tornado has been sighted in the area or is indicated by radar. Take cover immediately.
   b. Based on the results of the hazard vulnerability analysis, if this center is at risk for tornado, the center:
      i. Consults Emergency Management officials regarding the tornado warning system;
      ii. Monitors local media and alerts for tornado watches and warnings;
      iii. Has established procedures to inform personnel when tornado warnings are posted and considers the need for spotters to be responsible for looking out for approaching storms;
      iv. Educates staff on Areas of Refuge identified in Appendix 2;
      v. Considers the amount of space needed during a tornado, including consideration adults each generally require about six square feet of space and nursing home residents may require more space;
      vi. Identifies Areas of Refuge considering the best protection in a tornado is usually an underground area. If an underground area is not available, consider:
         1. Small interior rooms on the lowest floor without windows;
         2. Hallways on the lowest floor away from doors and windows;
         3. Rooms constructed with reinforced concrete, brick, or block with no windows or heavy concrete floor or roof system overhead; and
         4. Protected areas away from doors and windows. **Note: Auditoriums, cafeterias, and gymnasiums covered with flat, wide-span roofs are not considered safe.**
      vii. Makes plans for evacuating personnel away from lightweight modular offices or mobile home buildings. These structures offer no protection from tornadoes;
      viii. Conducts periodic tornado drills; and
      ix. Reviews the **Take Cover** Procedure and instructs affected individuals to **Take Cover** inside the center in a safe area if necessary.
   c. Emergency procedure: Tornado Watch
      i. The following announcement is made in the event of a Tornado Watch: "**Medical Alert. We are activating severe weather protocols. A tornado watch has been issued for this area** effective until _____ (*time watch*

ends). A **tornado watch** means current weather conditions may produce a tornado. Close all draperies and blinds throughout the center and await further instructions. Please continue with your regular activities."

ii. The above message is repeated several times after the first announcement, and then approximately hourly until the **watch** has terminated;
iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover procedures (described above);
v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position.
    1. The Incident Commander monitors weather alerts on radio and television.
vi. Staff closes all window drapes and blinds;
vii. Staff distributes flashlights, towels, and blankets to staff and residents;
viii. First aid and medical supplies are secured and taken to central area for refuge;
ix. Staff secures outside furniture, trash cans, etc.;
x. After the **Tornado Watch** has been cancelled and the Incident Commander has determined the dangerous situation has passed, an announcement is made: **"All Clear, Repeat, All Clear"**; and
xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

d. Emergency procedure: Tornado Warning
    i. The following announcement is made in the event of a Tornado Warning: "**Medical Alert. We are activating severe weather protocols. A tornado warning** has been issued for our area. Immediately implement Take Cover procedures. Repeating—a **tornado warning** has been issued for our area. Immediately implement Take Cover procedures." ;
    ii. The above message is repeated several times after the first announcement and then hourly until the **warning** has terminated;
    iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
    iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover/Evacuation procedures (described above);
    v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position;
    vi. The Incident Commander monitors weather alerts on radio and television;
    vii. First aid and medical supplies are secured and taken to central area for refuge;
    viii. Upon hearing this announcement, all personnel follow the Shelter-in-Place/Take Cover procedures to provide for the safety of the residents, visitors, and themselves;
    ix. After the Tornado warning is over and the Incident Commander has determined the dangerous situation has passed, am **"All Clear, Repeat, All Clear"** announcement is made to inform affected parties that the **Take Cover** situation has ended;
    x. Upon issuance of the All Clear announcement, residents are taken back to their rooms; and

xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

EARTHQUAKE PROCEDURE

Earthquake: An earthquake is a sudden, rapid shaking of the ground caused by the breaking and shifting of rock beneath the Earth's surface. This shaking can cause buildings and bridges to collapse; disrupt gas, electric, and phone service; and sometimes trigger landslides, avalanches, flash floods, fires, and huge, destructive ocean waves (tsunamis). Buildings with foundations resting on unconsolidated landfill, old waterways, or other unstable soil are most at risk. Buildings or trailers and manufactured homes not tied to a reinforced foundation anchored to the ground are also at risk since they can be shaken off their mountings during an earthquake. Earthquakes can occur at any time of the year.

Hazards Associated with Earthquakes: When an earthquake occurs in a populated area, it may cause deaths, injuries and extensive property damage. Ground movement during an earthquake is seldom the direct cause of death or injury. Most earthquake-related injuries result initially from collapsing walls, flying glass, and falling objects, or from people trying to move more than a few feet during the shaking. Some of the damage in earthquakes is predictable and preventable.

Aftershocks: Aftershocks are smaller earthquakes following the main shock and can cause further damage to weakened buildings. Aftershocks can occur in the first hours, days, weeks, or even months after the quake. Some earthquakes are actually foreshocks, and a larger earthquake might occur.

1. The following hazards ARE considered if an earthquake may have caused structural damage to the center:
    a. Water system breaks: may flood basement areas;
    b. Exposure to pathogens from sanitary sewer system breaks;
    c. Exposed and energized electrical wiring;
    d. Exposures to airborne smoke and dust (asbestos, silica, etc.);
    e. Exposure to blood borne pathogens;
    f. Exposure to hazardous materials (ammonia, battery acid, leaking fuel, etc.);
    g. Natural gas leaks creating flammable and toxic environment;
    h. Structural instability;
    i. Insufficient oxygen;
    j. Confined spaces;
    k. Slip, trip or fall hazards from holes, protruding rebar, etc.;
    l. Falling objects;
    m. Fire;
    n. Sharp objects such as glass and debris;
    o. Secondary collapse from aftershock, vibration and explosions;
    p. Unfamiliar surroundings;
    q. Adverse weather conditions; and/or
    r. Noise from equipment (generators/heavy machines)
2. In planning considerations for earthquakes, the center:

a. Completes the HVA and determines the probability of an earthquake;
b. Consults with Emergency Management officials regarding earthquake preparedness and response expectations;
c. Identifies safe areas in the center; for example, under a sturdy tables or desks, against interior walls away from windows, bookcases, or tall furniture, considering that the shorter distance the center's occupants need to move to safety, the less likely occupants will be injured;
d. Secures furniture, appliances and other large items in accordance with applicable requirements to help comply with safety compliance and reduce potential damage and injury;
e. Uses NHICS Form 251, Center Systems Status Report, to assess the center following an earthquake;
f. The findings from NHICS Form 251 assist the Incident Commander in determining if the center needs to be evacuated or if occupants can shelter-in-place following the initial earthquake;
g. Trains staff, residents, and families on immediate response procedures to an earthquake including the steps to evacuate or shelter-in-place;
h. Conducts drills to prepare staff and residents for earthquakes;
i. Tracks costs associated with the earthquake's damage;
j. Identifies primary and secondary communications systems;
k. Prepares to address the psychological impact an earthquake can have on residents and staff; and
l. If an immediate peril is identified like a gas leak, uncontrolled fire, or threat of building collapse, the center may immediately evacuate in accordance with the **Evacuation Procedures described in Internal Responsibilities.**

FLOOD/FLASH FLOOD/DAM FAILURE

Flood Watch: An announced Flood Watch indicates local flooding is possible. To the extent practicable, the center team listens to the local radio and television stations for information and prepares to evacuate.
Flood Warning: An announced Flood Warning indicates flooding is already occurring or will occur soon. The center team takes precautions immediately after being made aware of this warning. Center teams prepare to move to higher ground and evacuate.

1. Planning considerations for floods:
    a. The risk of flood is assessed in the Appendix 1: Hazard Vulnerability Assessment. If flood is a probable risk, the center:
        i. Considers purchasing a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup, and staff listens for flood watches and warnings;
        ii. Reviews the local community's emergency plans and becomes familiar with the planned evacuation routes and areas of higher ground;

iii. Inspects onsite areas potentially subject to flooding and onsite areas to which records and equipment could be moved making plans to move records and equipment as needed;
iv. Reviews the center insurance coverage for flooding;
v. Undertakes flood proofing measures, as necessary. These measures include:
1. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings;
2. Installing watertight doors;
3. Constructing movable floodwalls; and
4. Installing pumps to remove flood waters.

b. Note: The center may undertake other emergency flood proofing measures generally less expensive than those listed above but require substantial advance warning. They include:
i. Building walls with sandbags;
ii. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil; and/or
iii. Constructing a single wall by stacking small beams or planks on top of each other.

c. The center evaluates the need for backup systems, such as:
i. Portable pumps to remove flood water;
ii. Alternate power sources such as generators or gasoline-powered pumps; and
iii. Battery-powered emergency lighting.

2. Emergency procedure: flooding general procedures
a. In the event of an expected flood, the following announcement is made:
i. **"Medical Alert-We are activating severe weather protocols. A flood/flash flood watch or warning has been issued for this area effective until _____ (*time watch ends*).** A **flood watch** means that current weather conditions may produce flooding. A **flood warning** indicates flooding is occurring in the area. Please await further instructions." The center provides additional instructions as known and necessary.
ii. Administrator and DON are notified if not on the premises;
b. Center staff accounts for all residents and staff members;
c. Center management staff convene together for a briefing and instruction;
d. The Incident Commander activates this plan to manage the incident. (The most qualified staff member on duty at the time assumes the Incident Commander position);
e. The Incident Commander decides whether to flood proof (see above) or evacuate based on geographical location and history of flooding of the center as well as the results of the evacuation analysis discussed above. If evacuation is necessary, the evacuation processes described above are followed; and
f. The situation is only deemed "under control" after the local authorities have concluded emergency operations and the Incident Commander has declared the situation "safe."

3. **EMERGENCY JOB TASKS: FLOODING**
4. Administrator/Incident Commander:
i. Determine to flood proof the center or evacuate;

ii. If decision is to evacuate, use the evacuation procedures described above; and
iii. Account for residents, staff, and visitors.

b. All Staff/Management:
   i. Assist with flood proofing the center if necessary.

HURRICANES, TROPICAL STORMS AND FLOODING

This center consults with Emergency Management Office to determine flood zone and hurricane evacuation zones, and monitors flood watches and warnings. (Note: Wind damage from a hurricane can necessitate evacuation even if there is no threat of flooding from the storm surge.)
If hurricane or tropical storm warnings are issued for the area, the center team makes plans to protect outside equipment and structures, and follows guidance from the EMS regarding evacuation and other precautions. The center also makes and implements plans to protect windows, such as by use of permanent storm shutters or installation of window covers.
The center also considers and implements backup systems as needed, such as portable pumps to remove flood water and alternate power sources, such as generators or gasoline-powered pumps.

1. Hurricane and tropical storm threat and watch center procedures
   a. Local authorities issue a ***"Watch"*** when a hurricane or tropical storm is expected to hit within 36 hours. The center then makes the following announcement is:
      i. **"Medical Alert: We are activating severe weather protocols. A hurricane/tropical storm watch has been issued for this area effective until _____ (*time watch ends*)."**
   b. After the announcement, each department leaders contacts their staff and creates a schedule of employees to work during the emergency. Staff is scheduled to work:
      i. Before the storm strikes;
      ii. During the storm; and
      iii. After the storm.
   c. The Incident Commander alerts alternate care facilities and transportation providers of the potential evacuation; and
   d. The Incident Commander and center team considers resident acuity/status, infection control precautions in determining transportation needs. (Refer to the procedures above regarding Shelter-in-Place or Evacuation.)

PANDEMIC INFLUENZA

EPIDEMIC GENERAL STATEMENT

The leadership team (Administrator, DON/Resident Care Director, and Center Medical Director) complete the **Epidemic Preparedness Checklist.** If there is an outbreak in the center, the leadership team directs activities.

EPIDEMIC GUIDELINES

1. When an epidemic is declared, follow instructions from clinical leadership to implement the following:
    a. If a severe staffing shortage is apparent, deploy alternative staffing and implement altered standards of care;
    b. Implement use of the **Daily Symptom Screening Form** for all new admissions, re-admissions, staff, visitors, and vendors; and
    c. Make provisions to accommodate overcrowding.
2. **Refer to:**
    a. Epidemic Preparedness Checklist
    b. Influenza Preparedness Plan PowerPoint (on Central)
    c. Altered Standards of Care
    d. Daily Symptom Screening Form
    e. Outbreak Intervention Tiers for Influenza and Gastroenteritis (on Central)

3. General guidelines
    a. Residents with symptoms of or confirmed with targeted epidemic illness should remain in their rooms. Limit transport to medically necessary purposes;
    b. Place a sign stating "Stop-See Nurse Before Entering/For Instructions" on the door;
    c. If there is a widespread outbreak of residents with targeted epidemic illness, or symptoms of influenza, use existing partitions (smoke doors, separate floors) to establish restricted entrance areas in the building furthest away from common areas used by residents and staff;
    d. Label the area as "Stop-See Nurse Before Entering/For Instructions" on the entrances to the area;
    e. Allow serial use of N95 disposable respirators within this area to conserve respirators/masks if the respirator/mask supply is in question;
    f. Place a surgical mask on residents with influenza or other respiratory illness symptoms who are required to be moved out of the restricted area or their rooms;
    g. Instruct visitors:
        i. To limit movements within the building;
        ii. On limiting hand contact with surfaces in the center; perform hand hygiene after surface contact;
        iii. On respiratory hygiene/cough etiquette; and
        iv. On hand hygiene before entering and when leaving the resident room and with any resident contact.
    h. Perform hand hygiene immediately after removing mask or respirator or any PPE;
    i. Treat all excretions, secretions and body fluids as potentially infectious; and

j. Wash hands with soap and water if hands visibly soiled or caring for resident with C. diff or any gastrointestinal infection or use an alcohol-based hand gel.

EMERGING INFECTIOUS DISEASES

1. Definition: Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:
    a. New infections resulting from changes or evolution of existing organisms;
    b. Known infections spreading to new geographic areas or populations;
    c. Previously unrecognized infections appearing in areas undergoing ecologic transformation; and
    d. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

2. General Preparedness for Emergent Infectious Diseases (EID)
    a. Center leadership will be vigilant and stay informed about Emerging Infectious Diseases (EID) with the assistance of Corporate and Divisional Clinical leaders. They will keep Divisional administrative and clinical leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
3. Local Threat
    a. Once notified by the public health authorities at either the federal, state and/or local level the EID is likely to or already has spread to the center's community, the center activates specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities;
    b. The center's Infection Preventionist (IP), with assistance from the National Infection Prevention and Control Team as needed, researches the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies;
    c. Based on the specific disease threat, the center reviews and revises internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated;
    d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing;
    e. If EID is spreading through an airborne route, then the center activates its respiratory protection plan (refer to GHC Policy and Procedure SH408 Respiratory Protection Program) to ensure employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure;
    f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information;
    g. Brief contractors and other relevant stakeholders on the center's policies and procedures related to minimizing exposure risks to residents;
    h. Post signs regarding hand hygiene and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the center along with the instruction that anyone who is sick must not enter the building; and

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the center, screening for exposure risk and signs and symptoms may be done, if possible, prior to admission of a new resident and/or allowing new staff persons to report to work.

4. Self-screening:
    a. Staff will be educated on the center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
        i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health;
        ii. Precautionary removal of employees who report an actual or suspected exposure to the EID;
        iii. Self-screening for symptoms prior to reporting to work; and
        iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
5. Self-isolation:
    a. In the event there are confirmed cases of the EID in the local community, the center may consider closing the center to new admissions, and limiting visitors based on the advice of local public health authorities.
6. Environmental cleaning: The center follows current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
    a. Engineering controls: The center uses appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.
7. Instructions to manage suspected case(s) in the care center:
    a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation/precaution room and notify local public health authorities;
    b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible. Resident to wear mask during the transfer;
    c. If the suspected infectious person requires care while awaiting transfer, follow center policies for isolation/precaution procedures, including all recommended PPE for staff at risk of exposure;
    d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE;
    e. If feasible, ask the isolated resident to wear a mask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated resident unless it advised otherwise by public health authorities;
    f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation/precaution room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC;

g. Implement isolation/transmission-based precautions (TBP) procedures in the center (isolation/TBP rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities; and
h. Activate quarantine (separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

ARMED INTRUDER GENERAL GUIDELINES

In situations in which there is lead-in time to a potential armed intruder violence threat against the center, the center management team discusses actions to be taken by the center and questions to ask the intruder.

1. During an armed intruder event, the center follows steps, when possible, staff will determine which of the "Four Outs" will be the best for their survival:
    a. "Get Out": Identifying current residents, visitors and staff for potential exit from the center. Individuals will proceed to exit the building until they find a safe place. (This is the best choice if staff can safely do so.);
    b. "Lock Out": Identifying if residents, visitors and staff could be protected by potentially locking them in the center, preventing entry by the intruder. Individuals will get behind a locked or barricaded door. This action is the next best choice and if it is safe to do so, the best way to protect residents from becoming a victim;
    c. "Hide Out": Identifying current residents, visitors, staff and locations for potential concealment within the center. Staff will hide in inconspicuous places in the center. Staff can help residents by hiding them in plain sight (e.g. Put extra linens on a resident's bed when the resident is bed-ridden; or
    d. "Take Out": Establishing a plan to stop the armed intruder's activities. Staff will use diversions and weapons of opportunity to take out the Armed Intruder. When considering a takeout plan, if there are several people, use diversions and make a plan to gang up on the Armed Intruder.
2. In addition, a staff member calls 911 when safe to do so. Gives the 911 operator specific details to aid in law enforcement's response to the event. Uses a center phone even if just to leave an open line to the 911 operator;
3. The fire alarm is not pulled/activated; and
4. Refer to the Armed Intruder Training and associated Armed Intruder Table Top Exercise for more information on the center's plan and practices used to manage these emergencies.

WINTER STORMS

Background
Winter storms are often an underestimated threat. For the frail elderly, the single greatest threat posed by winter is the loss of body heat. Normal aging is accompanied by a decline in the ability to thermo-regulate. Chronic ailments and acute injuries exasperate the ability to self-regulate body temperature. In fact, fifty percent of cold-related injuries happen to individuals over the age of 60.

1. Preparing for the Storm
    a. Before the snow begins:
        i. All departments must inventory existing supplies and order low supplies prior to snowfall;
        ii. Generator fuel must be checked and generator test run. If your generator uses diesel or propane, the tank should never fall below ½ tank fill level at any time; and
        iii. Snow blower fuel must be checked and test run.
    b. After snow has started to fall:
        i. Parking lot entrance, fire lane and all facility exits must be kept clear;
        ii. Fire hydrants are to be kept accessible at all times; and
        iii. Areas for ambulances and supply vehicles take priority over parking areas.
2. Winter Hazard Communication
    a. The National Weather Service issues outlooks, watches, warnings, and advisories regarding potentially hazardous winter weather:
        i. Outlook: this is essentially a forecast, informing the public winter storm conditions are possible in a 2 to5 day timeframe. Actions at this time are to monitor local media for weather condition updates;
        ii. Advisory: winter weather conditions are expected and could cause significant inconvenience and could potentially create hazardous conditions. However, if one is prepared and cautious, advisory conditions should not be life threatening;
        iii. Watch: winter storm conditions are possible within a 36 to 48-hour window. Begin preparations; and
        iv. Warning: potentially hazardous winter weather is occurring or will occur in 24 hours.
3. Wind Chill
    a. Wind chill can be a significant problem. Exposure to cold can lead to frostbite or hypothermia. The elderly are highly susceptible. Regardless of whether the temperature is 32F or -32F, cold has the same effect. Wind chill is not the actual air temperature, but is the impact of the combination of wind and cold upon exposed skin. Moving air conducts heat away from the body faster.

Wind Chill Chart

Adapted from the National Weather Service, Originally Published 11/01/01.

Temperature across top, wind speed down left side.

Calm	40	35	30	25	20	15	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	36	31	25	19	13	7	1	-5	-11	-16	-22	-28	-34	-40	-46	-52	-57	-63
10	34	27	21	15	9	3	-4	-10	-16	-22	-28	-35	-41	-47	-53	-59	-66	-72
15	32	25	19	13	6	0	-7	-13	-19	-26	-32	-39	-45	-51	-58	-64	-71	-77
20	30	24	17	11	4	-2	-9	-15	-22	-29	-35	-42	-48	-55	-61	-68	-74	-81
25	29	23	16	9	3	-4	-11	-17	-24	-31	-37	-44	-51	-58	-64	-71	-78	-84
30	28	22	15	8	1	-5	-12	-19	-26	-33	-39	-46	-53	-60	-67	-73	-80	-87
35	28	21	14	7	0	-7	-14	-21	-27	-34	-41	-48	-55	-62	-69	-76	-82	-89
40	27	20	13	6	-1	-8	-15	-22	-29	-36	-43	-50	-57	-64	-71	-78	-84	-97
45	26	19	12	5	-2	-9	-16	-23	-30	-37	-44	-51	-58	-65	-72	-79	-86	-93
50	26	19	12	4	-3	-10	-17	-24	-31	-38	-45	-52	-60	-67	-74	-81	-88	-95
55	25	18	11	4	-3	-11	-18	-25	-32	-39	-46	-54	-61	-68	-75	-82	-89	-97
60	25	17	10	3	-4	-11	-19	-26	-33	-40	-48	-55	-62	-69	-76	-84	-91	-98

Frostbite Times

30 Minutes

10 Minutes

5 Minutes

1. Response to wind chill
    a. To ensure residents do not suffer from exposure to cold, consider the following:
        i. Providing extra attention to residents who wander or are at risk for elopement;
        ii. Clothing in loose-fitting layers and an insulated head covering, even indoors;
        iii. Attempt to ensure that residents remain dry;
        iv. Should a person succumb to cold, warming the person slowly, starting with the body core. Do not start warming with the arms and legs, as this will drive cold blood toward the heart which can trigger heart failure. Change the resident into warm, dry clothing and then cover them with a blanket. Avoiding providing alcohol, coffee, or any other hot beverage or food. Discuss administration of medications with the attending provider;
        v. Providing high calorie foods and snacks for staff and residents;
        vi. Providing extra blankets. (If possible, hypo-allergenic blankets should be used. Residents who wish to use their own wool blankets or quilts with other natural fibers should be allowed to do so, but they should not be allowed to share these items as other residents may be allergic to the natural fibers); and
        vii. Monitoring residents and increasing hydration activities; increased clothing and use of blankets may increase sweating. Dry air associated with extremely cold weather may also lead to residents dehydrating faster.

2. If the heating system suffers a significant mechanical failure during cold weather, consider evacuation;
3. Residents on medical oxygen should be given alternate safe means of staying warm and should be kept away from any potential source of ignition; and
4. Evacuation under icing conditions is not a good idea. Be prepared to shelter in place in winter.

Refer to Loss of Utilities Heating Failure if center heat is compromised.

1135 WAIVERS

1. In the event a major disaster or public health emergency is declared by the Secretary, the facility reserves the right to request a waiver in accordance with section 1135 of the Social Security Act, and by which certain statutory requirements and or services may be modified or waived during the duration of the emergency;
2. Under the waiver the role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials is such that sufficient services and healthcare items will be provided to the maximum extent feasible and in part, modifies requirements that physicians and other healthcare professional hold licenses in the State in which they provide services if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area).

VOLUNTEERS

The Center may use volunteers in an emergency or other emergency staffing strategies as necessary to provide for the care and treatment of patients. The Center collaborates with the local Emergency Management Services and state or federally designated health care professionals to address surge needs during an emergency. Involvement of volunteers in management of emergencies is addressed in this EPP.

1. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers;
2. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations;
3. Staff are monitored through use of the staffing schedules (updated as needed).
4. Volunteers, visitors, and others are monitored using the visitor log (typically kept in the reception area);
5. The center maintains current information all center personnel and volunteers with addresses and phone numbers for contact purposes; and
6. The Incident Commander/designee coordinates with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event staff is needed in alternate locations. Trained volunteers are permitted to transport, move and assist residents if necessary.

Refer to Exhibit 8. NHICS Form 523, Volunteer Staff Registration.

ANNUAL REVIEW AND SIGN-OFF

1. The Safety Excellence Team and the Administrator reviews and approves this manual and associated appendices and supporting documentation:
    a. Prior to implementation;
    b. After regulatory updates;
    c. If new hazards are identified or existing hazards change;
    d. After tests, drills, or exercises, if issues requiring corrective action have been identified;
    e. After actual disasters/emergency responses;
    f. After infrastructure changes;
    g. At each update or revision; and
    h. At least annually.
2. Staff Training
    a. All staff are trained and demonstrate competency during orientation and annually with materials based on this Emergency Preparedness Plan and corresponding policies and procedures. The center maintains electronic and/or written documentation of training. Administrators must ensure training is completed as required.
3. Staff Testing: Exercises, Drills and Simulations
    a. This center conducts internal and external training exercises, drills, and simulations **at least annually and in accordance with applicable local, state, and federal guidelines**. This training is discussed further in the center's Emergency Preparedness Compliance Guide.
        i. This center participates in full-scale, community-based exercise or, when a community-based exercise is not accessible, an individual, facility-based exercise.
        ii. This center conducts an additional exercise that may include, but is not limited to the following:
            1. a second full-scale community-based exercise or individual,
            2. a facility-based full scale exercise, or
            3. a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.
        iii. If this center has experienced an actual natural or man-made emergency requiring activation of the emergency plan, the center will not need to participate in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the event; and
        iv. The center documents completion of these activities. This documentation includes an analysis of the center's response to the exercise and emergency events, and revises this Emergency Preparedness Plan as needed.
    b. Exercises, drills, and simulations are used to practice emergency procedures and to identify concerns prior to a crisis or disaster situation;
    c. Drill evaluation are be conducted on different levels of management within the center;
    d. Drill evaluations are not confined to routine fire or evacuation drills;

e. Drill evaluations are used to verify planning, response, and recovery programs are in place for the center;
f. Outside resources, including local emergency responders/support services, are invited to periodically participate in, observe, and evaluate internal exercises, drills, and simulations; and
g. Exercises, drills, and simulations are documented to include:
    i. Who participated;
    ii. Concerns identified;
    iii. Corrective actions taken to correct deficient areas; and
    iv. Reports of such activities are retained within the center per state and federal regulations.

Refer to:
Appendix 24: Annual Review and Sign-off

STATE AND LOCAL REQUIREMENTS

The center may be required to follow more stringent state and local regulations than guided within this manual. As such, additional regulations are analyzed and complied with as necessary.

Refer to:
Appendix 25: State and Local Requirements

POLICIES AND PROCEDURES LINKS

Corporate Policies and Procedures
Emergency Preparedness
Emergency Preparedness: Evacuation and Waivers
Emergency Preparedness: Medical Records
Emergency Preparedness: Shelter in Place
Emergency Preparedness: Supplies
Significant Events Reporting

Food and Nutrition Services Procedures
Food Service Emergency Plan (P&P 6.3)
Food Service Emergency Procedures (P&P 6.4)

Omnicare LTC Pharmacy Services
LTC Facilities Receiving Pharmacy Products and Services from Pharmacy
Relocation of Residents or Pharmacy Services During an Emergency or Disaster

Center Operations
OPS100 Accidents/Incidents
OPS142 Transfer Agreements
OPS161 Facility Assessment
OPS164 Utilization of Outside Resources during an Emergency

Preventative Maintenance Policies and Procedures
Emergency Generators

Safety and Health Policies and Procedures
SH100 Safety Management Program
SH601 Personal Protective Equipment
SH602 Personal Protective Equipment: Assessment of
SH604 Procurement and Distribution of Respirators: Airborne Illness

FEDERAL DEFICIENCIES (ETAG) CROSSWALK

Provided as reference. **Users are strongly encouraged to refer to Genesis Central for up to date policies and procedures and to search for key words within this document and on Central for additional information.**

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0001	Establishment of the Emergency Program	Corporate P & P 1.22, Emergency Preparedness	Completed EPP (Full Plan) Completed EP Compliance Guide Appendices
E-0004	Development Maintain EP Program	Same as above	Same as above
E-0006	Maintain and Annual EP Updates	Same as above	Same as above
E-0007	EP Program Population	Center Operations P & P OPS 161 Facility Assessment	EPP Appendix 23. Description of Center Patient/Resident Population
E-0009	Process for EP Collaboration	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	References to collaboration throughout EPP
E-0013	Development of EP Policies and Procedures	Refer to Links Above	Refer to Links Above
E-0015	Subsistence Needs for Staff and Patients	Refer to Links Above	References throughout EPP
E-0018	Procedures for Tracking of Staff and Patients	Corporate P & P 1.22, Emergency Preparedness	Refer to Exhibit 3 and Exhibit 7 NHICS Forms 255 and 252 and references to these forms in the EPP
E-0020	Policies and Procedures including evacuation	Refer to Links Above	References to Evacuation throughout EPP
E-0022	Policies and Procedures for Sheltering	Corporate P & P 1.31, Emergency Preparedness: Sheltering in Place	References to Sheltering in Place in EPP
E-0023	Policies and Procedures for Medical Documents	Corporate P & P 1.30, Emergency Preparedness: Medical Records	Refer to Section LL, Receiving Center: Medical Records

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0024	Policies and Procedures for Volunteers	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Refer to Section XXIX. Volunteers and Exhibit 8, N HICS Form 523, Volunteer Staff Registration
E-0025	Arrangement with Other Facilities	Center Operations P & P OPS142 Transfer Agreements and OPS 164 Utilization of Outside Resources During an Emergency	Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0026	Roles under a Waiver Declared by the Secretary	Center Operations P & P OPS163 Utilization of Outside Resources during an Emergency	Refer to Section XXVIII. 1135 WAIVERS
E-0029	Development of Communication Plan	Corporate P & P 1.22, Emergency Preparedness	Refer to section V. COMMUNICATION PLAN and associated exhibits
E-0030	Names and Contact Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Appendix 3: Center Administrative/Staff Contact List
E-0031	Emergency Contact Information	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Appendix 7: Emergency Resources and Contacts
E-0032	Primary/Alternate Means of Communication	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN
E-0033	Methods of Sharing Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN and Appendix 7: Emergency Resources and Contacts as well as references to evacuation and medical records throughout the EPP

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0034	Sharing Information on Occupancy/Needs	Corporate P & P 1.22, Emergency Preparedness, Center Operations P & P OPS 142 Transfer Agreements	Refer to Section VII, SURGE CAPACITY and Appendix 13, Surge Capacity, and Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0035	LTC and ICF/IID Family Notifications	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. Communication Plan and Section III. General Guidelines, D. Notification of Plan
E-0036	Emergency Prep Training and Testing	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0037	Emergency Prep Training Program	Corporate P & P 1.22, Emergency Preparedness	Vital Learn Reports and Completed Attestations; refer to Emergency Preparedness Compliance Guide
E-0039	Emergency Prep Testing Requirements	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0041	LTC Emergency Power	Preventative Maintenance P & P 2.0, Emergency Generators	Refer to Section XII, Loss of Utilities, Appendix 2, Building Construction and Safety, and Appendix 15, Utility Shut Off Procedures
E-0042	Integrated Health Systems	Not Applicable	Not Applicable

PLAIN LANGUAGE EMERGENCY NOTIFICATION SCRIPT

TAKE COVER

"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."

"All Clear, Take Cover is over" is then paged to signal the Take Cover situation has ended.

LOSS OF UTILITIES

"Facility Alert-We are activating Loss of Utilities protocols- (Describe loss of Power and Location). Please continue your duties and listen for further instructions."

BOMB THREAT

"Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions."

NUCLEAR, CHEMICAL, OR RADIATION FALLOUT

"Facility Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."

FIRE

"Facility Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."

INTERNAL OR EXTERNAL DISTURBANCE

"Security Alert- We have a disturbance (Location). Please listen for further instructions."

HOSTAGE/ARMED INTRUDER SITUATION

"Security Alert-We are activating Hostage/Armed Intruder protocols- We have a Hostage/Armed Intruder situation (Location). Please listen for further instructions."

ELOPEMENT

"Medical Alert-We are activating Missing Resident protocols- The Resident was last seen (location)."

TORNADO WATCH

"Medical Alert-We are activating severe weather protocols- A tornado watch has been issued for this area effective until _____ (time watch ends)." (Repeated after five (5) minutes and then hourly until the watch has terminated.)

TORNADO WARNING

"Medical Alert-We are activating severe weather protocols- A tornado warning has been issued for our area. Immediately implement Take Cover procedures. Repeating—a tornado warning has been issued for our area. Immediately implement Take Cover procedures." (Repeated after five (5) minutes and then hourly until the warning has terminated)

FLOOD WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- A flood/flash flood watch or warning has been issued for this area effective until _____ (time watch ends)."

HURRICANE WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- a hurricane/tropical storm watch has been issued for this area effective until _____ (time watch ends)."

GENERAL ALL CLEAR ANNOUNCEMENT

"All Clear, Repeat, All Clear"

Emergency Preparedness Plan (EPP) List of Appendices

- Appendix 1: Hazard Vulnerability Analysis (HVA)
- Appendix 2: Building Construction and Life Safety
- Appendix 3: Center Administrative/Staff Contact List
- Appendix 4: Emergency Operation Center Designation
- Appendix 5: Area Administrative Staff Contact List
- Appendix 6: Company Contacts
- Appendix 7: Emergency Resources and Contacts
- Appendix 8: Additional Resources
- Appendix 9: Transfer Agreements
- Appendix 10: Short-term Evacuation Plan
- Appendix 11: Triage of Casualties
- Appendix 12: Emergency Supplies and Location of Critical Equipment
- Appendix 13: Surge Capacity
- Appendix 14: Emergency Water Supply
- Appendix 15: Utility Shut-off Procedures
- Appendix 16: Potential Explosives List
- Appendix 17: Special Care Unit Fire Procedure
- Appendix 18: Fire Sprinkler Shut-Down Procedures
- Appendix 19: Fire Alarm Reset Procedures
- Appendix 20: Security Plan
- Appendix 21: Elopement Drill Documentation Form
- Appendix 22: Succession Plan
- Appendix 23: Description of Center Patient/Resident Population
- Appendix 24: Annual Review and Sign-Off
- Appendix 25: State and Local Requirements
- Appendix 26: Insertions from Compliance Guide Completed Tasks

Appendix 1: Hazard Vulnerability Analysis (HVA)

Instructions
Evaluate each event type using the hazard specific scale, using an all-hazards approach that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address a wide spectrum of emergencies/disasters.

Event Type
This column includes the event, risk or disaster you are assessing. Additional events may be added and evaluated in the Assessment; use the blank lines for these items.

Probability
Rate the probability of the risk occurring on a scale of zero (event will not occur) to 3 (event is very likely to occur). To rate the probability of an event occurring, at a minimum consider the known risk of the event occurring based on historical data and manufacturer/vendor statistics.

- Scale: How often has the event occurred within the last year to 10 years?
  - There is no likelihood of this event occurring in this setting/area (i.e., volcano). = score of 0 (no additional entries are required for this event type)
  - Event has not occurred in the past 10 years = score of 1
  - Event occurs every 3 to 10 years = score of 2
  - Event occurs approximately every 1 to 3 years = score of 3

Note: The Probability of human events (i.e., workplace violence, mass casualties) can never be assessed with a probability score of 0. These types of events have the score of 0 identified as N/A in the HVA.

Risk
Rate the associated risk of each event to patients and staff, property, finances (such as the cost to replace, cost of repair, time to recover and the potential interruption or inability to provide services). Input the highest associated score.

- Scale: If the event occurs will it result in:
  - A threat to human health, safety or life? Could the event result in significant injury or death? Score = 5
  - Property Damage? Score = 4
  - Economic Loss or Legal Ramifications? Will employees be able to report to work? Will patients be able to get to the center? Would the center be at risk for fines, penalties, or other legal interventions? Score = 3
  - Systems Failure? Score = 2
  - Loss of Community Trust or Goodwill? Score = 1

Preparedness
Rate the center's level of preparedness for the event.

- Scale: If the event occurs the center is:
  - Well prepared: the center has a current plan, the staff is aware of the plan and has participated in drills, back-up systems are available = score of 1
  - Partially prepared: the center has a plan, with current documents and contracts. Staff may require additional training or drills, center may need back-up systems = score of 2

- Not Prepared: the center does not have a plan at all, or only has a plan, and has not trained the staff or collected associated documents and contracts, and does not have back-up systems = Score of 3

Using the HVA

For each row, Multiply the Probability score by the sum of the Risk and Preparedness scores from all columns, enter score Review and highlight the events types with highest Hazard Vulnerability (HV) scores. These events pose the greatest risks to the center, and are carefully considered and prepared for as the center completes the rest of the appendices in the EPP, and associated training and drills.

Hazard Vulnerability Assessment

Center Name Keene Center Business Unit #: _____ Date: 11/1/22

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			HV SCORE
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	←*Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
HURRICANE		X			X							X	
TORNADO		X			X							X	
SEVERE THUNDERSTORM	X				X							X	
SNOWFALL	X				X							X	
BLIZZARD	X				X							X	
ICE STORM		X			X							X	
EARTHQUAKE		X			X							X	
TIDAL WAVE				X					X		X		
EXTREME TEMPERATURES		X				X						X	
DROUGHT				X		X						X	
FLOOD, EXTERNAL			X		X							X	
WILD FIRE			X								X		
LANDSLIDE			X								X		
VOLCANO				X									
PANDEMIC				N/A	X						X		
ELECTRICAL FAILURE		X			X							X	
GENERATOR FAILURE		X			X							X	
TRANSPORTATION FAILURE		X			X						X		
FUEL SHORTAGE		X			X						X		
NATURAL GAS FAILURE		X			X							X	
SEWER FAILURE		X			X							X	
STEAM FAILURE		X			X								
FIRE ALARM FAILURE		X			X							X	
COMMUNICATION FAILURE		X			X						X		

VENT TYPE	PROBABILITY				RI					PREPAREDNESS			TOT
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	← *Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
MEDICAL VACUUM FAILURE				N/A			X				X		
HVAC FAILURE		X									X		
INFORMATION SYSTEM		X					X				X		
FIRE, INTERNAL			X			X					X		
FLOOD, INTERNAL			X			X					X		
HAZMAT, INTERNAL			X			X					X		
MASS CASUALTY – TRAUMA			X	N/A	X						X		
MASS CASUALTY – MEDICAL			X	N/A		X					X		
MASS CASUALTY – HAZMAT			X	N/A	X						X		
HAZMAT EXPOSURE			X	N/A	X						X		
TERRORISM – BIOLOGICAL			X	N/A	X						X		
TERRORISM – CHEMICAL			X	N/A	X						X		
HOSTAGE SITUATION			X	N/A	X						X		
CIVIL DISTURBANCE (RIOT)			X	N/A		X					X		
LABOR ACTION			X	N/A		X					X		
BOMB THREAT			X	N/A	X						X		
WORKPLACE VIOLENCE			X	N/A	X						X		
DOMESTIC VIOLENCE			X	N/A	X						X		
BUILDING BREAK-IN			X	N/A		X					X		
AUTO BREAK-IN			X	N/A			X				X		
MEDICATION THEFT			X	N/A			X				X		
ASSAULTS (OUTSIDE)			X	N/A					X		X		
ELOPEMENT		X		N/A	X							X	
KIDNAPPING			X	N/A	X						X		

Appendix 2: Building Construction and Life Safety

Instructions: Enter information as prompted.

A. Building Construction Type/Year Built (refer to Life Safety Survey for details): Masonry / Brick 1978

B. Have additions been constructed? Yes X No

1. If additions have been constructed, in what year(s)?

_____

C. Number of Stories: 3

D. Number of Buildings: 1

E. Number of Beds: 106

F. Approximate Number of Staff per Shift: 1st = 45, 2nd=20, 3rd=12

G. Fire Alarm System –
Name of Monitoring Service: Direct link to Keene Fire

H. Generator Vendor Name: Power Up

Generator Vendor Phone Number: 603-657-9080/ 866-420-4906

1. Type, phase and voltage of generator: Kohler 3 phase 102-208
2. Areas of the building supplied by emergency power: Complete building coverage
3. Fuel Type: Diesel
4. Fuel Capacity: 1278 gallons
5. Fuel Duration: 102-142 hours 4-6 days
6. Fuel Tank above or below ground level?: Above Ground
7. How/When is generator tested?: Weekly under partial load
8. Is generator above projected flood level?: Yes, except if local dam is breached.

I. Is the building constructed to withstand hurricanes or high winds? X Yes No
If Yes:
   1. What is the highest category of hurricane or wind speed that the building can withstand? 150 miles per hour
   2. What is the highest category of hurricane or wind speed that the center roof can withstand 100 miles per hour
   3. Is the center in a flood plain? **X** Yes No
   4. If the center is in a hurricane zone, is a storm surge expected? Yes **X** No

J. General description of resident/patient population:
Rehab and long term care residents and patients. Medical conditions vary. Ambulatory and non ambulatory residents with a changing resident population.

For the safety of building occupants, the Emergency Preparedness Leadership Team identifies the best available refuge areas in the center. Many buildings contain rooms or areas designed to offer some degree of protection from all but the most extreme tornadoes and winds. In buildings without specific rooms designed and constructed to serve as safe rooms, the goal should be to select the **best available refuge areas** - the areas that will provide the greatest degree of protection.

In general, the **best available refuge areas** meet the following criteria:

- **Interior rooms.** Rooms without an exterior wall or window are less likely to be penetrated by windborne debris. Examples include resident bathrooms, small office areas without windows, janitor closets, clean and soiled utility rooms, pantry storage rooms, medication rooms, basement rooms and corridors, central supply rooms, center restrooms, staff locker rooms, and closets.
- **Location below ground or at ground level.** Upper floors are more vulnerable to wind damage.
- **No glass in the room.** Typically, windows and glass doors are extremely vulnerable to high wind pressures and the impact of windborne debris.
- **Reinforced concrete or reinforced masonry walls.** Reinforced walls are much more resistant to wind pressures and debris impact, but can fail if the roof deck is blown away.
- **Strong connections between walls and roof and walls and foundation.** Walls and roofs are better able to resist wind forces when they are securely anchored to the building foundation.
- **Short roof spans.** Roofs with spans of less than 25 feet are less likely to be lifted up and torn off by high winds.
- **Long central corridors** often qualify as the best available refuge areas. In addition to having desirable structural characteristics (e.g., short roof spans, minimal glass area, and interior locations), corridors usually are long enough to provide the required amount of refuge area space and can be quickly reached by building occupants. **If a corridor is chosen, marking the high wind area of refuge boundaries at least 30 feet from a glass door or window is advisable**, as well as educating staff to keep occupants within the boundaries and to close all doors leading to the corridor during a high wind event.

*Note: The best available refuge areas do **not** ensure the safety or survival of their occupants. They are simply the areas of a building in which survival is most likely.*

If the center is unsure whether a particular location is appropriate to use as a high wind area of refuge, the Team refers to Federal Emergency Management Agency FEMA's Best Available Refuge Area Checklist to evaluate appropriate areas of refuge

Part B: Refuge Areas

List all areas of refuge according to the guidelines above and mark these areas on the center floor plan:

1. 1st floor conference room.
2. Hallways- 1st floor
3. Library- Concern Glass
4. Main Dining Room 1st floor- Concern Glass
5. Rehab Therapy Room- Concern Glass
6. Beauty Salon- No Glass
7. Recreation Therapy Room- Concern Glass
8. Staff Lunch Room- Inside location no glass.
9. 2nd & 3rd Floor Day Lounge- Concern Glass
10. Inside Hallway Main Floor
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

an emergency (e.g. incident commander, public information officer, patient liaison, etc.). For example, a Facility Incident Commander may be the Administrator. Also, a unit manager may be the facility's identified person as the Safety Officer.

NOTE: INSERT LIST OF ALL STAFF CONTACT LIST HERE: INCLUDE ALL STAFF, PHYSICIANS, LOCAL LTC FACILITIES AND VOLUNTEERS. REVIEW AND UPDATE AS NEEDED.

Appendix 4: Emergency Operation Center Designation

In the event of an emergency/disaster, the center must have 2 areas identified from which the emergency would be managed. The location should have internet and phone access, as well as access to emergency supplies and this EPP, if possible.

The Emergency Operation Center (EOC) will be located in:

1st floor Conference Room

The secondary Emergency Operation Center (EOC) will be located in:

Administrator's Office

Appendix 5: Area Administrative Staff Contact List

INSTRUCTIONS: Fill in the necessary contact information below. Contact as needed based on this EPP.

Area:	Name	Contact Number
Sr. VP Operations	Shayne Hutchinson	(304) 419-5057
Sr. VP Medical Affairs	Carolyn Blackman	(401) 479-4144
SVP Clinical Operations	Julie Britton	(215) 803-5644
MP/RED, Operations	Teale Howe	(603) 571-0279
VP/Director of Clinical Ops	Tina Osborn	(978) 602-0092
Clinical Quality Specialist	Audrey Kerin	(802) 323-6714
	Kristen Marois	(603) 325-8345
VP Property Management	Perry Valentine	(610) 806-2602
Director of Employee Safety	Cynthia Fleming	(603) 387-9380
Region Property Manager	Mike Lenoch	(603) 315-0565
Region/Area HR Manager	Jessica Foley	(603) 686-4396
OmniCare Pharmacy		

CareLine: 1 (866) 745-2273

Appendix 6: Company Contacts

Corporate Office	Genesis HealthCare, 101 E State St., Kennett Square, PA 19348	
Executive Chairman	David Harrington	david.harrington1@genesishcc.com
EVP & CFO	Orrin Feingold	orrin.feingold@genesishcc.com
EVP & COO	Melissa Powell	melissa.powell4@genesishcc.com
SVP Human Resources	Brandon Poole	brandon.poole@genesishcc.com
SVP Medical Affairs	John Loome	410-494-7671
SVP & CIO	Joe Montgomery	610-716-7439
EVP	Michael Sherman	610-864-9751
SVP Spend Management and Support Services	David Bertha	610-247-8822
VP Compliance	Maria Suarez	505-468-2384
IT Help Desk	Help Desk Rep.	800-580-3655
Director, Risk & Insurance Services	Janice Burnap	505-259-1913
GHC Claims & Litigation	Bette Pfeiffer	610-925-2415 610-925-2419 (FAX)

*Communication with media is guided by division Business development leaders. Refer to Crisis Communication Contacts on Central for details.

Appendix 7: Emergency Resources and Contacts

Instructions: Enter information into the table as prompted below. Emergencies involving fire, death or serious injury are reported in accordance with state and federal guidelines. Other reporting and engagement is completed as needed during an emergency.

COUNTY/LOCAL Emergency Management Agencies

County:	Cheshire
Contact/Title:	Herb Stephens, Area Director of Winchester
Address:	1 Richmond Rd
City, State Zip	Winchester, NH 03470
Phone Number:	603-355-0858

State Emergency Management Agency

State:	**New Hampshire**
Contact/Title:	Department of Safety
Address:	33 Hazen Drive
City, State Zip	Concord, NH 03305
Phone Number:	603-271-2231

Federal Emergency Management Agency (FEMA)

Region:	United States
Contact/Title:	Department of Homeland Security
Address:	99 High St.
City, State Zip	Boston, MA 02110
Phone Number:	877-336-2734

COMMUNITY RESOURCES CONTACTS:

Agency:	**Name:**	**Phone:**
County Health Department	Eileen Fernandez	603-354-5454 x2130
LTC Ombudsman	Fleurette Grenier	603-271-4375
State Licensing and Certification Agency	NH Board of Nursing	603-271-2823
County DHHR Office	DHHR- Keene	603-357-3510
Poison Control Center	Northern New England	800-222-1222
Tribal Contact		
Other		

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

Appendix 8: Additional Resources

Use this form to maintain contact information for emergency support services.

NHICS FORM 258 | CENTER RESOURCE DIRECTORY

	CONTACT (COMPANY/AGENCY/NAME)	**PHONE NUMBER** - PRIMARY	**PHONE NUMBER** - SECONDARY	**E-MAIL**	**FAX / WEBSITE**
Agency for Toxic Substances and Disease Registry (ATSDR)	Poison Control	800-232-4636	770-488-7100		www.aapcc.org
Ambulance/EMS	911	911			
American Red Cross	Keene Chapter	603-352-3210			www.redcross.org
Biohazard Waste Company	Stericycle	866-783-7422			www.stericycle.com
Buses	Delano Company	603-399-4371			
Cab, City	Adventure Taxi	603-355-1484			www.advlimo.com
Emergency Management Agency	FEMA	877-336-2734			www.fema.gov
CDC		800-232-4636			www.cdc.org
Clinics	Dartmouth Hitchcock	603-354-5420			www.dartmouth-hitchcock.org
Coroner/Medical Examiner	Cheshire County Coroner	603-271-1235			
Dispatcher - 911	911	911			
Emergency Operations Center (EOC), Local	Keene Dispatch Center	603-357-9861			
Emergency Operations Center (EOC), State	NH Dept of Safety	603-271-2231			
Engineers:					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
HVAC	HVAC	Granite State Plumb	603-529-3322		
Mechanical	Mechanical	Pappas Contracting	603-313-7107	603-380-5252	
Structural	Structural				
Environmental Protection Agency (EPA)	Environmental Protection Agency	NH Dept of Environmental services	603-271-3500		
Epidemiologist	Epidemiologist	NH Dept of Health	603-624-6466		
Family	Family	*SEE FAMILY CONTACT LIST*			
Fire Department	Fire Department	Keene Fire Department	603-209-1742		
Food Service	Food Service	Sysco	508-285-1000		
Fuel	Fuel	Cheshire Oil	603-352-0001		
Funeral Homes/Mortuary Services	Funeral Homes/Mortuary Services	Foley Funeral	(603) 352-0341		
Generators	Generators	Power up Generator	866-420-4906	603-657-9080	
HazMat Team	HazMat Team	Keene Fire Dept.	911		
Health Department, Local	Health Department, Local	Keene Health Dept.	603-357-9836		
Heavy Equipment (e.g., Backhoes, etc.)	Heavy Equipment (e.g., Backhoes, etc.)	Holmes Construction	603-231-3242		
Home Repair/Construction Supplies:	Home Repair/Construction Supplies:	Home Depot	603-355-2113		

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Hospitals:	Cheshire Medical Center	603-354-5400			www.**cheshire-med**.com
Hotel	Best Western				bestwestern.com/Official
Housing, Temporary					
Ice, Commercial	Sysco	508-285-1000			
Laboratory Response Network					
Laundry/Linen Service	People's Linen	(603) 352-2038			peopleslinen.com
Law Enforcement:	Keene Police Dept.	603-352-2222			www.keenepd.org
City Police	Keene Police Dept.	603-352-2222			www.keenepd.org
County Sherriff					
Highway Patrol	NH state police	603-271-1162			
Licensing & Certification District Office	Michael Fleming	(603) 271-9499			https://www.dhhs.nh.gov/contactus/index.htm
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:	Keene Center	603-357-3800			
Media:	WMUR Channel 9				
Print	Keene Sentinel	603-352-1234			
Radio					
Radio					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
TV					
TV					
TV					
Medical Gases					
Medical Supply	Medline	800-633-5463	603-320-2926		
Medication, Distributor:	OMNICARE	603-625-6406			www.omnicare.com
Moving Company:					
Pharmacy, Commercial:	OMNICARE	603-625-6406			www.omnicare.com
Poison Control Center	Northern NE Poison Center				https://www.nnepc.org/
Portable Toilets					
Radios:	Keene Center/Langdon Place	357-3800			
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds	Joerns	800-826-0270			joerns.com

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Biomedical Devices	Medline	1-800-633-54 63			www.medline.com
Medical Devices	Medline	1-800-633-54 63			www.medline.com
Oxygen Devices					
Radios					
Restoration Services (e.g., Service Master)					
Road Conditions	*CALTRANS*	*1-800-427-7623*			
Salvation Army					
Shelter Sites					
Staff	*SEE STAFF CONTACT LIST*				
Surge Facilities	Listed with Administrator				
Trucks:					
Refrigeration	Sysco	508-285-1000			
Towing					
Utilities:					
Gas	Liberty Utilities	603-209-2586			
Power	Eversource	800-662-7764			www.eversource.com
Sewage	Keene Water dept.	(603) 352-6550			https://keenetx.com/departments/utilities
Telephone					
Water					
Ventilators					
Water Vendor – Potable, Portable Shower/Portable Toilet	Sysco	See above			
Other:					

Appendix 9: Transfer Agreement

Use this form to document every transfer agreement for transportation and reception of residents (e.g. other Long-Term Care Centers, Hospitals, and Ambulance Companies). **Reminder: Execute at least one agreement with a Long Term Care Center more than 50 miles away.**

Type of Service:	Hospital
Name:	Cheshire Medical
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Ambulance/Transport
Name:	Diluzio
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Long Term Care Facility
Name:	Langdon Place of Keene
Address:	126 Arch Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-3902

Type of Service:	Long Term Care Facilty
Name:	298 Westwood
Address:	Main Street
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 352-7311

Type of Service:	Long Term Care Facility
Name:	Pleasant View Center
Address:	239 Pleasant Street
City, State, Zip	Concord, NH 03301
Phone Number:	(603) 226-6561

Type of Service:	Long Term Care Facility & Evacuation Center
Name:	Applewood Rehabilitation Center
Address:	8 Snow Road
City, State, Zip	Winchester, NH 03470
Phone Number:	(603) 239-6355

Type of Service:	Long Term Care Facility
Name:	Cedar Crest
Address:	91 Maple Avenue
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 358-3384

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Appendix 10: Short-Term Evacuation Plan

Enter the information requested below. Describe the center's plan for short-term evacuation procedures. Consider custody issues for patients in specialty care units, accountability process for visitors and vendors, maintaining clear approach areas for emergency equipment and personnel, and a communication plan when developing these procedures.

Short-term evacuation will be used if immediate evacuation of the center is needed for safety considerations (e.g. the structural integrity of the building is compromised or there is an active fire in the center). Employees, staff, and residents will gather at established meeting spaces outside the center. Choose gathering points away from where emergency personnel will be responding to the center. Plan to use cell phones to communicate the short-term evacuation activation to the MP, transportation services, short-term evacuation site, and the long-term evacuation sites to indicate a long-term evacuation is possible. Plan for no re-entry to the building until it is determined it is safe to do so.

(Note: While areas such as school gymnasiums and churches are not good evacuation sites for a long-term evacuation, they may be used if the structural integrity of the center is compromised. If it is determined a long-term evacuation is necessary, follow the center's plan for evacuation using the short-term evacuation area as the sending center.)

PLAN: Designate area of short-term evacuation site for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients.

Meeting Place 1: Cedarcrest

Meeting Place 2: _____

Transportation Services: Deluzio, Adventure Limousine

Potential Locations: Local stop over location agreement with Cedarcrest on Maple St.

Additional Information:

_____

_____

_____

Appendix : Triage of Casualties (update 1/15/2017)

Instructions:

In the event of an internal or external disaster resulting in injuries, all casualties will be triaged using the priority Mass Casualty criteria and tags identified below. The Director of Nursing and Medical Director or designees will coordinate the process in collaboration with emergency personnel. Where appropriate, victims from external disasters will be triaged at the ambulance entrance.

Priority 1 Immediate (Red): Serious, but salvageable life threatening injury/illness

Victims with life-threatening injuries or illness (such as head injuries, severe burns, severe bleeding, heart-attack, breathing-impaired, internal injuries) are assigned a priority 1 or "Red" Triage tag code (meaning first priority for treatment and transportation).

Priority 2 Secondary (Yellow): Moderate to serious injury/illness (not immediately life-threatening)

Victims with potentially serious (but not immediately life-threatening) injuries (such as fractures) are assigned a priority 2 or "Yellow" (meaning second priority for treatment and transportation) Triage tag code.

Priority 3 Delayed (Green): 2 types

- Victims who are not seriously injured, are quickly triaged and tagged as "walking wounded", and a priority 3 or "green" classification (meaning delayed treatment/transportation). Generally, the walking wounded are escorted to a staging area out of the "hot zone" to await delayed evaluation and transportation.
- Delayed also includes those victims with critical and potentially fatal injuries or illness, indicating no immediate treatment or transportation.

Priority 4 Deceased (Black):

Victims who are found to be clearly deceased at the scene with no vital signs and/or obviously fatal injuries are classified as deceased or priority 4 (Black) in the triage coding system.

Planned Triage Locations

After triage, casualties will be moved to the following locations for treatment, evaluation, and transportation, as appropriate:

Priority 1: Library holding area
Priority 2: Library holding area and rehab department
Priority 3: Dining room-due to its size and location
Priority 4: Unit lounge or holding area on first floor

Appendix 12: Emergency Supplies and Location of Critical Equipment

Instructions: *Enter the location of emergency supplies; add additional items as necessary.*

ITEM	LOCATION
Radio (transistor) weather / radio alert	reception
Flashlight / Glow Sticks (extra batteries and bulbs)	nursing units
Self-stick tags for identification purposes	nursing units
Basic tool kit (hammer, pliers, screwdriver(s), knife, etc.)	***maintenance department***
Shovel(s)	maintenance dept and shed
Drinking water supply per contract	dietary
Disposable eating equipment	dietary
Food, emergency supply	dietary
Waterless hand cleaner	medical storage
Respirators, gowns, gloves and masks	medical storage
Linens, blankets, adequate in case of power failure	laundry dept
Emergency first-aid kit	nursing
Trash Bags	laundry
Log or tablet to list residents/patients/employees leaving the Center	reception & nursing
Incontinent supplies (briefs), disposable wash cloths	medical storage
Room thermometers	maintenance
Blood pressure cuffs	nursing
Stethoscopes	nursing
Mass Casualty Tags (red, yellow, green, blue, black)	
Policy and procedure manuals	online
Personal protective equipment	nursing
MSDS	maintenance
Master keys	

FIRE EXTINGUISHERS	LOCATION
1st floor	dining room, kitchen, utility hall, reception, rehab, activities
2nd floor	near oxygen room, north and south ends
3rd floor	across from nurses station, north and south ends

Appendix 13: Surge Capacity

Instructions: Enter information into the table as prompted below.

This analysis assists the center in determining the maximum number of patients that may be accommodated if the center is asked to expand services through the local EMS or to meet the terms of a Memorandum of Understanding (MOU) with another provider.

Location	Number of Possible Additional Beds (Based on 70 Sq. Ft./Bed)	Priority Level of the Area (from least desirable to most (Scale: 1 – 10)	Comments (Ex: Possible Isolation Area or Specialty Area)
Private Rooms Which Can Accept Additional Beds	N/A-0		
Semi-Private Rooms Which Can Accept Additional Beds	N/A-0		
Additional Bed Space Dining Rooms	1st floor DR =10	10	
Additional Bed Space Activities Room	remove table=5	5	
Additional Bed Space Rehab Gym	move tables =4	5	
Additional Bed Space Corridor Ends			
Additional Bed Space Lounge Area			
Additional Bed Space Specialty Areas (Ex: Dementia Unit)	Library=4	10	
Additional Bed Space Other Areas			
Other	Conference room=3	8	
Total Additional Beds (Surge Capacity)	26		

Appendix 14: Emergency Water Supply

Instructions: Enter information into the table as prompted below.

1. Potable Water Contract Information

Company: Garelick Farms

Address: Farm Road

City: Boston

State: MA

Zip: 02010

Contact Person: _____

2. Emergency Water Supply

The center may prioritize use of water for activities as follows:

i. Drinking
ii. Medicating
iii. Dietary use
iv. Personal hygiene
v. Waste water (mopping)

The Red Cross, FEMA and USGS recommend an emergency supply of one gallon of water per person, per day. The center has calculated this need as follows:

- Total bed capacity = 106 + 80 Total approximate expected staff per day = 186 Total people
- Total people X 3 days = 558 gallons of water

The center's water source amounts and locations are as follows (enter applicable amounts and sites:

a. Primary

i. _____ gallons bottled water. Location(s): _____

ii. _____ gallons water in barrels. Location(s): _____

iii. _____ gallons in ice machine(s) Location(s): _____

iv. TOTAL: _____ gallons*

(*Note: should meet or exceed gallons calculated in # 2, Above)

b. Secondary

i. _____gallons in water heaters. Location: _____

ii. _____gallons in toilet tanks.

iii. _____gallons in other _____. Location: _____

iv. _____gallons in other _____. Location: _____

Appendix 15: Utility Shut-O Procedures

In the event of utility disruption, call the Administrator and Maintenance Director immediately. The Administrator or designee will be responsible for notifying the appropriate state agencies, as required. Enter the information required below.

Utility Shut-Off Locations

1. Water: Boiler Room
2. Electricity: Electrical Room
3. Gas: Electrical Room
4. Heat: Boiler Room
5. Fire Sprinkler System: Boiler Room
6. Oxygen Room: 2nd floor, 3rd floor
7. Oxygen Manifold Shutoff: Not applicable

Generator/Battery System

The generator may be used in emergency situations.

Generator Location: Outside building to East

Extra Fuel Storage Location: N/A

Location of generator Start Up Procedures: Electrical Room

In an emergency situation, the following individuals have the authority to "shut off" the utilities:

Administrator, Maintenance Director, Incident Commander, Maintenance Assistant

---

Use diagrams and instructions on the shut off values, utility controls to explain and use each utility shut-off.

For centers that maintains an onsite fuel source to power the emergency generator(s), insert the contract with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency. (INSERT CONTRACT FOLLOWING THIS PAGE.)

Appendix 16: Potential Explosives List

Instructions: Enter all potential explosives and current location.

ITEM	LOCATION
Oxygen Storage	2nd and 3rd floor
Generator Fuel	outside building to the east
Gasoline/additional fuel	storage shed outside maintenance (metal shed)
Chemical Closet	Maintenance Department

Appendix 17: Special Care Unit Fire Procedure

The purpose of this section is to plan for the safety of Specialty Care Unit (SCU) residents in case of a fire or fire drill. Insert the required information below. *Due to the profile of the SCU residents, procedures may vary from routine center policy.*

In case of a fire or fire drill in any other zone in the building (outside of the SCU):

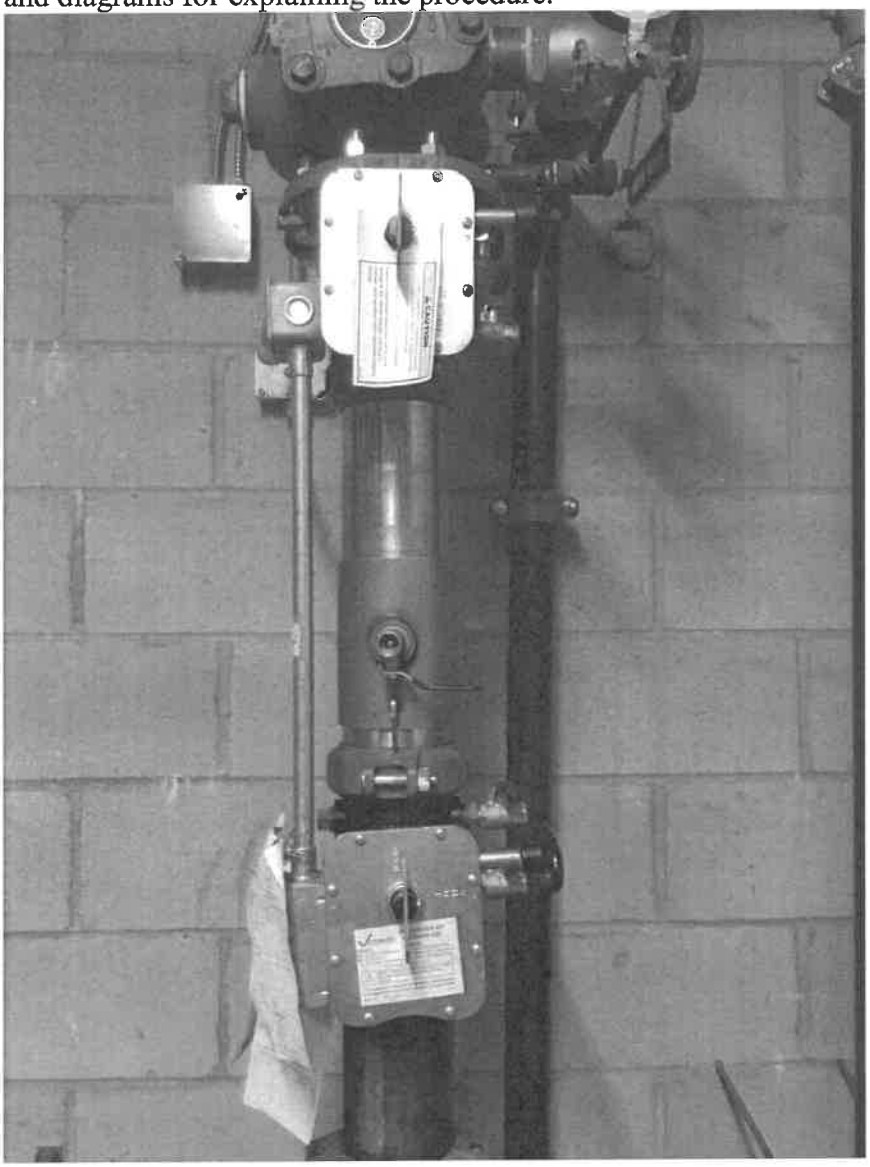
- All SCU residents who are not in bed will be kept together in a specific area.
- SCU staff close all doors in the unit and stay with SCU residents.
- Any residents who are in bed will remain in bed with the room door closed until all clear.

If fire or fire drill is in the SCU:

- SCU staff close all doors to rooms.
- SCU staff move residents past fire doors to safe area.
- SCU staff remain with the SCU residents until all clear.
- If residents are in bed, staff move residents potentially in immediate danger to safe area.

Appendix 18: Fire Sprinkler System Shut-Off Procedures

Instructions: Insert the center's fire sprinkler system's shut-off procedures using pictures and diagrams for explaining the procedure.



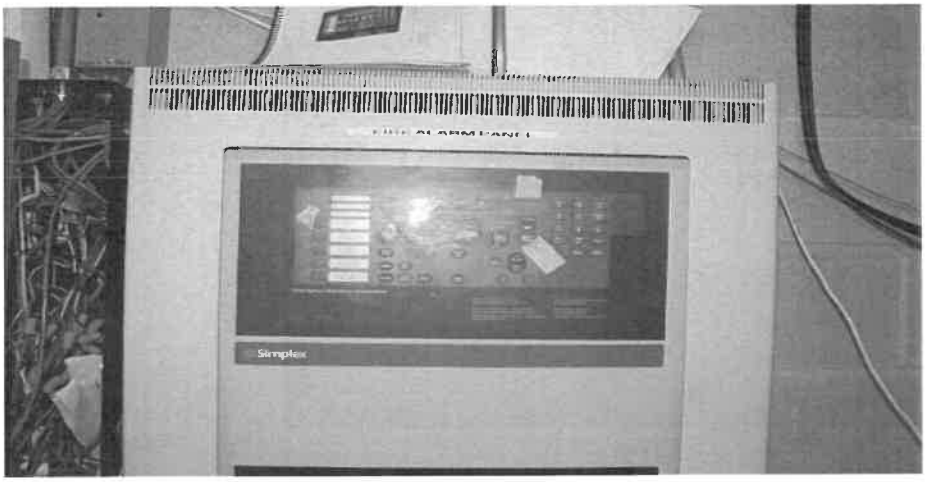
Appendix 19: Fire Alarm Reset Procedures

Insert the center's fire alarm shut-off procedures. Use pictures and/or diagrams to help provide a detailed explanation.

Main Fire Alarm Panel inside the electrical room.
Fire Dept and Maintenance Staff use only to silence, reset and maintain/acknowledge the fire alarm and emergency condition.

If fire alarm is activated, due to malfunction or fire, the fire department will reset and shut off.

Reset procedure:
Silence Alarm, Hit Reset in manual controls.



Appendix 20: Security Plan

This form is used to describe the center's plan for access and perimeter security. Instructions: Enter the location of entrances and exits and the security plan for each in the table below.

Entrance/ Exit Location	Used by/ Purpose	Restricted access (Keypad/ lock)		Frequency of entry code change	Type of alarm system	Current signs on door?	Locked/ Open Days/Times		Lighting Evaluation *	Comments and/or Corrective Actions
		YES	NO							
Example: Kitchen Backdoor (by ramp)	*Employees to take out trash; supply vendors.*	*Y*		*Monthly, Qtrly*	*Wander-guard, Watch Mate, IBI, or Catchall.*	*Marked as exit, no sign on outside of door*	*Daily*	*5:00 a.m. – 8:00 p.m.*	*Adequate*	
Main Entrance	employees, visitors	Y		As needed	wanderguard	Exit	daily	8am-6 pm	adequate	
utility hall-1st floor, house keeping, central supply, kitchen	exit only		N	N/A	None	None	interior open daily		adequate	
2nd and 3rd floor stairs-north & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
2nd and 3rd floor stairs-central	employees	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor-North & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor dining room	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	

Appendix 20: Security Plan

Lighting Evaluation: When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting and remove brush or debris to eliminate shadowed areas.

Interior Building Security:

Describe what the center has in place for stairwell protection (if applicable). Included in the description may be door security alarms/keypads, persons responsible for updating/changing entry codes, CCTV cameras and how the system is monitored, or other systems used for stairwell protection.

Front door live video monitoring that is on 24/7 that may be viewed at the 2nd Floor nursing station when staff are present

Front Doors are electronically locked at 9:30 PM and reopen electronically at 5:30 AM. Other exterior doors are locked and secured after hours. Most exterior doors and stairwell doors are secured via magnetic locks tied into our Secure Care wandering system. All Magnetic doors release with an audible local alarm sounding if appropriate pressure is applied for 15 seconds.

Lighting Adequacy- When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting to eliminate shadowed or dark areas.

Describe the check-in procedures for visitors and how identification badges for employees and/or visitors being used.

All employees have identification badges that they are required to wear while on duty. Visitors are strongly encouraged to sign in at the front entrance sign-in Log.

Appendix 20: Security Plan

Describe how the following are used for Resident-Specific Security:

Security measures for special units.

No special units.

- Resident Elopement Wander Guards.
- Electronic alarms systems such as door alarms.
- Communication call bells.

Wanderguard system, locked doors with keypad entry after 6pm.

Wander system near elevators, center stairs, at front door and all 1st floor exits. Tap bells and hand bells.

Communication call bells.

Visitor Log Protocol.

All visitors are screened and checked in at the reception desk upon arrival.

Appendix 21 :LOPEMENT DRILL DOCUN NTATION FORM

Drill Date and Time:_____ Unit:_____

Check all that apply:

____ Nurse alerts all staff of missing resident with plain, simple language. For example, "Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.

____ Each unit sends a person to the unit that announced the code to learn the name and description of the missing resident.

____ A person is designated as the House Person in Charge (HPIC) of the search. The HPIC coordinates the search so that the in-house and outside searches occur at the same time.

____ Each unit charge nurse directs in-house staff to search room to room and all potential areas of the Center: resident rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen, bathrooms, dayrooms/lounges, courtyards, and employee lounges.

____ HPIC assures all areas/floors of the building are searched.

____ During open kitchen hours, dietary staff search the kitchen and related areas, including walk-in refrigerators/freezers.

____ During closed kitchen hours, the HPIC assigns a staff member to search the kitchen and related areas.

____ HPIC sends two staff members outside to search the grounds.

____ Outside searchers go out the front door (or door designated by HPIC), one to the left and one to the rig search the building perimeter and grounds, and meet at the back door.

____ If one does not arrive at the back door, the other staff member proceeds to that staff member in case help was needed.

____ Both staff members return into the building together.

____ All unit, kitchen, and grounds search findings are reported to the HPIC immediately.

____ Staff are able to verbalize what to do if resident is not located by the end of the search.

____ Staff are able to verbalize documentation and follow-up requirements.

Comments:

Plan of Correction (if indicated):

Signature of Person Conducting Drill:_____

Appendix 22: Succession Plan

During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.

When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. In the absence of the Administrator, The Director of Nursing (DON) acts as the Incident Commander. In the absence of the Administrator and DON, the following team members act as the Incident Commanders, in priority order.

Administrator Name: Patrick Lyons

DON Name: Brandice French

Incident Commanders in absence of Administrator and DON:

Name and Title: Daniel Birmingham

Name and Title: Amanda Stubbs

Name and Title: Melanie Lucius

Appendix 23. Description of Center Patient/Resident Population (Insert from or Refer to Center Facility Assessment. See OPS 161, Facility Assessment for details.)

Appendix 24: Annual Review and Sign-Off

This EPP has been reviewed, with changes noted, and approved by the Safety Committee and Administrator:

Safety Committee Chairman Name: Daniel Birmingham

Safety Committee Chairman Signature and Date: _____

Administrator Name: Patrick Lyons

Administrator Signature and Date: _____

Appendix 25: State and Local Requirements

If your state/county/city/municipality has more stringent requirements, enter those requirements below, or insert reference materials. Contact your local EMS for information.

Appendix 26. Insertions from Compliance Guide Completed Tasks

Instructions: After this page, insert the following completed documents from the Emergency Preparedness Compliance Guide:

1. **Resident Council Minutes indicating dates/times of presentations of the EPP.**
2. **Contact with Local Emergency Management Services (EMS) Form.**
3. **Community-Based Drill After Action Report**
4. **Training Acknowledgement Forms (Staff)**
5. **Tabletop Exercise**

Exhibit 1: Food and trition Services – Sample Emergenc; enu, Level 1: No Power

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bu
	3/4 cup	Cold Cereal	Cold Cereal, Moistened	Cream of Wheat or Rice 1/2 cup	Cream of Rice 1/2 cup
	1/4 cup	Cottage Cheese	Cottage Cheese	Puree Cottage Cheese 1/2 #10 scoop	Cottage Cheese
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1-1/2 cup	Beef Stew, Cnd	Beef Stew, Cnd, Ground	Puree Beef Stew, Cnd	GF Peanut Butter & Jelly Sandwich 1 each
	1/2 cup	Seasoned Green Beans	Seasoned Green Beans	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Tuna Salad Sandwich	Plain Tuna Salad on Wheat	Puree Tuna Salad,Puree Bread 1 serving	GF Tuna Salad Sandwich
	1/2 cup	Seasoned Beets	Seasoned Beets	Puree Seasoned Beets 1 #8 scoop	Seasoned Beets
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1/4 cup	Scrambled Egg	Scrambled Egg	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1 each	Roasted Chicken	Roasted Chicken,Grd, Moistened 1 #12 scoop	Puree Roasted Chicken 1 #12 scoop	Roasted Chicken
	1/2 cup	Mashed Potatoes	Mashed Potatoes	Mashed Potatoes	Fresh Mashed Potatoes
	1/2 cup	Scalloped Tomatoes	Scalloped Tomatoes	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Ice Cream/Pudding	Smooth Ice Cream/Pudding	Smooth Ice Cream/Pudding	GF Pudding
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	3/4 cup	Soup, Cnd	Puree Soup, Cnd	Puree Soup, Cnd	
	2 packet	Saltines			
	1 each	Grilled Cheese Sandwich	Grilled Cheese Sandwich,No Crust	Puree Grilled Cheese Sandwich 1 serving	GF Grilled Cheese Sandwich
	1/2 cup	Three Bean Salad	Plain Three Bean Salad	Puree Three Bean Salad 1 #8 scoop	Fresh Three Bean Salad
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1 each	Hard Cooked Egg	Scrambled Egg 1/2 cup	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg 1/2 cup
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	2 ounce	Baked Ham	Baked Ham,Grd,Moistened	Puree Baked Ham 1 #12 scoop	Baked Ham
	1/2 cup	Sweet Potatoes	Sweet Potatoes	*Puree Sweet Potatoes 1 #10 scoop	Sweet Potatoes
	1/2 cup	Wax Beans	Chopped Wax Beans	Puree Wax Beans 1 #10 scoop	Wax Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Sliced Meat Sandwich	Sliced Meat Sandwich, Ground, Moistened	Puree Sliced Meat Sandwich	GF Sliced Meat Sandwich
	1 packet	Mustard	Mustard	Mustard	Mustard
	1/2 cup	Baked Beans	Mashed Baked Beans	Puree Baked Beans 1 #10 scoop	Seasoned Green Beans
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered

Exhibit 2. Sample Emergency Snack M

Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
2 each	*Assorted Cookies	*Puree Sugar Cookies 1 #16 scoop	*Puree Sugar Cookies 1 #16 scoop	GF Cookies
1 each	Chocolate Cream Cookie (S)	Choc. Cream Cookies (S)	Puree Choc. Cream Cookies 1 #16 scoop	GF Cookies
1 each	Oatmeal Crème Cookie (S)	Oatmeal Crème Cookie (S)	Puree Oatmeal Crème Cookie 1 #16 scoop	GF Cookies
1 packet	*Graham Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
4 each	Vanilla Wafers	Puree Vanilla Wafers 1 #24 scoop	Puree Vanilla Wafers 1 #24 scoop	GF Cookies
1 ounce	Cheese Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
1 ounce	Cheese Puffs	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1 ounce	Pretzels (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
4 packet	Saltines (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1/2 cup	Applesauce	Applesauce	Applesauce	Applesauce
1/2 cup	Mandarin Oranges	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Mandarin Oranges
1/2 cup	Peaches	Peaches	Puree Peaches 1 #10 scoop	Peaches
1/2 cup	Pears	Pears	Puree Pears 1 #10 scoop	Pears
1/2 cup	Pineapple Tidbits	Crushed Pineapple	Puree Pineapple 1 #10 scoop	Pineapple Tidbits
1 each	Fresh Apple	Applesauce 1/2 cup	Applesauce 1/2 cup	Fresh Apple
1 each	Banana	Chopped Banana 1/2 cup	Mashed Banana 1/2 cup	Banana
1/2 cup	Cantaloupe	Soft Chopped Cantaloupe 1/2 cup	Puree Cantaloupe 1 #10 scoop	Cantaloupe
1/2 cup	Grapes	Applesauce	Applesauce	Grapes
1 each	Fresh Orange	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Fresh Orange
1/2 cup	Watermelon	Chopped Watermelon 1/2 cup	Puree Watermelon 1 #10 scoop	Watermelon
1/2 cup	Apple Juice	Apple Juice	Apple Juice	Apple Juice
1/2 cup	Orange Juice	Orange Juice	Orange Juice	Orange Juice
1/2 cup	Cranberry Juice	Cranberry Juice	Cranberry Juice	Cranberry Juice
1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
1/2 cup	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt
1/2 cup	Smooth Pudding	Smooth Pudding	Smooth Pudding	GF Pudding

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 255 | MASTER RESIDENT EVACUATION TRACKING FORM

1. INCIDENT NAME:		**2. FACILITY NAME:**	
3. DATE PREPARED:		**4. RESIDENT TRACKING MANAGER:**	

5. RESIDENT EVACUATION INFORMATION

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

6. CERTIFYING OFFICER:		**7. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: OPERATIONS BRANCH
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER LEADER

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Exhibit 3
Revised Oct[illegible]r 1, 2022

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 260 | INDIVIDUAL RESIDENT EVACUATION TRACKING FORM

1. FACILITY NAME:		2. DATE:	
3. UNIT:			
4. RESIDENT NAME:		5. AGE:	
6. MEDICAL RECORD #:		7. SIGNIFICANT MEDICAL HISTORY:	
8. ATTENDING PHYSICIAN:			
9. FACILITY NOTIFIED:	☐ YES ☐ NO	CONTACT INFORMATION:	_____

10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY):

☐ HOSPITAL BED ☐ GURNEY ☐ WHEEL CHAIR ☐ AMBULATORY ☐ SPECIAL MATTRESS	☐ IV PUMPS ☐ OXYGEN ☐ VENTILATOR ☐ BLOOD GLUCOSE MONITOR ☐ RESPIRATORY EQUIPMENT	☐ SERVICE ANIMAL ☐ G TUBE PUMP ☐ MONITOR ☐ OTHER ☐ OTHER	☐ FOLEY CATHETER ☐ OTHER ☐ OTHER ☐ OTHER ☐ OTHER

ISOLATION:	☐ YES ☐ NO	TYPE:	_____

11. DEPARTMENT LOCATION

ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD SENT:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG SENT:	☐ YES ☐ NO		
BELONGINGS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
VALUABLES:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
MEDICATIONS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		

12. ARRIVING LOCATION

ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD RECEIVED:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG RECEIVED:	☐ YES ☐ NO		
BELONGINGS RECEIVED:	☐ YES ☐ NO		
VALUABLES RECEIVED:	☐ YES ☐ NO		
MEDICATIONS RECEIVED:	☐ YES ☐ NO		

13. SPECIAL CONSIDERATIONS

TIME TO STAGING AREA:		TIME DEPARTING TO RECEIVING FACILITY:	
DESTINATION:		ARRIVAL TIME:	
TRANSPORTATION:	☐ AMBULANCE UNIT ☐ HELICOPTER ☐ BUS ☐ OTHER: _____		
ID BAND CONFIRMED:	☐ YES ☐ NO	ID BAND CONFIRMED BY:	

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: OPERATIONS SECTION – ADMIT/TRANSFER & DISCHARGE UNIT
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING

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Exhibit 5: **NHICS FORM 251: CENTER STATUS REPORT**

1. INCIDENT NAME:		2. CENTER NAME:	Keene Center
3. DATE PREPARED:		4. TIME PREPARED :		5. OPERATIONAL PERIOD:	

SYSTEM STATUS CHECKLIST		
COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
FAX	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/PATIENT RECORDS/TIME CARD SYSTEM/INTRANET, ETC.)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NURSE CALL SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PAGING – PUBLIC ADDRESS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RADIO EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SATELLITE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM – CELL	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
VIDEO-TELEVISION-INTERNET-CABLE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
CAMPUS ROADWAYS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FIRE DETECTION/SUPPRESSION SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FOOD PREPARATION EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ICE MACHINES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
LAUNDRY/LINEN SERVICE EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RESIDENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
PHARMACY SERVICES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
DIETARY SERVICES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
DOOR LOCKDOWN SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SURVEILLANCE CAMERAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELECTRICAL POWER-PRIMARY SERVICE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SANITATION SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NATURAL GAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
AIR COMPRESSOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ELECTRICAL POWER, BACKUP GENERATOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELEVATORS/ESCALATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HAZARDOUS WASTE CONTAINMENT SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OXYGEN	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PNEUMATIC TUBE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STEAM BOILER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SUMP PUMP	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WELL WATER SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER HEATER AND CIRCULATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

Exhibit 6: NHICS FORM 259 | MASTER CENTER CASUALTY/FATALITY REPORT

1. INCIDENT NAME:		**2. CENTER NAME:**	
3. DATE/TIME PREPARED:		**4. OPERATIONAL PERIOD DATE/TIME:**	
5. REPORTED CASUALTY/FATALITY			
RESIDENT NAME:			**MEDICAL RECORD #:**
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:			**MEDICAL RECORD #:**
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:			**MEDICAL RECORD #:**
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:			**MEDICAL RECORD #:**
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:			**MEDICAL RECORD #:**
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**

Exhibit 7: NHICS FORM 252 | SECTION PERSONNEL TIME SHEET (STAFF TRACKING SHEET)

6. FACILITY NAME:	Keene Center		
7. FROM DATE/TIME:		**8. TO DATE/TIME:**	
9. SECTION:		**10. TEAM LEADER:**	

11. TIME RECORD

#	EMPLOYEE (E)/VOLUNTEER (V) NAME (PLEASE PRINT)	E/V	EMPLOYEE NUMBER	NHICS ASSIGNMENT/ RESPONSE FUNCTION	DATE/TIME IN	DATE/TIME OUT	SIGNATURE	TOTAL HOURS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

1. CERTIFYING OFFICER:		**2. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY, INCLUDING VOLUNTEERS

NHICS 252

Exhibit 8: NHICS FORM 253 | VOLUNTEER STAFF REGISTRATION

12. FACILITY NAME:	Keene Center					
13. FROM DATE/TIME:		14. TO DATE/TIME:				
15. REGISTRATION						
NAME (LAST NAME, FIRST NAME)	**ADDRESS** (INCLUDE CITY, STATE, ZIP)	**SOCIAL SECURITY NUMBER**	**TELEPHONE**	**CERTIFICATION/ LICENSURE & NUMBER**	**REFERENCE CHECK**	**SECTION ASSIGNMENT**
16. CERTIFYING OFFICER:		17. DATE/TIME SUBMITTED:				

Exhibit 9. EPIDEMIC PREPAREDNESS CHECKLIST

	Person Responsible	Date Completed
Planning and Decision Making		
Administrator/Executive Director is responsible for preparedness planning		
Create a multidisciplinary planning committee to include administration, medical director, nursing, reception, environmental, and others as needed; meet a minimum of monthly to evaluate your plan		
Incorporate epidemic preparedness into your Emergency Preparedness plan		
Develop plan to ensure that patient identification is on all patients/residents		
Complete the Emergency Numbers and Contacts List (refer to *Emergency Preparedness Plan: Attachment C*) ➢ **Include local, regional, or state emergency preparedness groups**		
Prepare updated employee contact list		
Ensure Test Kit is available, as indicated (i.e., Influenza)		
Communications		
Designate a person who will be responsible for **daily monitoring of updates (i.e., GHC Flu page)** and internal communications to staff, patients, and responsible parties		
Establish a system for communication with patients and families		
Maintain a list or database for patients' regular clinic, physician, or dialysis appointments in order to cancel non-essential appointments		
Education		
The Nurse Practice Educator/Practice Development Specialist or designee is responsible for coordinating education		
In-service all staff on Emergency Preparedness *(*may also refer to *Influenza Preparedness PowerPoint, if applicable)*		
In-service staff on infection control procedures and precautions, respiratory hygiene/cough etiquette		
Infection Control		
Post signage (Respiratory Hygiene/Cough Etiquette, Hand Hygiene, visitor sign in reception area)		
Implement respiratory hygiene/cough etiquette throughout the facility, as necessary		
Develop a plan for cohorting patients ➢ Discuss with VPMA and CQS if facility will confine all affected patients to one area, close off wings that are affected, or just confine sick patients and their roommates to their rooms		
Implement surveillance of targeted epidemic illness cases in the facility per Infection Control policies		
Collect information on: ➢ Incoming patients – confirmed or suspected targeted epidemic cases ➢ Number of new cases of targeted epidemic illness within the facility		
Report confirmed or suspected cases of targeted epidemic illness to the VPMA		
General Staff Management		
Develop plan for 100% vaccination of staff, if applicable; Administrator/ED and/or DON/RCD will have a personal conversation with staff who decline vaccination		
In collaboration with Area leadership, develop plan for 30% absenteeism; submit plan to MP		

	Person Responsible	Date Completed
➢ Number and categories of personnel needed to keep facility open or take patient overload ➢ Conduct a daily assessment of staffing status (refer to *Daily Review Form*) ➢ Develop plan for work/rest schedule as needed (i.e., place to sleep when extended work hours are necessary)		
Avoid floating staff if possible		
Educate staff to self-assess and report symptoms that they may be having before reporting to work		
Educate staff to develop a child care plan for school closings		
Review guidelines for Altered Standards of Care		
Discuss with staff the possibility of helping with essential patient care at times of severe staffing shortages		
Sick Staff		
Follow protocols for sick staff: ➢ Employees who develop symptoms during work hours should be sent home ➢ Employees who have been ill but are recovered may provide care to patients		
Alternative Staff		
If needed discuss use of alternative staff with SVP, VPMA and VPCO. Develop plan for use of employees not usually involved in patient care to perform basic patient care with supervision (Refer to *Alternative Staff Guidelines*)		
Influx of Infectious Patients		
Develop plan for patients requiring hospitalization ➢ Patient transport ➢ Lists of hospitals with contact information		
Develop plan to accommodate overcrowding and to ensure that an inflow of infectious patients does not overstretch the facility's resources ➢ Capacity of facility ➢ Number of empty beds/cots ➢ Patient care equipment ➢ Availability of treatment options ➢ Availability of vaccine and antiviral drugs ➢ Staffing resources		
Develop strategies to aid hospitals by admitting non-influenza patients not affected		
Environment		
Address whether adequate storage is available for additional supplies, e.g., water, food, medical supplies		
Make arrangements for additional storage, if needed		
Store adequate supplies/equipment (located in appropriate areas of building)		
For droplet precautions, position beds are at least three feet apart if setting up alternate bed areas		
Food Service		
Provide emergency food and disposable supplies are maintained		
Maintain hard copy of resident roster from Tray Trakker		
Develop staffing plans for full-day shifts (12 to 16 hours)		

Exhibit 10. DAILY SYMPTOM SCREENING FORM

INSTRUCTIONS: Use this form during an outbreak to screen **all** new admissions, re-admissions, staff, visitors, and vendors for symptoms of the illness before reporting to duty. Fill in specific symptoms monitored in the associated columns below. If staff report with symptoms meeting the clinical criteria, recommend follow-up treatment and send them home. (Note: this form may be modified based on specific outbreak.)

Name of Screener				**Title**					
Date	**Name**	**Time**		**Symptoms**			**Status**		
			Temperature	______	______	______	**OK to work/visit**	**Exclude from duty/visit**	**Screener initials**
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Temperature <100°F, OK to work/visit.

Temperature >100°F with any of above symptoms, exclude from duty/visit.

Exhibit 11. ALTERED STANDARDS OF CARE (ASC) FOR EPIDEMIC/PANDEMIC

In most cases, the order to use ASC will be initiated by state authorities. Following a declaration by the Governor that there is an emergency which is detrimental to the public health, the DPH/HHSD may order adherence to ASC priorities and protocols.

Principles for Allocation of Limited Resources and ASC Protocols

Priority for limited medical resources and ASC protocols will be based upon the allocation of scarce resources to maximize the number of lives saved. This allocation will be:

1. Determined on the basis of the best available medical information, clinical knowledge, and clinical judgment;
2. Implemented in a manner that provides equitable treatment of any individual or group of individuals based on the best available medical information, clinical knowledge, and clinical judgment;
3. Implemented without discrimination or regard to sex, sexual orientation, race, religion, ethnicity, disability, age, income, or insurance status.

ASC protocols will recognize:

- Any changes in practices necessary to provide care under conditions of scarce resources or overwhelming demand for care
- An expanded scope of practice for health care providers
- The use of alternate care sites, at facilities other than health care facilities
- Reasonable, practical standards for documentation of delivery of care

Individual Rights

Civil liberties and patients' rights will be protected to the greatest extent possible; however, it is recognized that the protection of the public health may require limitations on these liberties and rights during an epidemic.

Provider Liability

Health care providers who provide care in accordance with the priorities and ASC protocols, including care provided outside of their scope of practice or scope of license, will be considered to have provided care at the level at which the average, prudent provider in a given community would practice.

Priority Activities for ASC

The term "altered standards" has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation. It could also mean changing who provides various kinds of care or changing privacy and confidentially protections temporarily.

Because there are no nationally defined altered standards of care, Genesis HealthCare has established the priorities listed below. However, state/federal authorities are in the process of developing altered standards of care which may supersede Genesis priorities.

Nursing:

- Basic personal hygiene
- Use of hospital gowns for residents as opposed to personal clothing to reduce laundry
- Turning
- Toileting
- Feeding
- Medication Pass
- Critical documentation only – fever, change in condition, incidents

Housekeeping:

- Focus on high-touch surfaces such as tabletops, side rails, door knobs, telephones, time clocks, faucets, etc.

Dietary:

- Minimum nutritional requirements for three meals a day
- Therapeutic diets will be evaluated on an individual basis
- Essential documentation only

Social Services:

- Limit activities to current pandemic issues
- Essential documentation only

Laundry:

- Additional shifts may be needed to handled increased demands

Maintenance:

- Suspend preventive maintenance activities to reallocate resources

Recreation Services:

- Suspend activities to reallocate resources

Admissions:

- Limited to only those associated with the epidemic
- Consider marketing personnel reallocation to local centers

Business Office, Human Resources, Central Supply, Medical Records, Clerical Functions:

- Limit to essential functions only to reallocate resources

Survey & Certification
Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

Not Started	In Progress	Completed	Tasks
			• **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			• **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).

			• **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *
			- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
			- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
			- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
			- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:
			  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel
			  - An adequate supply of potable water (recommended amounts vary by population and location)
			  - A description of the amounts and types of food in supply
			  - Maintaining extra pharmacy stocks of common medications
			  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
			- Identifying and assigning staff who are responsible for each task
			- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days
			- Contract established with multiple vendors for supplies and transportation
			- Develop a plan for addressing emergency financial needs and providing security

			• **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: * - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees. - Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established - Adequate food supply and logistical support for transporting food is described.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- The amounts of water to be transported and logistical support is described. - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation - Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff. - Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - It is described whether staff family can shelter at the facility and evacuate.
			• **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *
			• **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			• **Facility Reentry Plan**: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			• **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

Survey & Certification
Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			• **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			• **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: - Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. - Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.
			• **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.
			• **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			• **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - Encourage family participation
			• **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes
			• **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			• **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: - Exercises or drills must be conducted at least semi-annually - Corrective actions should be taken on any deficiency identified
			• **Loss of Resident's Personal Effects:** Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

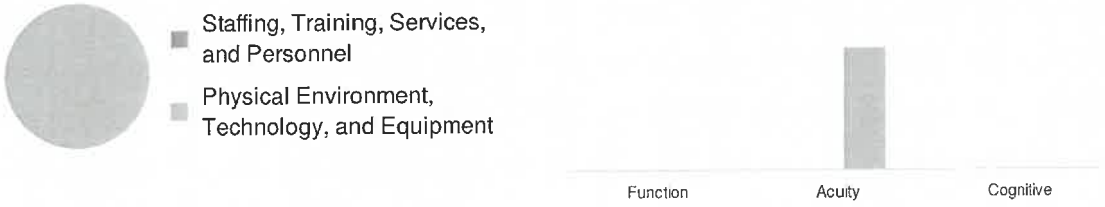
Facility Assessment

Keene Center

305051: Keene Center - 55070, Keene, NH

Keene Center
NAME

Insufficiencies by Category & Type



1
INSUFFICIENT CATEGORIES

3
ACTION/PLAN IN PLACE

Dec 1, 2022 - Dec 22, 2022

Last Activity: Dec 26, 2022

ADC: 98

Licensed Beds: 106

I. Resident Population Profile - Dec 2, 2021 - Dec 1, 2022

Admissions/Stays Summary

	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Number of Admissions/Stays in Past Year	329	100	N/A
Number of Admissions/Stays ending in Community Discharge	111	33.7	Low
Number of Admissions/Stays ending in Death	46	14	Very High
Number of Admissions/Stays ending in Hospitalization	76	23.1	Low
Number of Admissions/Stays ending in Other Discharge	8	2.4	Low
Number of Ongoing Stays	88	26.7	N/A
Number of Short Stays (Less than 100 days)	189	57.4	Low
Number of Short Stays 1-14 Days	68	36	N/A
Number of Short Stays 1-30 Days	133	70.4	N/A
Number of Short Stays 1-60 Days	170	89.9	N/A
Number of Short Stays 1-90 Days	186	98.4	N/A
Number of Long Stays (100 days or more)	114	34.7	High

Number of Post-acute Admissions/Stays	302	91.8	High

A. Function, Mobility, & Physical Disabilities

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Global Function (Barthel) Index			
ADL Function Low	168	51.1	Low
ADL Function Moderate	31	9.4	Very Low
ADL Function High	92	28	High
Activities of Daily Living (ADL) - Assistance Required: 1 Person			
Daily Care (excluding Bathing)	269	81.8	High
Bed Mobility	114	34.7	Low
Transfer	134	40.7	High
Walk in Room	94	28.6	Low
Toilet Use	153	46.5	High
Eating	172	52.3	High
Bathing	191	58.1	Very Low
Dressing	183	55.6	Low
Hygiene/Grooming	194	59	Low
Activities of Daily Living (ADL) - Assistance Required. 2+ Persons			
Daily Care (excluding Bathing)	165	50.2	High
Bed Mobility	145	44.1	High
Transfer	100	30.4	Low
Walk in Room	3	0.9	Low

Toilet Use	115	35	High
Eating	2	0.6	High
Bathing	75	22.8	High
Dressing	89	27.1	High
Hygiene/Grooming	73	22.2	High
Mobility			
Independently Ambulatory (No Assistive Device)	0	0	N/A
Independently Ambulatory (With Assistive Device)	1	0.3	N/A
Ambulation with Assistance (No Assistive Device)	23	7	N/A
Ambulation with Assistance (With Assistive Device)	122	37.1	N/A
In Chair All or Most of Time	197	59.9	N/A
With Contractures	165	50.2	Very High
Physically Restrained	1	0.3	High

Rehabilitative Services (for those receiving therapy)	Avg. Number of Days	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Speech-Language Pathology and Audiology Services	2.2	33	10	High
Occupational Therapy	3.3	217	66	High
Physical Therapy	2.8	177	53.8	Low
Respiratory Therapy	1.7	30	9.1	High
Psychological Therapy	1	1	0.3	N/A
Recreational Therapy	1	1	0.3	Very Low

1. Types of care required- Admissions tea ncluding IDT and hospital screener review potential ad sions and the services/equipment/staffing required to care for the resident. Center has a high population of residents that require ADL assistance. This includes bathing, dressing, grooming and toileting. High incidence of mobility assistance with device and mechanical lift. Types of care provided but not limited to - Skilled nursing care, long term care, advanced care planning, palliative care and veteran care. Supporting residents, families and caregivers throughout the continuum of their time with Keene Center. The Center creates an atmosphere similar to home building relationships for residents, family members and staff. Community partnering has been modified since the presence of COVID 19 and the need to modify the types of ways our center collaborates and connects with the community. Strive to deliver care that is culturally religiously and ethnically competent/sensitive. Embrace/welcome all who enter.

2. Services required- Center collaborates with rehabilitative services located on site - PT/OT/ST (via tele visit and proctor). Through collaboration residents are evaluated for developing plans for the resident to restore function and or maintain highest level of self performance. Health drive provides dental, podiatry opthamology and audiology services. Residents have the option of community based services as well. US Labs/Trident provide the lab services, x-ray and EKG services. Medi Telecare provides the mental health services. Omnicare provides the services pertaining to pharmacy and therapeutic oversight of medication regimes. Lincare is the provider for oxygen needs and respiratory therapy. HCS Inc. of Keene is the primary provider of Hospice service in the Center, however Compassus and Bayada are available options for residents as well. The Center provides infusion therapy around the clock with supplies from Omnicare. Wound care / pressure relieving / reducing Joerns. G-tube nutritional services - consultation with dietician / PCP. Partnership with the VA for veterans. Due to the ongoing requirements surround Covid 19 and the changing guidance surrounding testing, vaccines and isolation the senior leadership respond to the arising needs and adapt the training/ education.

3. Staff/Personal required- Center employs a full senior leadership team overseeing each department. Nurses, LNA, medical records, Director of nurses, NPE, ICP, Unit Managers, CRC, Skin Lead make up the clinical team. SSD director, and Admissions director back each other up in their respected areas. Recreation department- Full time activity director, two full time assistants and a bus driver for the center 1-2 days a week. Dietary and Housekeeping services are contracted with Health Care Service Group. Dietary-FSS, Dietician (8 hours weekly), cooks, and diet aides. Housekeeping and Laundry- Director, laundress, and housekeepers. Maintenance Department- Full time director and full time assistant. Rehabilitation team is contracted through- Genesis Rehabilitation group. PT/OT/ST. Genesis Physician Service- Medical director and a part time NP to transition to a full time NP first of 2023.

4. Staff Competency- New clinical staff complete competencies on hire, and annually. When a new treatment modality is introduced training is provided. Gaps in performance are identified and further education is provided to elevate performance.

5. Physical plant environment required- Center has 53 resident rooms (semi private) with beds. Rooms are duel certified to accommodate for placement of SNF customers throughout the center. Full kitchen, Main dining room and a family room on each resident floor that serves as a dining room/recreation location for residents that require physical assistance/supervision when dining. Center has a vented, and approved oxygen storage room. External generator that runs dedicated outlets (identified with red face plates) Laundry room is equipped with three washers, and three gas dryers. Therapy room is equipped with various pieces of equipment for treatment modalities. Center has one storage pod for equipment storage. Extra rehab equipment- wheelchairs, walkers, splints, wedges, ect. are stored in the rehab room closet.. A small shed is located behind the building with excess rehab equipment, wheel chairs and supplies.

6. Medical and non-medical Center has a shared bus that is stored at a sister facility. The bus is shared with other buildings. The town of Keene has two ambulances, Diluzio and adventure limousine provide transportation to residents. Current transportation needs in the state of NH is in a state wide spread shortage. This has impacted the ability to schedule appointments, and the lack of follow through with transportation showing up as well as delayed transports from hospital to center. VA has a bus and they assist with scheduling appointments and booking transportation.

7. Health information technology resources required- Center uses PCC for the EMR. PCC is also the technology used for MAR/TAR. Sister centers also use PCC which would support center professionals wish access to view the EMR remotely. Nursing using E-Mar for medication administration and has a back up system for when the computer system is offline. POC is LNA documentation, SWIFT skin documentation, and Rehab optima for rehab documentation.

B. Acuity-Diseases, Conditions, & Treatments

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Acuity Index			
Acuity Index Low	121	36.8	Low
Acuity Index Moderate	149	45.3	High
Acuity Index High	59	17.9	High

Cancer			
Cancer	41	12.5	Very High
Heart/Circulation			
Heart Failure (CHF)	69	21	High
Peripheral Vascular Disease (PVD)	50	15.2	High
Gastrointestinal			
Cirrhosis	8	2.4	Very High
Gastroesophageal Reflux Disease (GERD) or Ulcer	128	38.9	Very High
Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease	6	1.8	Very High
Genitourinary			
Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)	95	28.9	Very High
Neurogenic Bladder	27	8.2	Very High
Obstructive Uropathy	1	0.3	Low
Infections			
Multidrug-resistant Organism	2	0.6	Low
Pneumonia	13	4	Low
Septicemia	14	4.3	High
Tuberculosis	0	0	None
Urinary Tract Infection (UTI)	21	6.4	Low
Viral Hepatitis	1	0.3	Low
Wound Infection	2	0.6	High
Metabolic			
Diabetes	128	38.9	High

Arthritis	116	35.3	Very High
Osteoporosis	46	14	Very High
Hip Fracture	23	7	High
Other Fracture	43	13.1	Very High
Neurological			
Alzheimer's	21	6.4	High
Aphasia	7	2.1	High
Cerebral Palsy	3	0.9	High
Cerebrovascular Accident (CVA, TIA) Stroke	43	13.1	High
Non-Alzheimer's Dementia	80	24.3	High
Hemiplegia or Hemiparesis	32	9.7	High
Paraplegia	9	2.7	Very High
Quadraplegia	5	1.5	High
Multiple Sclerosis	9	2.7	Very High
Huntington's Disease	0	0	None
Parkinson's	16	4.9	High
Tourette's	0	0	None
Seizure Disorder or Epilepsy	28	8.5	High
Traumatic Brain Injury	3	0.9	High
Nutritional			
Malnutrition	47	14.3	Very High

Anxiety Disorder	104	31.6	High
Depression	150	45.6	High
Manic Depression	16	4.9	High
Psychotic Disorder	11	3.3	High
Schizophrenia	7	2.1	Low
Post Traumatic Stress Disorder (PTSD)	3	0.9	High
Pulmonary			
Asthma, COPD, or Chronic Lung Disease	104	31.6	Very High
Respiratory Failure	45	13.7	Very High
Vision			
Cataracts, Glaucoma, or Macular Degeneration	38	11.6	Very High
Conditions			
Dehydrated	2	0.6	High
Swallowing Difficulty	49	14.9	Very High
Pain Frequency (Frequent or Almost Constant)	37	11.2	Low
Fever	4	1.2	Low
Vomiting	9	2.7	High
Internal Bleeding	10	3	Very High
Falls with Injuries	30	9.1	High
Falls Since Admission or Prior Assessment	53	16.1	High
One or More Unhealed Pressure Ulcers/Injuries	40	12.2	High
Shortness of Breath When Sitting	35	10.6	High

Unplanned Significant Weight Loss	25	7.6	High
Unplanned Significant Weight Gain	10	3	Low
Current Tobacco Use	6	1.8	Low
Treatments			
Chemotherapy	1	0.3	Low
Radiation	0	0	None
Oxygen	82	24.9	High
Suctioning	0	0	None
Tracheostomy	1	0.3	High
Invasive Mechanical Ventilator (ventilator or respirator)	0	0	None
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	8	2.4	High
IV Medications	4	1.2	Low
Transfusions	2	0.6	Very High
Dialysis	4	1.2	Low
Isolation	8	2.4	Very High
Parenteral/IV Feeding	3	0.9	High
Feeding Tube	4	1.2	Low
Mechanically Altered Diet	62	18.8	Low
Indwelling Catheter	46	14	High
External Catheter	3	0.9	High
Ostomy (urostomy, ileostomy, colostomy)	6	1.8	Low

Intermittent Catheterization	2	0.6	High
Urinary Toileting Program	0	0	None
Bowel Toileting Program	0	0	None
Injections	147	44.7	Very Low
Influenza Immunization	63	19.1	Low
Pneumococcal Immunization	59	17.9	Very Low
Medications			
Insulin	54	16.4	N/A
Psychoactive Medications	189	57.4	N/A
Antipsychotic Medications	29	8.8	N/A
Antianxiety Medications (anxiolytics)	36	10.9	N/A
Antidepressant Medications	168	51.1	N/A
Hypnotic Medications	2	0.6	N/A
Anticoagulant	89	27.1	N/A
Antibiotics	61	18.5	N/A
Diuretic	107	32.5	N/A

B.1. Acuity - Frequency of Potentially High-Risk Treatments

IV antibiotics	More than 6
IV fluids	1-5
IV other medications	1-5
PICC line	1-5
Surgical drains	1-5
Anticoagulation - INR monitoring	More than 6
Nebulizer Treatments	More than

Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	1-5
Bariatrics	1-5

B.2. Acuity - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable) Center provides a vast variety of care with higher prevalence of the following: Renal diseases, GI conditions, cardiac/ circulatory conditions including vascular, musculoskeletal- arthritis, and metabolic prevalence-diabetes. Neurological conditions include-TIA, CVA, and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Nutritional conditions- malnutrition, Psychosocial conditions- center has a high prevalence of depression, anxiety and PTSD. Pulmonary conditions with high prevalence include Asthma, COPD, and chronic lung disease. Sensory conditions including visual ailments have a high prevalence at the center. Other conditions with a high incidence include pain frequency, falls preadmission/post admission. Treatments- oxygen therapy, CPAP/BiPAP, IV Medications, mechanically altered diet, indwelling catheter, ostomy, injections- including insulin and immunizations. High prevalence of Psychoactive medication- predominantly antidepressants. Anticoagulant.

2. Services require (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other services outlined in the center functions- rehab, ancillary services, hospice, vision, dental, podiatry, mental health services, lab services, O2 etc. The center utilizes Third Eye for after hours/on call physicians. As well as with new equipment and PRN education.

3. Staff/Personal required- center has agreements/partnership with supporting services. Omnicare, Linecare, Joerns, GRS/powerback, GPS-Medical director/NP services. Staffing is linked to occupancy. Acuity is factored into overall staffing patterns, and modified as census goes up or down. .

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided.

5. Physical plant environment required - external generator runs the entire building. Central air conditioning units cool all common areas, and individual units are placed in the resident rooms, offices and common areas in Spring and removed in the Fall.

6. Medical and non-medical equipment required- Each unit is equipped with mechanical lifts and variety of sized slings. The shower rooms on each floor are equipped with a shower and whirlpool tub. Bladder scanner for use on both floors. The center has partnerships with various venders that provide equipment for the care of residents- Omnicare IV pumps, enteral feeding pumps. Linecare CPAP/BiPAP, medication carts that are serviced by Omnicare, the omnicell in the medication room for emergency/back up medications, nebulizer machines/O2 concentrators. Joerns wound vacs and specialty sleeping surfaces. The kitchen uses a Robo coupe machine to prepare mechanically altered textures. Keene Center has a facility bus for outings that is shared with three other homes.

7. Health information technology resources required- such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC in the EMR for center. Additional supporting technology such as programs like SWIFT for wound care and Omniview for pharmacy, POC and Rehab Optima.

C. Cognitive, Mental, & Behavioral Status

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Interviewable	239	72.6	Very Low
Memory Impaired on BIMS	58	17.6	High
Orientation Impaired on BIMS	97	29.5	Low
Recall Impaired on BIMS	86	26.1	High
Understanding Impaired	28	8.5	High
Decision Making Impaired	90	27.4	Very High

With Intellectual Disability or Developmental Disability	3	0.9	Very High
Dementia: Non-Alzheimer's or Alzheimer's Disease	82	24.9	Low
Wandering	25	7.6	Very High
Psychotic Symptoms	18	5.5	High
With Behavioral Health Care Needs	71	21.6	High
Resident Behavior Impacted Resident Care	10	3	High
Resident Behavior Impacted Others	3	0.9	High
Potential For Self Harm	0	0	None
Hearing Impaired	30	9.1	High
Speech Impaired	33	10	High
Vision Impaired	7	2.1	Low
Comatose	0	0	None

C.1. Cognitive - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable). Center provides a vast variety of care with higher prevalence of following: Cognitive diagnosis/conditions impacting cognition include - TIA, CVA and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Psychosocial conditions- Center has a high prevalence of depression, anxiety and PTSD. Sensory conditions including visual ailments have a high prevalence at Center. other conditions with a high incidence include pain frequency, falls pre-admission/post admission. High prevalence of Psychoactive medication- predominantly antidepressants.

2. Services required (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other service as outlined in center functions- rehab, ancillary services, hospices, vision, dental, podiatry, mental health services, lab services, O2 etc. Center utilizes Third Eye for after hours/on call physicians. Person centered care drives individual care planning, what matters to the resident supports the cognitive and mental health needs of the resident. The recreation team develop programs in collaboration with the residents.

3. Linecare, Joerns, GRS/powerback, GPS- Medical director/NP services. Meditelicare provides specialized mental health services, including medication reviews, talk therapy, in-service education on special topics.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing with services proficiency with services required and provided. Special ongoing training includes specialized dementia training, trauma informed care and topics that target techniques to care for those with cognitive/mental behavior health conditions.

5. Physical plant environment required- Secure care system at main entry, emergency doors and elevators. Center does not use bed/chair alarms. Center does have removable stop signs used for various rooms including resident rooms as a deterrent for wandering residents entering another persons room.

6. Medical and non-medical equipment required- Center has devices for audio, animatronic pets and weighted babies available that provide comfort for various levels of cognitive conditions. Keene Center has a facilities bus for outings that is shared with three other homes. Pocket

7. Health information technology resources required- IPAD or similar device for virtual visits. PCC is EMR.

D. Cultural, Ethnic, & Religious Factors

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Age			
Age less than 65	35	10.6	Low
Age 65 to 94	270	82.1	High
Age 95 or greater	24	7.3	High
Race/Ethnicity			
American Indian or Alaska Native	1	0.3	High
Asian	0	0	None
Black or African American	1	0.3	Low
Hispanic or Latino	1	0.3	Low
Native Hawaiian or Other Pacific Islander	0	0	None
White	325	98.8	Very High
PASRR			
PASRR level II indicates serious mental illness and/or intellectual disability or related condition	10	3	High
Other			
Male	133	40.4	High
Married	111	33.7	High
Need/Want Interpreter	0	0	None
Life Expectancy less than 6 Months	28	8.5	High
Receiving Hospice Care	27	8.2	High

D.1. Cultural - Activities, Services, & Places

Spiritual/Religious Services

Catholic

Other Christian

Other faith or world religion

Holiday Services

Christian holidays

Jewish Holidays

Accommodations for Worship

Time of day (e.g. sunrise, early AM, late afternoon, evening)

Noise (e.g. silence, quiet room)

Furniture (e.g. comfort for sitting, kneeling)

Media (e.g. books, videos, music)

Equipment (e.g. TV, CD player, etc.

Objects and/or icons (e.g. art, statues, votives, etc.)

Other accommodations

Places of Worship

Non-Christian spiritual setting

Other setting

Spiritual Counseling

Non-denominational

Priest

Minister

End of life counseling/visitation

Spiritual Reading/Study

Other sacred texts

D.2. Cultural - Food & Nutrition

Diet

Vegetarian

Sugar-free

Dairy

Dairy substitutes (e.g. soy)

Protein preferences (e.g. beef, pork, fowl, fish, vegetarian)

Other diet

Meal Time

Early (e.g. breakfast, coffee)

Mid-afternoon

Evening

Religious/Holiday Meals

None

D.3. Cultural - Daily Routine

Daily Routine Accommodations

Clothing and cosmetics (e.g. religious garments, jewelry, makeup, oils)

Gender preferences (e.g. same gender personal care providers)

Outside visitors (family, friends, partners, significant relations)

Place and times for privacy

Access to outdoors

Waking time

Bed time

Other daily routine accommodations

D.4. Cultural - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable): Center serves individuals from a vast group of religious affiliations. Center provides a vast variety of care with higher prevalence in the age groups 65 to 94. The Center does have customers in the younger and older age group as well. Our Center community is predominantly white, but have provided service to a diverse population. This includes the individual preferences of the resident- rise and bed time, when and what to eat, what to wear, how to spend their time, how they want to be addressed as well as other personal preferences. Our culinary team and recreation team collaborate to provide enriching experiences including multidenominational services and activities. The dietician supports the team regarding religious and cultural needs being met through nutritional services.

2. Services required- through assessment process, Center is able to determine specific services required by those in our care. Spiritual services include Catholic, Christian and nondenominational. The Center works with the resident/customer to ascertain the spiritual connection they require and seek partnership with community partners. Resident Council helps drive the nature of service desired.

3. Staff/Personnel required- The recreation, dietary and social service team collaborate with the residents to identify what matters to them, the frequency and types of spiritual/religious services, food and cultural preferences. Local clergy and religious leaders, volunteers and community groups.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided, including the importance of what matters to the resident.

5. Physical plant environment required - Space for worship, and spiritual services to accommodate large and small groups.

6. Medical and non-medical equipment required- center has a shared bus. PA system is available for use to project sound quality for all listeners. A podium is also available for those presenting.

7. Health information technology resources required- such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC is the EMR for the Center where care teams complete assessments and collect information specific to the resident and their spiritual/religious and cultural needs.

Supporting Documents

No records were found

II. Staffing, Training, Services & Personnel

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No
Eating	Sufficient	Sufficient	Sufficient	No
Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Not Applicable	Not Applicable	Not Applicable	No
Rehabilitative Services (for those receiving therapy)				

Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

Staffing and scheduling systems- Daily discussions regarding staffing on each of the floors/units. The unit managers provide updates on resident needs. The scheduler will make staffing adjustments based on census and acuity. Scheduler and clinical team meet daily/weekly for labor meetings to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted services are also evaluated by the IDT to develop plans to ensure services are provided during the identified gaps. During outbreak status and closing congregate activities/meals staffing is evaluated to determine adjustments that are required. Center has primary assignments with floaters that cover primary days off. In the event we have an outbreak of COVID 19 center will consult regional support team to develop staffing plan based on current guidance for staff to return to work. Caregivers collaborate via hey team leader, huddles, staff meetings and 1:1 to determine changes to work loads and assignments. All senior leaders with licenses support direct care staff and partner to ensure adequate numbers for safety and quality.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annually, and with identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff. Training is conducted through a variety of modalities. These include vital learn programs through online programming, education boards, and live education. Nursing competencies are conducted on hire and annually.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes, or process creation to impact overall quality of care and efficiency of process.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams complete analysis of data. Data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards, etc. evaluate improvement and development of PIPs/IA.

3. Corrective actions-QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance.

B. Acuity-Diseases, Conditions, & Treatments

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place

	0 0	0 3	0 0	Y-1 N-38
Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	In Progress	Sufficient	No
Nutritional	Sufficient	In Progress	Sufficient	Yes
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	In Progress	Sufficient	No
Pulmonary	Sufficient	Sufficient	Sufficient	No
Cataracts, Glaucoma, or Macular Degeneration	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	Sufficient	No
Radiation	Sufficient	Sufficient	Sufficient	No
Oxygen	Sufficient	Sufficient	Sufficient	No

Suctioning	Sufficient	Sufficient	Sufficient	No
Tracheostomy	Not Applicable	Not Applicable	Not Applicable	No
Invasive Mechanical Ventilator (ventilator or respirator)	Not Applicable	Not Applicable	Not Applicable	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Not Applicable	Not Applicable	Not Applicable	No
Dialysis	Not Applicable	Not Applicable	Not Applicable	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	Sufficient	Sufficient	Sufficient	No
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No
Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No

Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Our strategic business plan includes current clinical capabilities as well as identified opportunities in the market. The labor team evaluate capacity and competence of staff and needed training/competencies needed to provide the service. Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing and the acuity in the center.

2. Staff training and competency program- NPE spear heads the staff training and competence program. Through collaboration with IDT program is modified to meet the current needs/acuity. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborates with direct care staff to evaluate assignments and needed adjustments. Staff utilize the Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process. When new service opportunities present through market analysis with community partners staffing patterns/sufficiency is evaluated from the perspective of the proposed new service.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly with adhoc meetings throughout the month as needed. As part of the SBP and the QAPI service gaps are identified and PIP/IA are developed.

2. Business- SBP/market analysis and Safety Excellence Improvement activities and PIPs are identified.

3. Corrective actions- QAPI team members present minutes and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet gaps in performance.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □1	■0 □0	Y-0 N-11

Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	In Progress	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Sufficient	Sufficient	Sufficient	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted service are also evaluated by the IDT to develop plan to ensure services are provided during identified gaps.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals are included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments to communicate needs, suggestions for process changes or process creation to impact overall quality of care and efficiency of process. Direct staff assignments are never left "vacant" Keene Center fills all direct care assignments if uncovered by a primary or alternate with clinical leadership or licensed individual.

C.2. Cognitive - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to out QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams compete analysis of data (data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the team identification of Opportunities for

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet gaps in performance. The Hey Team Leader program provides a vehicle of feedback and efficient process to implement corrective action. Competency of staff while "in progress" a dedicated action plan may or may not be developed. Keene Center provided leaders with the option of completing the LNA program to increase the " all hands on deck" approach.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■ 0 □ 0	■ 0 □ 0	■ 0 □ 0	Y-1 N-10
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No
D. Cultural, Ethnic, & Religious Factors				
Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	Yes
Other	Not Applicable	Not Applicable	Not Applicable	No

D.1. Cultural - Sufficiency Analysis Summary

1. Staffing and schedules systems- Understanding the unique needs of each resident and their preference provides the guide for determining capacity and competence of staff. This includes seeking support services which include but not limited to clergy, religious groups, LGBT/inclusion groups.

2. Staff training and competency program- [redacted] spear heads the staff training and competence progr[redacted] Programs such as Trauma informed care.

3. A review of staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions and the process or creation to impact overall quality of care and efficiency of process. Being sensitive to matters to the customer- for example no male caregivers, does not take showers, or is a night owl.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvements activities and PIPs are identified. The excellence team complete analysis of data (data sources include but not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the teams identification of Opportunities for Improvement.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and additional suggested corrective actions required to meet the gaps in performance. The Hey Team Leader program provides a vehicle for feedback and efficient process to implement corrective action.

Supporting Documents

No records were found

III. Physical Environment, Technology, & Equipment

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	0 0	0 0	0 0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No
Eating	Sufficient	Sufficient	Sufficient	No

Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Not Applicable	Not Applicable	Not Applicable	No
Rehabilitative Services (for those receiving therapy)				
Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based in the center needs and customers being served drives the type/quantity of equipment and supply. Our Central Supply coordinator collaborates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Point of care charting for direct care, PCC for EMR. This also includes migration of supporting electronic systems that include but not limited to risk management, PIP process through Insight, Abaqis for the Center Facility Assessment. The electronic screening process at the front door provides format for the requirement of our Infection Control program.

2. Maintenance and activity logs- Maintenance utilizes TELS system for logging center upkeep, repairs, and routine maintenance. Safety committee collaborates for center opportunities. Specific assessments/evaluation like the Legionella water plan and NFP risk assessment are completed annually. Report is generated monthly to reflect completed and outstanding activities.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets m ly. Changes and upgrades to center physical environ , technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Additionally, our Hey Team Leader program is designed so that 100% of all staff across shifts and departments are able to communicate Opportunities for Improvement. OFI are brought to the QAPI committee for review. For example phone system functionally or the aging, whirlpool tubs, and aging in room heating units.

3. Corrective actions- The maintenance department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Additional tasks for maintenance are also entered into the system for completion/tracking. Once an OPI has been identified, corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be through center budget or capital request.

B. Acuity-Diseases, Conditions, & Treatments

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■1 □0	Y-1 N-38
Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	Sufficient	Sufficient	No
Nutritional	Sufficient	Sufficient	Sufficient	No
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	Sufficient	Sufficient	No
Pulmonary	Sufficient	Sufficient	Sufficient	No

Vision	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	Sufficient	No
Radiation	Sufficient	Sufficient	Sufficient	No
Oxygen	Sufficient	Sufficient	Insufficient	No
Suctioning	Sufficient	Sufficient	Sufficient	Yes
Tracheostomy	Sufficient	Sufficient	Sufficient	No
Invasive Mechanical Ventilator (ventilator or respirator)	Not Applicable	Not Applicable	Not Applicable	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Not Applicable	Not Applicable	Not Applicable	No
Dialysis	Not Applicable	Not Applicable	Not Applicable	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	Sufficient	Sufficient	Sufficient	No
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No

Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No
Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Equipment and Supply Inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and costumers being served drives the type/quantity of equipment and supply. Medical director/NP/PCP collaborate with the IDT to determine it.

2. Maintenance and activity logs- in addition to the TELS system for logging center upkeep, repairs, and routine compliance, the center utilizes a weekend manager program to ensure specific tasks are validated daily- like door checks for locking to ensure resident and staff safety. This supports the acuity of wandering and cognitively impaired folks.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly, changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence areas of focus. These are key performing areas including 5 star data. Once an OFI is identified and is brought to the QAPI committee for review. For example the training of a staff member to train CPR to keep to staff to ensure ongoing competence.

3. Corrective actions- Once and OFI has been identified corrective action can be developed including identifying resources needed to

need for capital requisition along with resid room heat registers.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-11
Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	Sufficient	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Sufficient	Sufficient	Sufficient	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and customers being served drives the type/quantity of equipment and supply. Our Center Supply coordinates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Meditelicare, telehealth visits, third eye all utilize the computer and internet to connect the provider with the residents. The access to internet, and the ability to facetime, zoom meetings etc. has supported the residents in staying connected, and for the cognitive folks to be able to "see" their loved ones, and seeing their provider on the screen provides a stronger experience.

2. Maintenance and activity logs- Maintenance collaborates with the vendors providing the service to our center. This includes installation and ongoing upkeep.

1. Facility QAPI plan- QAPI team meets monthly. Changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These areas of excellence review Key Performing areas including 5 star data. OFI are brought to the QAPI committee for review. For Example Accessing specialty services such as meditelicare for mental health partnering and Third Eye after hours coverage by physician were created as a result of gaps in services. These gaps were identified and a plan developed to remedy the gap.

3. Corrective actions- The maintenance department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Additional tasks for maintenance are also entered into the system for completion/tracking. Once and OPI has been identified corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be though center budget or capital request. Upgrade of our internet router was completed in 2022 as a result of outdated technology being identified.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■ 0 □ 0	■ 0 □ 0	■ 0 □ 0	Y-0 N-11
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No

D. Cultural, Ethnic, & Religious Factors

Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	No
Other	Sufficient	Sufficient	Sufficient	No

D.1. Cultural - Sufficiency Analysis Summary

1. Equipment and Supply inventory- having laptops and Wi-Fi internet available keeps residents connected with loves ones, religious groups and any other organization that has online connection. Center provides a guest internet connection for residents and guests to use while in the center. Center Provides local telephone services and the long term care residents provide their own phones. Center provides in room TV to use during their stay. Streaming movies and programs on smart tv is another option..

2. Maintenance and activity logs- Interruptions in service are addressed by the maintenance department for the coordination of restoring service. Excellence committees discuss ongoing issues that impact the quality of resident experience as it pertains to the environment, technology, and equipment.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI plan meets monthly, changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Satisfaction surveys conducted annually provide additional feedback on the above cited areas. Additionally, resident council meeting, care plan meeting and 72 hour meetings provide a forum for feedback.

3. Corrective actions- PIP/IA that are identified through formal and informal means are addressed through QAPI process. For example- food and nutrition action plan to improve the quality. Specific interventions may include a new electronic meal ticket process, training, auditing tray accuracy and satisfaction validated through resident food council and 1:1 interviews.

Supporting Documents

No records were found

IV. All Hazards Risk Assessment

No records were found

Supporting Documents

Name	Date Uploaded
Genesis Risk Assessment 2022 (4).pdf	Dec 27, 2022

V. Assessment Contributors

Medical Director/Designee

Dr. Leslie Pitts

Director of Nursing Services

Brandice French

Administrator/Executive Director

Patrick Lyons

Name	Title/Role
Daniel Birmingham (daniel.birmingham@genesishcc.com)	Maintenance Dir.
Sarah Rodgers (sarah.rodgers@genesishcc.com) (sarah.rodgers@genesishcc.com)	NPE
Amanda Kingsbury (amanda.stubbs@genesishcc.com) (amanda.stubbs@genesishcc.com) (amanda.stubbs@genesishcc.com)	IP
Melanie Lucious	UM 2nd Floor
Nicole Wilcox	UM 3rd floor

Supporting Documents

No records were found

Additional Supporting Documents

No records were found

Keene Center Neighborhood Relations Plan

Keene Center maintains active and friendly relationships with our neighbors and customers both abutting the property and in the community. Keene Center is an active participant with One Hundred Nights Shelter through volunteering and donations. Keene Center provides a school for Licensed Nurse Assistants to earn their certificates through training on site. Keene Center does require emergency medical vehicles to conduct business on the property, and no sirens and or disruptions have been reported from neighbors.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. CLSS-2024-08
Date Filled 2/27/24
Rec'd By CSM
Page 1 of 5
Tax Map# 226-075-000
Zoning District: High Density

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

- ○ Drug Treatment Center
- ○ Fraternity/Sorority
- ○ Group Home, Large
- ○ Group Home, Small
- ○ Group Resource Center
- ○ Residential Drug/Alcohol Treatment Facility
- ○ Homeless Shelter
- ○ Lodging House
- ☑ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 677 Court Street, Keene, NH 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Genesis Healthcare	**NAME/COMPANY:** Keene Center
MAILING ADDRESS: 101 E. State St. Kennett Sq, PA 19348	**MAILING ADDRESS:** 677 Court Street, Keene, NH 03431
PHONE: ~~603-357-3800~~ 505-468-4572	**PHONE:** 603-357-3800
EMAIL: lawdepartment@genesishcc.com	**EMAIL:** amanda.pickering@genesishcc.com
SIGNATURE: **DATE:**	**SIGNATURE:** Amanda McSweeney **DATE:** 2/27/24
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Amanda McSweeney **TITLE:** CFO/LNHA

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	**NAME/COMPANY:**
MAILING ADDRESS:	**MAILING ADDRESS:**
PHONE:	**PHONE:**
EMAIL:	**EMAIL:**
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** **TITLE:**

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Please review facility assessment that includes this information.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use. Please review facility assessment.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

Please review facility assessment.

City of Keene

FIRE DEPARTMENT

Office of the Fire Marshal

Office: 31 Vernon Street Keene, NH 03431

Telephone: (603) 357-9861 • **Fax:** 603-283-5668

KFDlifesafety@keenenh.gov

NOTICE OF VIOLATION AND ORDER TO CORRECT

Date of Inspection:	01/18/2024
Date of Notice:	02/19/2024
Occupancy:	Genesis Elder Care 677 Court Street Keene NH 03431
Owner:	CBYW KEENE PROPCO LLC 4500 DORR ST. TOLEDO, OH 43615

This Notice details the findings of the inspection conducted on 01/18/2024. Present at this inspection was Lt Meghan Manke. The buildings were inspected for compliance with the minimum standard for existing buildings as required by the State Fire Code and State Building Code. The building was inspected for fire and life safety concerns. Other problems with the building may need to be addressed that are outside the scope of this inspection. This Notice reflects the violations that were observed at the time of the inspection. Other violations may exist that were not observed at the time of the inspection. In summary, the building is classified as Healthcare. Below is a breakdown of the observed Fire Code Violations. Pursuant to RSA 154:2, II(a), RSA 47:17, XVI, and City Code Section 42-1, you are hereby ordered to correct the below violations within 45 days of receipt of this Notice.

VIOLATIONS OF STATE FIRE CODE

NFPA 1: 13.1.5. Testing. Detailed records documenting all systems and equipment testing and maintenance shall be kept by the property owner and shall be made available upon request for review by the AHJ.

Provide copy of most recent fire alarm test report. Email to mmanke@keenenh.gov prior to reinspection date.

NFPA 10: 7.3.1.1.1. Fire Extinguisher Maintenance Frequency. Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.

Extinguisher by women's employee bathroom (1st floor) has a 2020 tag on it

NFPA 101 : 8.1.2 Sprinkler System Automatic sprinkler systems that are installed, either for total or partial building coverage, must be installed and maintained in accordance with the sprinkler code.

Provide copy of most recent sprinkler test report. Email to mmanke@keenenh.gov prior to reinspection date.

NFPA 101: 7.2.1.8.1. Self-Closing Devices A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self -closing or automatic closing.

3rd floor bathroom/shower room - door closer is broken

NFPA 101: 7.9.2.1. Emergency Lighting. Emergency illumination shall be provided for a minimum of 1 1/2 hours in the event of failure of normal lighting.

Provide copy of most recent annual/90 minute test of emergency lighting. Email to mmanke@keenenh.gov prior to reinspection date.

Utilize template provided by KFD to implement monthly testing of all emergency/exit lighting.

Verify if lighting in stairwells is powered by generator

NFPA 13:8.6.6.1 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.

Storage must be 18" or below from ceiling (and/or from height of sprinkler piping) to ensure sprinkler heads can operate effectively:
-Maintenance office

CORRECTION OF VIOLATIONS OF STATE CODES

Due to the severity of these violations, you are hereby ordered to correct these violations within 45 days of receipt of this Notice; a reinspection will be conducted on 45 days from this Notice. City Code Sec. 42-1(a).

If a violation is unable to be correct within the timeframe provided, within 45 days of receipt of this Notice, you must provide an action plan to correct those violations. A corrective action plan may be sent to: KFDlifesafety@keenenh.gov.

APPEALS

If you disagree with Notice, you may appeal to the Keene Fire Chief, or his designee, **within 10 days of the date of your receipt of this Notice**. City Code Sec. 42-32; RSA 31:39-c, I. Your appeal must be sent to: KFDlifesafety@keenenh.gov.

If, following the Keene Fire Chief's or his designee's review, you disagree with the decision of the Keene Fire Chief or his designee, you may appeal the Keene Fire Chief's decision to the City of Keene's Board of Appeals **within 15 days of your receipt of the Fire Chief's decision**. RSA 674:34, I; City Code Sec. 2-741 - 2-743.

A request for a variance from or exception to the State Fire Code may be made to the State Fire Marshal. RSA 153:4-a, I; N.H. Admin. R. Saf-C 6005.04. Such a request may be made via: https://www.nh.gov/safety/divisions/firesafety/documents/variance-request-form.pdf. A copy of any request for a variance or exception made to the State Fire Marshal shall be mailed to the City of Keene Fire Department, 31 Vernon Street, Keene, NH 03431.

FURTHER INFORMATION

If you have any additional questions or concerns, do not hesitate to contact me at the contact information below.

MEGHAN MANKE
mmanke@keenenh.gov
FIRE PREVENTION OFFICER

CERTIFICATION OF DELIVERY

I, MEGHAN MANKE, certify that I delivered this Notice to the Owner listed above on via:

- ☐ Certified Mail
- ☐ In-Hand Delivery

Signature:

ATTACHMENTS

This Notice includes the following attachments:

18666894-677 Court Street Assembly Permit Exp 01312025.pdf

18666762-677 Court Street Genesis Violation Notice 01182024.pdf

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: KEENE CENTER GENESIS HEALTHCARE
Located at: 677 COURT STREET
KEENE NH 03431

To Operate: Nursing Home

This annual license certificate is effective under the conditions and for the period stated below:

License#: 03706
Effective Date: 06/01/2023
Expiration Date: 05/31/2024
Administrator: AMANDA H MCSWEENEY
Waivers:
1. He-P 803.18(d)(1)
Medical Director: LESLIE PITTS,MD

Total Number of Beds: 106

EFFECTIVE 10/2/2023 AMANDA MCSWEENEY IS THE NEW ADMINISTRATAOR

Chief Legal Officer

NEW HAMPSHIRE
Online Licensing

nh.gov
Licensing Home

Person Information

Name: Amanda Hamilton-Robbins McSweeney

Address Information

State: NH

License Information

License No: 3861 **Profession:** Nursing Home Administrators **License Type:** Nursing Home Administrator
License Status: Active **Expiration Date:** 12/31/2024

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: KEENE CENTER GENESIS HEALTHCARE
Located at: 677 COURT STREET
KEENE NH 03431

To Operate: Nursing Home

This annual license certificate is effective under the conditions and for the period stated below:

License#: 03706
Effective Date: 06/01/2022 Expiration Date: 05/31/2023
Administrator: PATRICK LYONS
Medical Director: LESLIE PITTS,MD

Total Number of Beds: 106

EFFECTIVE 10/11/2022 PATRICK LYONS IS THE NEW ADMINISTRATOR

Chief Legal Officer

CERTIFICATE OF LIABILITY INSURANCE

7/31/2022

DATE (MM/DD/YYYY): 07/23/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER: Lockton Companies 3280 Peachtree Road NE, Suite #250 Atlanta GA 30305 (404) 460-3600	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED: Trident Topco, LLC 1475385 and its subsidiaries See attached for Additional Insureds Names 930 Ridgebrook Road Sparks Glencoe MD 21152	INSURER A : Lloyd's	
	INSURER B : Zurich American Insurance Company	16535
	INSURER C : Coverys Specialty Insurance Company	15686
	INSURER D : American Zurich Insurance Company	40142
	INSURER E :	
	INSURER F :	

COVERAGES MAIN **CERTIFICATE NUMBER:** 16852582 **REVISION NUMBER:** XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR [X] Deductible: $100,000 GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC OTHER:	N	N	W2FA31210101	07/31/2021	07/31/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$ 1,000,000 $ 200,000 $ 5,000 $ 1,000,000 $ 3,000,000 $ 3,000,000 $
B	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY	N	N	BAP 1861365-04	07/31/2021	07/31/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX $ XXXXXXX
C	[X] UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [X] CLAIMS-MADE [ ] DED [ ] RETENTION $	N	N	005MD000027078	07/31/2021	07/31/2022	EACH OCCURRENCE AGGREGATE $	$ 15,000,000 $ 15,000,000 $
D B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	N	WC 1861364 04 WC 0614814 04	07/31/2021 07/31/2021	07/31/2022 07/31/2022	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
A	Professional Liability	N	N	W2FA31210101	07/31/2021	07/31/2022	Per Claim $1,000,000 Per Aggregate $3,000,000 Deductible $100,000	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
For Providers in PA that participates in MCare, primary limits of $500K/$1.5M. MCare limits of $500K/$1.5K apply excess of primary limits. All VA providers subject to $2,500,000/$7,500,000 limits effective 7/1/21.

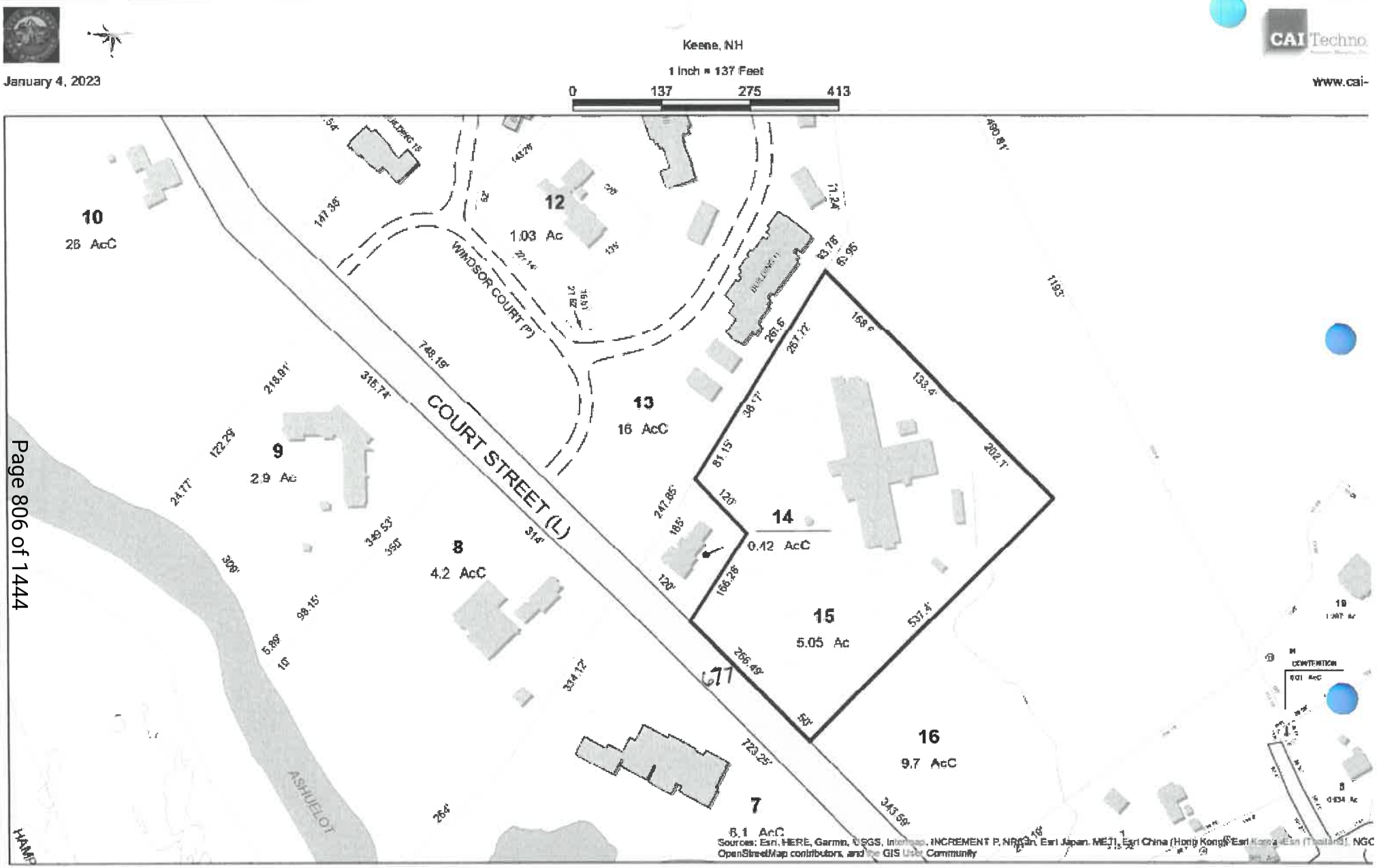
CERTIFICATE HOLDER

852582
KEENE CENTER
677 COURT STREET
KEENE NH 34311702

CANCELLATION See Attachments

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



Data shown on this map is provided for planning and informational purposes only. The municipality and CAI Technologies are not responsible for any use for other purposes or misuse or misrepresentation of this map.

677 COURT ST.

Location	677 COURT ST.	**Map/Lot #**	228/ / 015/000 000/000
Acct#	228015000000000	**Owner**	CBYW KEENE PROPCO LLC
Building Name		**Assessment**	$4,315,700
Appraisal	$4,315,700	**PID**	5666
Building Count	1		

Current Value

Appraisal			
Valuation Year	**Improvements**	**Land**	**Total**
2020	$3,910,600	$405,100	$4,315,700
Assessment			
Valuation Year	**Improvements**	**Land**	**Total**
2020	$3,910,600	$405,100	$4,315,700

Parcel Addreses

Additional Addresses
No Additional Addresses available for this parcel

Owner of Record

Owner	CBYW KEENE PROPCO LLC	**Sale Price**	$23,029,100
Co-Owner		**Book & Page**	2973/1191
Address	4500 DORR ST. TOLEDO, OH 43615	**Sale Date**	12/23/2016

Ownership History

Ownership History			
Owner	**Sale Price**	**Book & Page**	**Sale Date**
CBYW KEENE PROPCO LLC	$23,029,100	2973/1191	12/23/2016
FC-GEN REAL ESTATE LLC	$6,000,000	2703/0424	07/22/2011
MCKERLEY HEALTH CARE	$0	0978/0806	12/01/1979

Building Information

Building 1 : Section 1

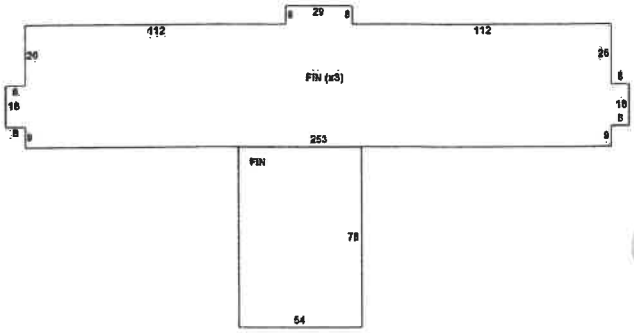
Year Built: 1980
g Area: 45,999
Replacement Cost: $5,913,171
Building Percent Good: 64
Replacement Cost Less Depreciation: $3,784,400

Building Attributes	
Field	**Description**
STYLE	Nursing Home
MODEL	Commercial
Grade	C
Stories:	3
Occupancy	1.00
Exterior Wall 1	Brick Veneer
Exterior Wall 2	
Roof Structure	Flat
Roof Cover	Membrane
Interior Wall 1	Drywall/Sheetrock
Interior Wall 2	Typical
ior Floor 1	Vinyl/Tile
Interior Floor 2	Carpet
Heating Fuel	Propane
Heating Type	Hot Water
Air Conditioning	Unit
Bldg Use	Commercial Improved
Bedrooms	
Full Baths	
Half Baths	
Extra Fixtures	
FBM Area	
Lighting	Above Normal
Frame	Fire Proof
Plumbing	Normal
Wall Height	10.00

Building Photo

(http://images.vgsi.com/photos2/KeeneNHPhotos/0007\262.0.jpg)

Building Layout



(ParcelSketch.ashx?pid=5666&bid=5666)

Building Sub-Areas (sq ft)			Legend
Code	**Description**	**Gross Area**	**Living Area**
FIN	Finished Area	45,999	45,999
		45,999	45,999

Extra Features

Extra Features				Legend
Code	**Description**	**Size**	**Assessed Value**	**Bldg #**
CNP	CANOPY	480.00 S.F.	$7,100	1

SPR1	SPRINKLERS-WET	45999.00 SF	$32,400	1
ELV1	ELEV PAS 2-3 STOPS	2.00 UNITS	$58,500	1
EE1	Enclosed Entry	88.00 S.F.	$1,100	1

La

Land Use

Use Code	201
Description	Commercial Improved
Zone	HD
Category	

Land Line Valuation

Size (Acres)	5.05
Depth	
Assessed Value	$405,100
Appraised Value	$405,100

Outbuildings

Outbuildings						Legend
Code	**Description**	**Sub Code**	**Sub Description**	**Size**	**Assessed Value**	**Bldg #**
LGT1	POLE & SINGLE LIGHT			1.00 UNITS	$300	1
FGR1	GARAGE- AVE			240.00 S.F.	$3,000	1
FN1	FENCE			480.00 S.F	$500	1
PAV1	PAVING- ASPHALT			21800.00 S.F.	$21,800	1
PAT1	PATIO- AVE			600.00 S.F.	$1,500	1

Valuation History

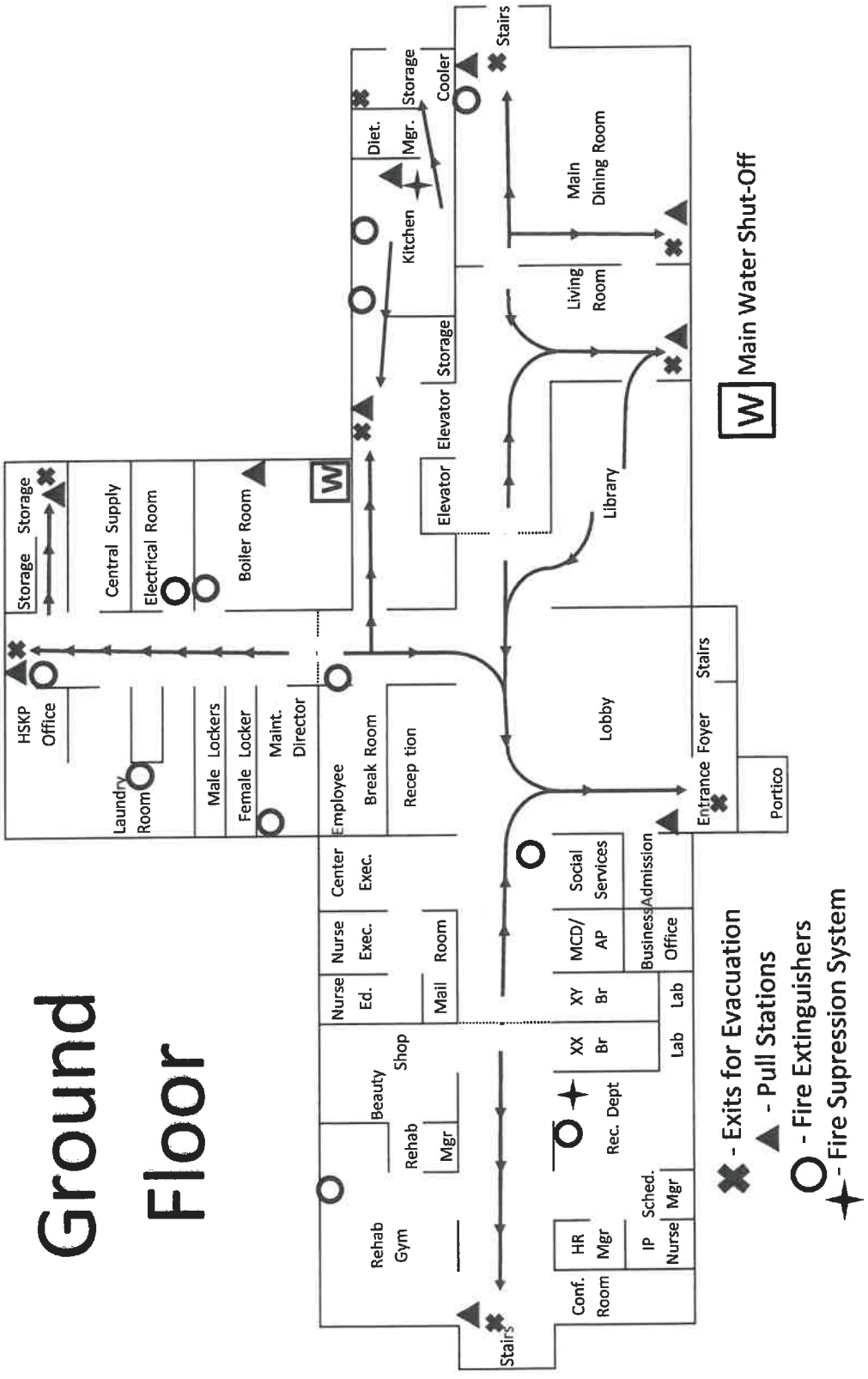
Appraisal			
Valuation Year	**Improvements**	**Land**	**Total**
2019	$3,910,600	$405,100	$4,315,700

Assessment			
Valuation Year	**Improvements**	**Land**	**Total**
2019	$3,910,600	$405,100	$4,315,700

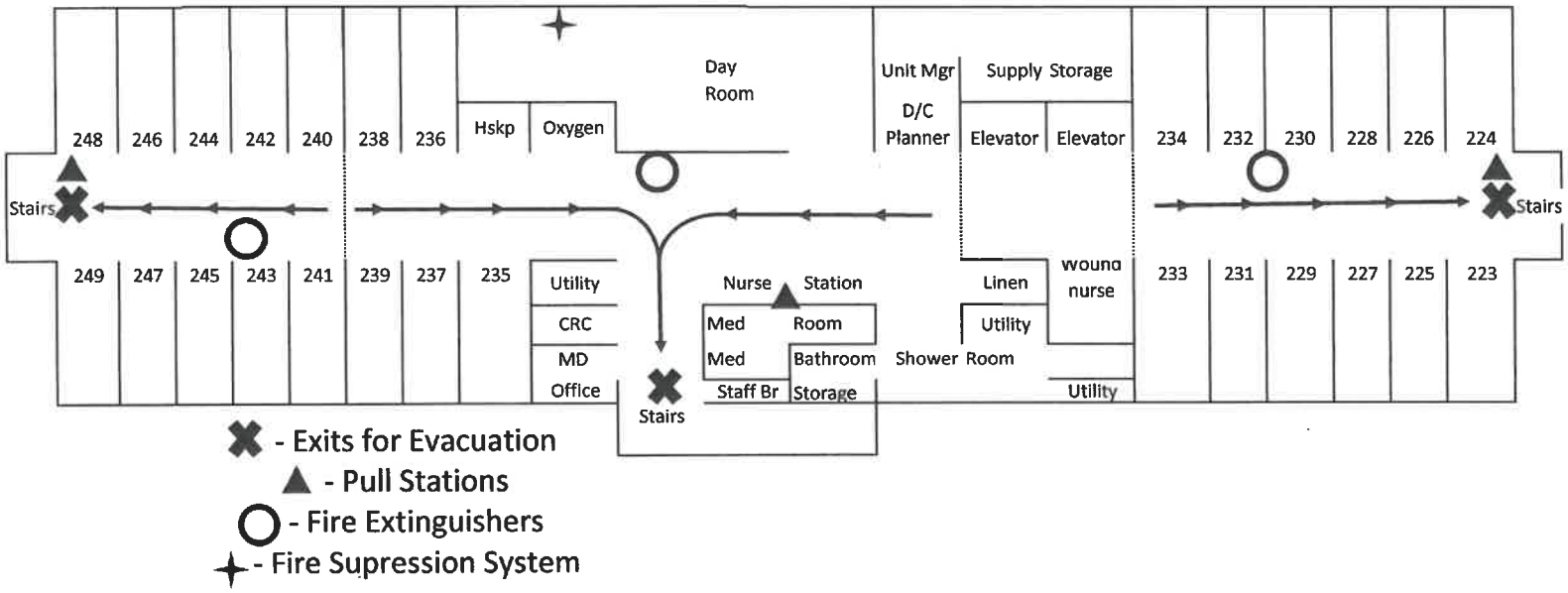
PROPERTY SITE INSPECTION

A. PROPERTY NAME:	**Genesis – Keene Center**	
Year built	1981	Acreage 9 acres
Renovations	Year: 2005-6	Cost: $400,000
:	Name: James R. Beeler, NHA	Experience: 17 yrs as NHA, 3.5 yrs. at Genesis
DON:	Name: Diana Wilson, RN	Experience: 8 yrs., 1 yr. as DON at Genesis

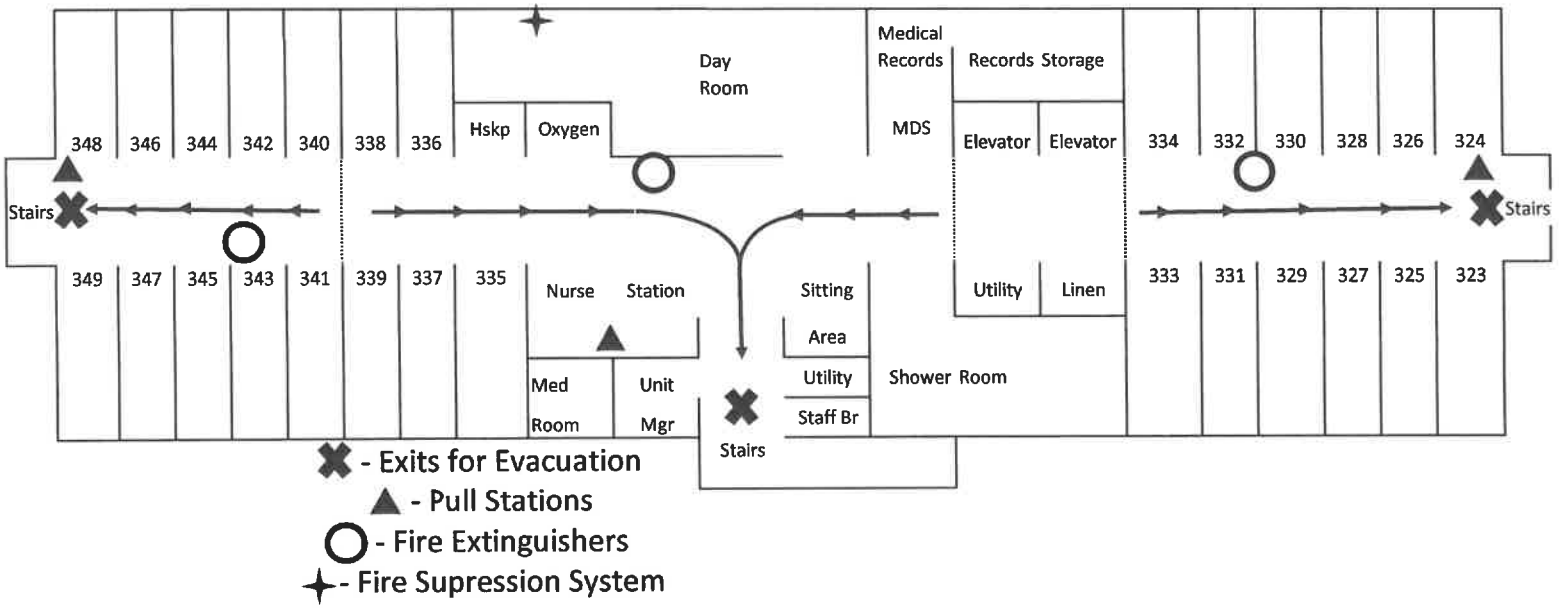
Occupancy	Total licensed beds: 106	Decertified beds: 0				
Census	Total: 101	Mcare: 13	Mcaid: 64	Private: 20	Mgd: 2	Other: 2
Annual Survey	When: 7/27/06	Tags (G or higher) 0	Resurvey: 10/06		Cleared: 10/2/06	
	If G - - description of incident					
Building Condition And Composite	Exterior: Brick	Interior: Drywall/steel/cement			ER generator Yes	
	Roof: Flat, tar	#Floors Three			FL/TX Hurricane Plan: Yes	
	Curb appeal Good	#Nurses Stations Two			Sprinklers: Full coverage	
	Signage Yes, new	Parking: 52 spaces				
Rates	Mcare: $395.00	Mcaid: $137.50	Private: $255.25	Semiprivate:	$237.25 ALZ	N.A.
Beds	Private: 2	Semi: 104	Triples: 0		Quads: 0	
Special Units (care)	None		Therapy:		PT, OT, Speech	
Amenities	Beauty: Yes	Van: No	Internet: Yes	Cable: Yes	Phones: New/yes Other:	
Other	Unions: None		Agency/Pool use:		None	
	Therapy (contract/inhouse)In-House		Housekeeping/Laundry: (contract/inhouse)		In-House	
CAP EX	Physical Plant issues: Minor	Kitchen: Good			Laundry: Aging	
	Boiler Good					
	PTacs/HVacs Good, but aging					
	Description of Work:					
	Budgeted Work for 2007: Complete Level II renovations of resident rooms, tub room, nursing station, other areas ($600,000)					
rral System	Top 3 or 2 Hospitals and proximity: 1. Cheshire Medical Center (Keene, NH – one mile)					
	2. Dartmouth-Hitchcock Medical Center (Lebanon, NH – 40 miles)					
	3. Monadnock Community Hospital (Peterborough, NH – 25 miles)					
Competitors	Top 3: 1. Harborside/Westwood (Keene, NH) 85 SNF beds			WHY? Proximity		Beds
	2. Langdon Place/Sun Health (Keene, NH) 25 SNF, 75 ALF			WHY? ALF beds		Beds
	3. Maplewood/Cheshire County Nursing Home 148 SNF, 20 ALF			WHY? County/size		Beds
Facility Demographics	Area Monadnock Region			Socioeconomic Diversified		
Major City	Keene, NH (pop. 15,000)					


Ground Floor
HSKP Office
Storage
Storage
Central Supply
Electrical Room
Boiler Room
W
Laundry Room
Male Lockers
Female Locker
Maint. Director
Employee Break Room
Recep tion
Elevator
Elevator
Storage
Kitchen
Diet.
Mgr.
Storage
Cooler
Stairs
Main Dining Room
Living Room
Library
Lobby
Entrance Foyer
Stairs
Portico
Center Exec.
Nurse Exec.
Nurse Ed.
Mail Room
Social Services
MCD/ AP
Business Office
Admission
XY Br
XX Br
Lab
Lab
Beauty Shop
Rehab Mgr
Rehab Gym
Rec. Dept
Conf. Room
HR Mgr
IP Nurse
Sched. Mgr
Stairs
W Main Water Shut-Off
- Exits for Evacuation
- Pull Stations
- Fire Extinguishers
- Fire Supression System

2nd Floor


Day Room
Unit Mgr
Supply Storage
D/C Planner
Elevator
Elevator
Hskp
Oxygen
248 246 244 242 240 238 236
234 232 230 228 226 224
Stairs
Stairs
249 247 245 243 241 239 237 235
233 231 229 227 225 223
Utility
CRC
MD Office
Nurse Station
Med Room
Med Bathroom
Staff Br
Storage
Stairs
Linen
Utility
Wound nurse
Shower Room
Utility
- Exits for Evacuation
- Pull Stations
- Fire Extinguishers
- Fire Supression System

3rd Floor


Day Room
Medical Records
Records Storage
MDS
Hskp
Oxygen
Elevator
Elevator
348 346 344 342 340 338 336
334 332 330 328 326 324
Stairs
Stairs
349 347 345 343 341 339 337 335
333 331 329 327 325 323
Nurse Station
Sitting Area
Utility
Linen
Med Room
Unit Mgr
Utility
Shower Room
Staff Br
Stairs
- Exits for Evacuation
- Pull Stations
- Fire Extinguishers
- Fire Supression System

Genesis Keene Center Security Plan

Genesis Keene Center's security measures include lighting in all parking lots, surrounding the building, and at all entrances. We have a security camera for after hours which monitors the front door to the building and allows staff caring for residents on the second floor to monitor activity after hours. All exterior doors except the front main entrance remain locked, with the maintenance door to the rear of the building being controlled by a key code pad. The code is changed periodically as needed. The main front door to the building is locked daily at 6pm and unlocked at 6am.

All privileged patient information is kept according to HIPAA guidelines. This included both written and electronic medical records.

All staff, visitors, and vendors are screened 24/7 by an electronic device monitoring temperature, and a time stamped photo is electronically kept on file for everyone entering the facility.

All staff wear picture name badges identifying their role at all times when in the building. All staff sign agreements upon hire acknowledging weapons, drugs, or alcohol are not allowed on the property.

Keene Center employs a "Wander Guard" system. Residents who may wander and need to be kept safe are free to move around the building, however entrance into stairwells, elevators, or outside doors is prohibited and doors will lock when a Wander Guard device attached to a resident gets within 24 inches of one of these areas.

Submitted with this Security Plan is the Keene Center Emergency Preparedness Plan.

MENU

Tasks in Use

Print List

Search for

All task types

Weekly

Category	Title	Assigned To			
Generators	**Exercise generator (with no load), perform routine checks, create entry in logbook.**		Regulatory	Logs	Maintenance
Resident Wandering System	**Check operation of door monitors and patient wandering system.**		Regulatory	Logs	Maintenance
Water Systems	**Inspect eye wash stations.**		Regulatory		Maintenance
Water Temps	**Test and log the hot water temperatures.**		Regulatory	Logs	Maintenance
Laundry Inspection	**Check dryer**		Maintenance		
Oxygen Concentrators	**In-House Maintenance**		Maintenance		
Resident Lifts	**Weekly Lift Rounds/Clinical Check-In**		Maintenance		

Monthly

Category	Title	Assigned To			
Defibrillators (AED)	**In-House Maintenance**		Regulatory		Maintenance
Elevators	**Firefighters' Emergency Operation Testing**		Regulatory		Maintenance
Emergency and Exit Lighting	**Conduct a 30 second functional test.**		Regulatory	Logs	Maintenance
Fire Extinguishers	**Check and initial fire extinguishers**		Regulatory		Maintenance
Generators	**Test generator under load, perform routine checks, create entry in logbook - Diesel**		Regulatory	Logs	Maintenance
Kitchen Exhaust Hoods	**Owner's Inspection - Quick Check**		Regulatory		Maintenance
Magnetic Exit Locks	**Test operation of doors and locks.**		Regulatory	Logs	Maintenance
Resident Lifts	**Inspect mobile lifts.**		Regulatory		Maintenance
Exhaust Fans	**Inspect exhaust fans for proper operation and clean if necessary**		Maintenance		
Facility Inspection	**Inspect kitchen small appliances**		Maintenance		
Resident Scales	**Check calibration of resident scales**		Maintenance		

Every 2 Months

Category	Title	Assigned To	
Grease Traps	**Inspect grease trap** Next due: February 2023		Maintenance

Every 3 Months

Category	Title	Assigned To				
Dryer Vent	**Complete In-House System Cleaning** Next due: January 2023		Regulatory		Maintenance	
Emergency and Exit Lighting	**Conduct a 90 minute operational test** Next due: February 2023		Regulatory	Logs	Maintenance	
Fire Drills	**Perform a fire drill during 1st shift- (Upload copy of drill with signature sheet to TELS when complete)** Next due: March 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 2nd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: January 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 3rd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: February 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Sprinkler System	**Have fire sprinkler system certified/inspected.** Next due: January 2023		Regulatory	Requires Doc	Maintenance	
Ice Machines	**Check filters (if present), clean coils, sanitize interior, delime as necessary** Next due: February 2023		Maintenance			
Rooftop Inspections	**Regular maintenance and safety inspection.** Next due: January 2023		Maintenance			

Every 6 Months

Category	Title	Assigned To			
Disaster Drills	**Conduct a Facility-based exercise (Disaster Drill)** Next due: June 2023		Regulatory	Requires Doc	Maintenance
Emergency Preparedness Drills	**Conduct elopement drill (Missing Resident Drill)**		Regulatory	Requires Doc	Logs	Maintenance

	Next due: February 2023				
Facility Safety	**Life Safety Documentation Audit** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Fire Alarm Test	**Have fire alarm system inspected by a contractor** Next due: April 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have Fire Suppression System inspected by outside contractor** Next due: March 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have hood cleaned by a certified contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Nurse Call System Test	**Conduct a test of the nurse call system.** Next due: March 2023		Regulatory	Logs	Maintenance

Every 12 Months

Category	Title	Assigned To			
Beds - Electric	**Bed Safety Audit 001-040 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 041-080 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 081-120 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Electrical	**Test and Document the Electrical Receptacle Inspections** Next due: September 2023		Regulatory	Requires Doc	Maintenance
Elevators	**Schedule certification and ensure certificate in unit is up-to-date** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Complete Risk Assessment - Click Instructions for the Assessment Tool and Procedure** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Inspect all facility window openings*** Next due: April 2023		Regulatory	Logs	Maintenance
Fire Extinguishers	**Have fire extinguishers certified.** Next due: July 2023		Regulatory	Requires Doc	Maintenance
Fire and Smoke Doors	**Inspection - Latch and Gap** Next due: June 2023		Regulatory	Logs	Maintenance
Generators	**Have generator serviced by contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Water Systems	**Complete training on Water Management Plan**		Regulatory	Maintenance	

	Review – Click on instructions Next due: December 2023	
Water Systems	**Water Management Plan Review - Upload your plan to TELS** Next due: November 2023	Regulatory Requires Doc Maintenance
HVAC - Air Handlers	**Inspect air filter, verify operation** Next due: October 2023	Maintenance
HVAC: Condensing Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
HVAC: Package Units	**Clean / change air filter and verify unit operation** Next due: October 2023	Maintenance
HVAC: Package Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
Resident Lifts	**Genesis Safe Handling Center Assessment - Lift Program** Next due: August 2023	Logs Maintenance
Safety Committee	**Conduct April Safety Committee Meeting** Next due: April 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct August Safety Committee Meeting** Next due: August 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct December Safety Committee Meeting** Next due: December 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct February Safety Committee Meeting** Next due: February 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct January Safety Committee Meeting** Next due: January 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct July Safety Committee Meeting** Next due: July 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct June Safety Committee Meeting** Next due: June 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct March Safety Committee Meeting** Next due: March 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct May Safety Committee Meeting** Next due: May 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct November Safety Committee Meeting** Next due: November 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct October Safety Committee Meeting** Next due: October 2023	Loss Prevention Requires Doc Maintenance

Safety Committee	**Conduct September Safety Committee Meeting** Next due: September 2023	Loss Prevention	Requires Doc	Maintenance	
TELS Masters Training	**TELS Offers Free Trainings - See instructions for further assistance** Next due: November 2023	Maintenance			
Vital Signs Monitors	**Unit Recalibration** Next due: August 2023	Maintenance			

Every 36 Months

Category	Title	Assigned To			
Emergency Generators	**Conduct a 4 hour Load test** Next due: November 2025	Regulatory	Requires Doc	Maintenance	

Every 48 Months

Category	Title	Assigned To			
Facility Safety	**Inspection and Testing - Fire Dampers and Smoke Dampers** Next due: November 2025	Regulatory	Requires Doc	Maintenance	

Genesis Healthcare Annual Mandatory Training

- Module 1 - Understanding the World of Dementia: The Person and the Disease
- Module 2 - Being with a Person with Dementia: Listening and Speaking
- Module 3 - Being with a Person with Dementia: Actions and Reactions
- Active Shooter in Long Term Care
- Residents' Bill of Rights & Staffs' Responsibilities
- Electrical Safety & Work-Related Practices 1
- Electrical Safety & Work-Related Practices 2
- Hazardous Communication
- Fire Safety
- Bloodborne Pathogens - BBP & PPE
- Elopement
- Access to Exposure & Medical Records
- Tuberculosis
- Infection Prevention and Control Overview
- Musculoskeletal Disorder Prevention
- Abuse Prohibition
- Respiratory Protection Training - Training on the use of Respirators
- Welcoming Program Centers Completion
- 2022/2023 Code of Conduct - All Staff
- GHC Emergency Preparedness Plan

Nurse Aide (CNA/LNA) Orientation Checklist

Employee Name:	Orientation Start Date"
Mentor Name:	Shift:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire.
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____

Date Checklist Completed: _____

CENTER TOUR & GENERAL INFORMATION	
Office Locations:	
• Scheduler • Director of Nursing • Center Administrator	• Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) • Unit Manager, Nursing Supervisor • Human Resources
Nursing Unit(s)	
Assigned Unit Introduction/Tour	
Bed Location Identification (door/window)	
Location of AED/crash cart ***By DAY 1 Orientation***	
Telephones: • Locations • Use & Paging Demonstration • Phone Directory	
Wandering System: • Location(s) • Demonstration & Code • Location of Elopement Book • Center Elopement Protocol	
Emergency Door Alarms (Codes)	
Location of Personal Protective Equipment (PPE)	
POLICY & PROCEDURE HIGHLIGHTS	
Communication	
Nurse to CNA Shift Report STOP AND WATCH (Early Warning Tool) CNA Assignment/Tasks	VItal Signs Weights Kardex
Safe Resident Handling	

Nurse Aide (CNA/LNA) Orientation Checklist

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Demonstration; *Specific to Center Type*
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Resident with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Resident Off the Floor S/P Fall**

Bed Rail Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Nurse evaluates need for bed rail
- If the bed rail is NOT indicated, the rail will be removed or secured in the DOWN position by maintenance
- Kardex indicating the use of the bed rail
- Immediately report any bed rail incidents

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based (Isolation) Precautions
- Respirator Fit Testing
- COVID protocols

Skin Health & Pressure Injury Prevention

- **Pressure Injury (Ulcer/Bed Sore) Prevention is a PRIORITY!**
- **Prompt Identification, Reporting and Interventions are Essential!**
  - Promptly report skin changes, skin concerns, or new/worsening wounds to the nurse supervisor
  - Promptly report interventions that are not working as intended or are missing &/or need replacement (e.g., heel lift boots, specialty surfaces)
  - Seek direction before using/applying any new intervention (e.g., heel lift boot)
- Refer to Kardex for:
  - Heel positioning devices/techniques/schedules
  - Turning/Repositioning devices/techniques/schedule
  - Skin care/incontinence care products & strategies
  - Seating devices (e.g. cushions, chairs)
  - Other individualized pressure injury prevention efforts

Elopement

- Resident Leaves the Premises Without Authorization
- Wandering Device use
- Report elopement behaviors to Nurse

Falls Management

- Center Process for Communicating High Risk Residents
- **Immediately Report Any Fall**
- Licensed Nurse evaluation required prior to moving the resident who had a fall
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a patient Off the Floor after Fall**

Nurse Aide (CNA/LNA) Orientation Checklist

Nutrition/Hydration:

- Thick Liquid (Dysphagia)/NPO Status Communication
- Diet Orders/Consistency
-
- Validation of Diet Order Prior to Serving

Current Center Survey Plan of Correction

- Review, if applicable

ADL Documentation ***(**Utilize SmartZone Application within PointClickCare as indicated)***

Complete Point of Care (POC) course - ***By Day 1 SmartZone****

- Review Center's process for documentation
- Review tub/shower schedule & documentation

Restorative Nursing

- Identifying Patients with Restorative Nursing Program (Kardex)
- Review Center's process for documentation (paper or electronic)

Patient Care Needs

- Inventory of Effects
- Patient Supplies (e.g. Basin, Urinal, etc.)
- Assistive Devices (eg. Walker, Wheelchair)
- Incontinence Products
- Special Care Needs: Tracheostomy, Dialysis, Ventilator, Infusion Devices, Enteral Feeding Devices, Oxygen/Respiratory Therapy

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Licensed Nurse (RN/LPN/LVN) Orientation Checklist

Employee Name:	Orientation Start Date:
Employee Job Title:	Mentor Name/Title:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire..
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____ Date Completed: _____

CENTER TOUR & GENERAL INFORMATION	
Office Locations: • Scheduler • Director of Nursing • Center Administrator • Human Resources	• Assistant Director of Nursing (ADON)/ Nurse Practice Educator (NPE) • Unit Manager, Nursing Supervisor • Central Supply • Other
Nursing Unit(s) (e.g., names of units, locations, secured/unsecured, etc.)	
Assigned Unit Introduction/Tour (e.g., medication room, utility rooms, kitchenette, etc.)	
Bed Location Identification (door/window)	
Location of AED/crash cart ***By DAY 1 Orientation***	
Location of Omnicell and/or Emergency Drug Kit	
Telephones: • Phone Directory(s)	• Use & Paging Demonstration
Wandering System: • Location(s) • Demonstration & Entry/Reset Code	• Location of Elopement Book • Center Elopement Protocol
Emergency Door Alarms (Codes)	
Location of Personal Protective Equipment (PPE) / Clinical Supplies	
POLICY & PROCEDURE HIGHLIGHTS	
Cardiac &/or Respiratory Arrest – *Must Be Completed By DAY 1 Orientation*	
• Location of Code Status Orders	• Center Process for Emergencies / Code
Communication	
Nurse to Nurse - Nursing Shift Report Nurse to CNA Shift Report STOP AND WATCH/Early Warning Tool CNA Assignment/Tasks	24 Hour Report Kardex Provider Notifications Patient/Patient Representative Notifications
Incident & Accident Reporting	

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

- PCC Risk Management Portal
- Event Completed for Any Patient Accident/Incident or Grievance/Concern
- Nursing Supervisor Notified of Any Accident/Incident
- Physician/Patient Representative Notification

Safe Resident Handling

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Transfer Reposition UDA
- Lift Demonstration; Specific to Center Equipment Brand
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Patient with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Patient Off the Floor S/P Fall**

Bed Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Bed Rail Evaluation (UDA): completed upon admission, readmission, quarterly, change in bed/mattress, & change in condition
- If the bed rail is NOT indicated, the rail must be removed or secured in the DOWN position by maintenance
- Requirements for bed rail use:
  - Utilize Bed Action Safety Grid to identify & minimize any zones of entrapment
  - Consent & physician order
  - Care Plan & Kardex indicating use of the bed rail

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based Precautions
- Antibiotic Stewardship
- Immunizations
- Respirator Fit Testing
- COVID Screening
- Cleaning and Disinfection
- Outbreak Management

Skin Health & Pressure Injury Prevention

- **Pressure Injury Prevention is a PRIORITY**
- **Skin Check** UDA admission & weekly
- **Braden** (or Norton Plus): admission, weekly x 4, quarterly, & with change in condition
- At Risk & Actual **CP & Kardex** initiated upon admission (no later than 24 hours after admission)
- Review **Guidelines** (Surfaces, Skin Care, Turning/positioning, Heels, Skin, Wound)
- Weekly Wound Evaluation (SWIFT)
- **Prompt Identification, Reporting & Interventions Essential**
- **Promptly** observe & respond to any reports of skin/ wound concerns by CNA or others
- **New Wound:** complete Change in Condition UDA, wound evaluation, notify provider/RP, update care plan, & obtain treatment order
- **PCC Risk Portal:** Completed for all new IHA pressure injuries

Elopement

- Patient Leaves the Premises Without Authorization
- Wandering Device Placement & Function Documentation Required
- PCC Risk Management Portal , Physician, Patient Representative, Administrator/Director of Nursing Notification, Preventive Intervention(s), Care Plan Updates

Falls Management

- Process for Communicating High Risk Patients **Immediately Report Any Fall**
- Nurse Evaluation Prior to Moving the Patient
- **Total Lift & (2) Staff Must Use Lift to upright Patient Off the Floor S/P Fall**
- Complete PCC Risk Management Portal for All Falls; Physician & Patient Representative Notification, Preventive Intervention(s), Care Plan updates
- **Neuro checks for ANY Fall Unwitnessed by Staff or Head/Facial Injury**

Neuro Checks Documented on Paper Flow Sheet

- Every 15 minutes x 2 hours, then
- Every 30 minutes x 2 hours, then
- Every 60 minutes x 4 hours, then
- Every 8 hours until least 72 hours has elapsed

Nutrition / Hydration

- Dysphagia/NPO Status communication process
- Diet Orders/Consistency
- Enteral Feeding: Administration / Pump
- *Diet Order Communication Form*
- Validation of Diet Order Prior to Serving

Controlled Substance Documentation

- New Orders for Schedule II-V Controlled Substances
- Delivery and Receipt of Controlled Substances
- Inventory of Controlled Substances
- Routine Reconciliation (e.g. Shift Count) of Controlled Substances
- Accessing Emergency Medications from eKit/Automated Medication Dispensing System (e.g. Omnicell)
- Disposal/Destruction of Expired or Discontinued Controlled Substances
- **Loss/Theft of Controlled Substances: Any Discrepancy Must Be Reported Immediately to Nursing Supervisor**

Notification of Patient Change in Condition

- eInteract Change in Condition UDA
- Print SBAR from Change in Condition UDA
- Complete PCC Risk Management Portal, if applicable
- Physician/Patient Representative Notification
- Changes in Orders or Treatment
- Transfer or Discharge
- STOP AND WATCH
- Clinical Dashboard Monitoring

Medication Administration *(**Utilize SmartZone Application within PointClickCare as indicated)*

Complete eMAR Order Supply Management course - ***By Day 1 SmartZone*****
Complete EMAR course - ***By Day 1 SmartZone*****
Complete Pharmacy Orders course - ***By Day 1 SmartZone*****

- Omnicell Access
- Medication Error Requires Physician & Patient Representative Notification
- Electronic Order Entry
- Medication Receiving
- EMAR Documentation
- 24 Hr. Chart Check
- Monthly Order Review
- Medication Not Available, Check Omnicell, Pharmacy & Physician Notification
- Medication Refusal Requires Physician Notification
- Behavior Monitoring Documentation
- Medication Disposal
- Omniview Medication Returning
- Omniview Resident Discharge
- Omniview Resident Leave of Absence

PointClickCare (PCC) *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Assessments Management course - ***By Day 1 SmartZone*****
- Assessment and Progress Notes
- Document Manager
- UDA Schedule
- Dashboard
- Care Plan(s)
- Lab and Radiology

Admissions / Discharges *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Resident Entry course - ***By Day 1 SmartZone*****
- Nursing Documentation UDA Upon Admission
- Bed Rail Evaluation UDA
- Skin Check UDA
- Discharge Documentation UDA and Discharge Transition Plan
- Omniview Patient Discharge
- Baseline Care Plan

Point of Care Testing

- Finger Stick Glucose, Fecal Occult Blood, Hemoglobin, INR, Influenza, SARS antigen testing performed according to manufacturer instructions.

Infusion Therapy

- **Nurses Who Lack Infusion Experience Must Complete an Approved Infusion Education Program Prior to Caring for Patient with Infusion Devices**
- **RN ONLY UPON HIRE:** May perform assessment and management of Short Peripheral Catheters and Midline/PICCs
- IV Pumps

Respiratory Management

- Oxygen Administration.
- Location of Oxygen/Respiratory Equipment.
- CPAP / BiPAP / Tracheostomy Care
- Respiratory Equipment: Supply Cleaning, Disinfection, Labeling/Replacement
- Aerosol Generating Procedures

Current Center Survey Plan of Correction

Review, if applicable

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Keene Center Health and Safety Plan

Please see attached Infection Control Policies and Procedures

1. Patient Placement in Transmission Based Precautions
2. Discontinuing Transmission Based Precautions
3. Droplet Precautions
4. Special Droplet and Contact Precautions
5. Standard Precautions
6. Respiratory and Hygiene/Cough Etiquette
7. Contact Precautions

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC306 Patient Placement in Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 2

POLICY

Transmission Based Precautions (Airborne Infection Isolation (AII), Contact, Droplet) will be implemented when indicated. The precautions should be the least restrictive possible for the patient. Personal Protective Equipment (PPE) will be readily available near the entrance to the patient's room.

Transmission Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission, more than one Transmission Based Precautions category may be required. Whether used singly or in combination, they must always be used in addition to Standard Precautions. The type of PPE and precautions used depends on the potential for exposure, route of transmission, and infectious organism/pathogen (or clinical syndrome if an organism is not yet identified).

PURPOSE

To prevent the transmission of infectious disease.

PROCESS

1. Notify the attending physician or Medical Director (in the absence of the attending physician) and the Infection Preventionist if there is reason to believe that an individual has an infectious disease.

2. Initiate Precautions (Standard plus Airborne Infection Isolation, Contact, or Droplet) as indicated. May utilize *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions* to guide choice of precautions. Post "STOP. Please see nurse before entering room." sign on door.

    2.1 Empirically initiate Transmission Based Precautions based on signs and symptoms that are consistent with a communicable disease.

        2.1.1 If laboratory tests confirm diagnosis, continue with precautions indicated.

        2.1.2 If test(s) results are negative, adjust or discontinue precautions as indicated.

3. Notify patient, family/health care decision maker, and all departments of precautions.

4. Instruct patient and visitors regarding Precautions and use of personal protective equipment (PPE) as indicated.

4.1 Patients on Transmission Based Precautions should remain in room except for medically necessary care.

5. Document in medical record:

5.1 Notification of physician;

5.2 Initiation of Precautions;

5.3 Notification of patient, family/health care decision maker, and departments;

5.4 Instructions to patient and visitors.

Refer to:

- *Airborne Infection Isolation Precautions policy*
- *Contact Precautions policy*
- *Droplet Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC302 Discontinuing Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 1

POLICY

Transmission Based Precautions will be discontinued when it has been determined that the risk of transmission of disease is over.

PURPOSE

To discontinue precautions when indicated.

PROCESS

1. Refer to *"Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions"* to evaluate the appropriateness of discontinuing Precautions.

2. When appropriate duration criteria has been met, consult with Infection Preventionist or Director of Nursing to consider the discontinuation of Precautions.

3. When discontinuation of Transmission Based Precautions is appropriate:

   3.1 Notify all departments;

   3.2 Instruct patient and visitors that Precautions are no longer needed;

   3.3 Return patient to his/her room if a move to a separate room occurred, if indicated;

   3.4 Inform the Environmental Services Department to perform discharge/turnover cleaning;

   3.5 Remove "STOP" signs once discharge/turnover cleaning is complete.

4. Document:

   4.1 Discontinuation of Precautions;

   4.2 Instruction of patient and visitors;

   4.3 Room change, if indicated.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC303 Droplet Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 3

POLICY

Droplet Precautions will be followed in addition to Standard Precautions when caring for a patient who has known or suspected infection by microorganisms that are transmitted by droplets (large particle droplets, larger than 5 µm in size); for example, influenza. State regulations will be followed when applicable.

PURPOSE

To prevent transmission of infectious agents by droplets.

PROCESS

1. Place patient in private room, if possible.

    1.1 Patient may cohort with an individual who has the same organism.

        1.1.1 Avoid placing immunocompromised patients with patients who are on Droplet Precautions.

    1.2 When neither private room nor cohorting is possible, patient may share a room with a roommate with limited risk factors. Maintain spatial separation of at least three feet between the infected individual and others, including other patients and visitors.

    1.3 Draw curtain between patient beds.

    1.4 Special air handling is not necessary.

    1.5 May keep door to room open.

2. Post a "STOP. Please see nurse before entering room." sign on door.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and use of personal protective equipment (PPE).

4. Staff will put on surgical mask upon entry to room of infected individual. Handle items contaminated with respiratory secretions (e.g., tissues) with gloves.

    4.1 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles/face shield should be worn.

4.2 Change personal protective equipment and perform hand hygiene between contact with patients in the same room.

4.3 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.

4.4 Before exiting room, remove and bag PPE and wash hands.

4.4.1 Remove bagged PPE from room and discard in soiled utility.

5. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/containment of infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

5.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

5.2 For patients being transported outside of the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

6. Dedicate personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

6.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *COVID-19 policy*

- *Respiratory Hygiene/Cough Etiquette procedure*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC310 Special Droplet and Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	12/07/22
REVIEW DATE:	
REVISION DATE:	
PAGE:	1 of 2

POLICY

Special Droplet and Contact Precautions will be used to prevent transmission of infectious organisms that can be spread via pathogens that spread through the air or by direct person-to-person respiratory transmission. An example of a disease requiring special droplet and contact precautions is SARS-CoV-2. State regulations will be followed, when applicable.

PURPOSE

To prevent the spread of infectious agents.

PROCESS

1. Display Special Droplet/Contact Precautions sign outside the patient/resident (hereinafter "patient") room on the door.

2. Keep the patient's door to the room closed unless doing so would endanger the patient.

3. Instruct patients and visitors regarding the precautions in use and the required personal protective equipment (PPE).

    3.1 Have the patient wear a surgical mask anytime staff is in the room.

4. Wear proper PPE including respiratory protection (N95 respirator), eye protection, gown, and gloves prior to entering the room of those who require Special Droplet and Contact Precautions.

    4.1 Before exiting the room, remove gown and gloves and bag PPE and perform hand hygiene. Once outside of the room, remove and clean eye protection. Discard N95, perform hand hygiene, and don a new mask.

    4.2 Remove bagged PPE from the room and discard it in the soiled utility.

5. Limit transport of patients to essential medical purposes. If transport out of the room is necessary:

    5.1 Place a surgical mask on the patient and instruct them to observe respiratory hygiene and cough etiquette;

    5.2 Transport personnel need to wear a surgical facemask during transport if the patient is masked.

5.2.1 If the patient is not masked, transport personnel need to wear an N-95 respirator;

5.3 Notify the receiving location of precautions.

6. Dedicate use of personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment, when available.

7. If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7.1 Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. The duration of these transmission-based precautions will be determined per Centers for Disease Prevention & Control (CDC) guidance for discontinuing precautions for persons with COVID.

Refer to:

- *COVID-19 policy*
- *Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *Safety and Health Policies and Procedures:*
  - *Personal Protective Equipment policy*
  - *Respiratory Protection Program policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC307 Standard Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/21
PAGE:	1 of 4

POLICY

All blood and body fluids are considered potentially infectious and, therefore, Standard Precautions are always used when providing patient/resident (hereinafter "patient") care.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Perform hand hygiene per *Hand Hygiene* policy.
2. Wear gloves whenever exposure to any of the following is planned or anticipated:
   - 2.1 Blood, blood products, and other potentially infectious materials (all body fluids including urine, feces, saliva) except sweat;
   - 2.2 Mucous membranes;
   - 2.3 Wound drainage;
   - 2.4 Drainage tubes;
   - 2.5 Non-intact skin;
   - 2.6 Potentially contaminated intact skin (i.e., patient incontinent of stool or urine).
3. Change gloves:
   - 3.1 Between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms;
   - 3.2 After contact with patient and/or surrounding environment (including medical equipment);
   - 3.3 During patient care if hands move from contaminated body site to clean body site.
4. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.

5. Wear mask, eye protection, and face shield during procedures/care that are likely to generate droplets/splashing/spraying of blood/body fluids/secretions or excretions.

    5.1 During aerosol generating procedures (i.e., suctioning of respiratory tract) if patients not suspected of being infected with an organism for which respiratory protection is otherwise recommended (i.e., TB, influenza).

    5.2 Wear face mask if in contact (i.e., within three feet) with a patient with a new, acute cough or symptoms of a respiratory infection (i.e., influenza-like illness).

6. Wear gowns:

    6.1 During procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

    6.2 Remove gown and perform hand hygiene before leaving the patient's environment..

7. Prevent transmission of microorganisms from used equipment.

    7.1 Wear gloves and PPE as needed when handling used equipment soiled with blood and/or body fluids.

    7.2 Do not use reusable equipment for the care of another individual until it has been cleaned and disinfected appropriately.

        7.2.1 Disposable equipment may be used when available.

    7.3 Discard single use items promptly.

8. Before exiting room, remove and bag PPE and perform hand hygiene.

    8.1 Remove bagged PPE from room and discard.

9. Provide routine cleaning and disinfection of environmental surfaces, beds, bed rails, bedside equipment, and other frequently touched surfaces.

10. Handle, transport, and process used linen soiled with blood and/or body fluid in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other individuals and the environment.

11. Follow Sharps safety (refer to *Safety and Health Policies and Procedures, Needle Handling and Sharps Injury Prevention* policy).

12. Follow respiratory hygiene/cough etiquette.

13. Use protective mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is possible.

14. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions, or wound drainage in a single patient room, when available).

15. **Safe Injection Practices:**

    15.1 Use aseptic technique to avoid contamination of sterile injection equipment.

    15.2 Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single use items. They should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

    15.3 Use fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion or administration set.

    15.4 Use single dose vials for parenteral medications whenever possible.

    15.5 Do not administer medications from single dose vials or ampules to multiple patients or combine leftover contents for later use.

    15.6 If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.

    15.7 Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

    15.8 Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

Refer to:

- *Hand Hygiene policy*
- *Linen Handling policy*
- *Cleaning and Disinfecting policy*
- *Respiratory Hygiene/Cough Etiquette procedure*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures:*
  - *Needle Handling and Sharps Injury Prevention policy*
  - *Personal Protective Equipment policy*

Genesis

PROCEDURE:

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Post signs at entrances instructing patients/residents (hereinafter "patients") who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection and to practice Respiratory Hygiene/Cough Etiquette. Refer to CDC for examples of signage.

2. **Respiratory Hygiene/Cough Etiquette**:

   2.1 Individuals who have signs and symptoms of a respiratory infection (cough, congestion, runny nose, or increased production of respiratory secretions) should:

      2.1.1 Cover the nose and mouth with a tissue when coughing or sneezing.

      2.1.2 Use tissues to contain respiratory secretions. Dispose of used tissues in a waste receptacle.

      2.1.3 Perform hand hygiene after contact with mucus and contaminated objects. Hand hygiene consists of:

         2.1.3.1. Hand washing with plain soap and water, OR

         2.1.3.2. Using alcohol based hand rub.

3. **Masking and Separation of Persons who have Respiratory Symptoms:**

   3.1 Offer masks to persons who are coughing, when tolerated and appropriate. Masks with ear loops or with ties may be used to contain respiratory secretions.

   3.2 Encourage persons with a respiratory infection to maintain separation of least three feet away from others.

4. **Droplet Precautions:**

   4.1 Health care personnel should observe Droplet Precautions when examining or caring for a patient who has symptoms of a respiratory infection.

      4.1.1 These Precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

   4.2 Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a surgical mask must be worn while providing patient care.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC301 Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 3

POLICY

In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the resident/patient (hereinafter "patient") or the patient's environment (e.g., C. *difficile*, norovirus, scabies). State regulations will be followed when applicable.

Contact Precautions should also be used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. For patients colonized with multi-drug resistant organisms, refer to *Modified Enhanced Barrier Precautions* policy.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Place patient in private room, if possible.
    - 1.1 Patient may cohort with an individual who has the same organism.
    - 1.2 Do **not** place colonized or infected patient with another patient who has:
        - 1.2.1 A different multi-drug resistant organism;
        - 1.2.2 An invasive device such as a port, IV line, track, or indwelling bladder catheter;
        - 1.2.3 A recent post-operative wound;
        - 1.2.4 Open wound(s) (including pressure injury);
        - 1.2.5 Severe immunosuppression (e.g., cancer, HIV, etc.).
2. Place a "STOP. Please see nurse before entering room." sign on door.
    - 2.1 Print Precautions sign in color or order from Smartworks.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and the use of personal protective equipment (PPE).

4. Staff must use barrier precautions before or upon entering the room. PPE must be worn before contact with the patient or the patient's environment

   4.1 Wear gown and gloves.

   4.2 Wear eye protection if splashing of infectious material is likely.

   4.3 Change gloves and gowns during care if gloves/gowns come in direct contact with infectious material.

   4.4 Change gown and gloves, and perform hand hygiene before providing care to other patient in the room.

   4.5 Before exiting room, remove and bag gown and gloves and wash hands upon exiting room.

      4.5.1 Remove bagged PPE from room and discard in soiled utility.

      4.5.2 Wash hands.

5. Dedicate personal care equipment (e.g., thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

   5.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

6. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/ containment of .infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

   6.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

   6.2 For patients being transported outside the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Multi-Drug Resistant Organisms (MDROs) policy*
- *Modified Enhanced Barrier Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

Center Emergency Preparedness Plan (EPP) 2022/2023

Center Name: Keene Center
Address: 677 Court Street, Keene, NH 03431
Phone Number: 603-357-3800

This document outlines the center's integrated approach to emergency preparedness. When appropriate, the center team contacts local emergency response services officials and other healthcare providers, to participate in collaborative and cooperative planning efforts. This Emergency Preparedness Plan is reviewed and updated annually, and on an as-needed basis.

IMPORTANT NOTE: After this document has been reviewed completed by the center Emergency Preparedness Leadership Team, it must be saved electronically on Central and printed and stored in multiple, unlocked locations that may be accessed by center staff.

SAFETY PHILOSOPHY

This center is committed to operating in a manner that promotes the safety, health, and well-being of our staff while providing the quality care to all of our customers. We strive to continually develop, promote, and enforce safe work practices and provide a healthful working environment consistent with established federal, state, and accreditation requirements. This center encourages team cooperation and collaboration with local, tribal, regional, state and/or federal emergency preparedness officials to participate in an integrated response during disaster and emergency situations.

Information contained in the Emergency Preparedness Plan (the "Plan") is based on available best practices. The Plan has been prepared as guidance for emergency response and crisis management. It cannot be assumed that the Plan takes into consideration all potential events, scenarios, and/or circumstances. As a result, the Plan is designed to be flexible based on the specific and unique circumstances, conditions, and/or events related to any emergency situation. Notably, while the Plan has been developed consistent with legal authority, the experiences and judgments of those responsible for local leadership and implementation of the Plan will determine how best to utilize it in an emergency situation. This center does not make any guarantees or representations related to the absolute sufficiency and comprehensiveness of the Plan, and notes that additional information/steps may be required in the event of an actual emergency.

Throughout this document, the terms "disaster" and "emergency" are used. Emergency is defined as a serious, unexpected, and often dangerous situation requiring immediate action; disaster is a sudden event, such as an accident or a natural catastrophe, that may cause great damage or loss of life. This Plan is written to address both types of events. The term "staff" is also used, to reference center employees, contract personnel, regularly scheduled volunteers and medical professionals that provide service to center residents and patients.

In the event of a public health crisis such as the coronavirus ("COVID-19") outbreak, policies and procedures may be temporarily modified or adjusted to align with Company and facility needs and/or directives issued by federal, state, local health care, and/or regulatory authorities. These modifications may be communicated either through Company notices or other communications

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EPP GENERAL STATEMENT/PURPOSE

THE PURPOSE OF THIS PLAN IS TO PROVIDE GUIDELINES FOR THE CENTER TO:

1. Respond effectively during disasters/emergencies;
2. Reduce human vulnerability to adverse effects of the disaster or emergency;
3. Reduce environmental and structural vulnerability to adverse effects of the disaster/emergency;
4. Provide care and services to the center's residents/patients during an emergency and/or an evacuation;
5. Identify staff responsibilities during an emergency;
6. Provide timely and effective communication;
7. Provide for recovery after the emergency.
8. Comply with relevant legal authority and guidance including but not limited to: Life Safety Codes, OSHA's Employee Emergency Action Plans (29 CFR 1910.38), CMS guidelines, elements of the Nursing Home Incident Command System (NHICS), and any pertinent state/local requirements.

SCOPE OF PLAN

THIS CENTER HAS THE POTENTIAL OF BEING AFFECTED BY, BUT NOT LIMITED TO, THE FOLLOWING EMERGENCIES:

1. Threats to security;
2. Utility failures;
3. Weather conditions;
4. Structural damage from fires or explosions;
5. Chemical spills;
6. Community disasters; and
7. Community, regional, national or global infectious disease outbreaks.

THESE SITUATIONS MAY REQUIRE:

1. Suspension of routine processes (further described below);
2. Center employees performing non-routine tasks should understand the task completely.
    a. If a staff member does not know how to safely perform the task, the employee is guided to ask their department head for instructions on how to safely perform the task.
    b. If the department head is not aware of the task's safety considerations, the department head will contact the Director of Employee Safety for guidance.
3. Triage;
4. Decision-making regarding evacuations and sheltering-in-place;
5. Evacuation of residents/patients, visitors and personnel;
6. Resident elopement; and
7. Acceptance of unscheduled admissions.
    a. The Center only accepts admissions within its scope of care unless directed by a regulatory agency.

THIS PLAN IS DEVELOPED SPECIFICALLY FOR THIS CENTER BASED ON A SITE-SPECIFIC HAZARD VULNERABILITY ASSESSMENT, AND INCLUDES:

1. A developed and tested incident management process, including the center's communication plan;
2. A corresponding analysis of the resources of the center;
3. Center-specific planning and response tools for emergency management; and
4. Elements that promote collaboration, interoperability, and communication with state, local, tribal and community resources.

This center provides a copy of this completed plan to the local Emergency Management Services on an Annual Basis, and as necessary.

Refer to: Appendix 1: Hazard Vulnerability Assessment (HVA)

GENERAL GUIDELINES

WHEN POSSIBLE, THIS CENTER TAKES ADVANTAGE OF AVAILABLE LEAD-TIME BEFORE EMERGENCIES. STAFF SHOULD:

1. Immediately report all potential emergency and/or disaster situations to the Administrator or designee and the Director of Nursing (DON);
    a. Notify additional department heads or designees as instructed by the Administrator.
    b. Administrator/designee: Notify the Marketing President (MP) of any potential emergency situation. Provide a copy of this completed plan to the local EMS;
2. Keep a radio/television tuned to an emergency weather channel or other Emergency Alert System broadcaster on at all times;
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, communication plan and contact information;
4. Locate the emergency and protective action supplies. Replenish if necessary;
5. Clear corridors of obstructions;
6. Reassure residents/patients, visitors, and team members;
7. Assist in the Incident Commander (see below) determinations regarding the number and mix of employees necessary if emergency is activated;
8. Notify the Administrator, DON, or designee of the potential staffing and supply needs;
9. Conserve resources (e.g., water, linen, supplies, etc.);
10. Keep phone lines free of personal calls;
11. Ensure a supply of food and water is available for residents/patients and staff in collaboration with the Dining Services Director;
    a. The center acknowledges during a disaster visitors may be present. The center's first priority for water and food distribution is to staff and residents.
    b. Note: Water can be used indefinitely as long as container intact. Dates do not imply expiration.
12. Be sure resident census is updated and accurate;
13. Estimate the number of ambulatory and non-ambulatory residents, and identify residents on transmission-based precautions that will need cohorting or segregation from other residents;
14. Identify residents with communication impairments, limited English proficiency, and plan for interventions to provide effective communication, such as interpreter services, large print or translated materials.
15. Centers with pets or resident service animals should consider the pets/animals in any emergency situation - i.e. food, water, care needs, and handling/controlling the animal.

NOTIFICATION and INCIDENT COMMANDER

1. During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.
2. When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. Refer to Appendix 22 for the center succession plan.
3. The Incident Commander is responsible for activation, implementation, and termination of the Emergency Preparedness Plan, staff assignments, patient oversight and associated documentation.
4. The Incident Commander is responsible for contact, and collaboration with, as appropriate:

a. Department heads;
b. MP;
c. Residents and responsible parties;
d. State Licensing Board;
e. Local, tribal, regional, state or federal emergency management officials; and
f. State Ombudsman Office.

LEVELS OF EMERGENCY

1. After determining an emergency situation exists, the Incident Commander declares an emergency. The levels of emergency are:
   a. ***Alert.*** Disaster possible; increased awareness. Administrator or designee notified;
   b. ***Stand By.*** Disaster probable, ready for deployment. All department heads notified;
   c. ***Activate.*** Disaster exists, deployment. Department heads or designees report to Center; and
   d. ***Stand Down.*** Disaster contained, resumption of normal activities.

NOTIFICATION OF PLAN

1. Residents are notified of the EPP via a statement in the Admission Kit and a posting in the Center.
2. The Administrator requests time to review the EPP during Resident Council meetings.

Refer to Posting GHC 5408 in SmartWorks and the Emergency Preparedness Compliance Guide.

COMMAND AND CONTROL

1. The Incident Commander coordinates activities in the center;
2. All staff are generally considered to be essential for the duration of a declared emergency; and
3. Emergencies are typically managed from a central location, identified as the Emergency Operations Center.

Refer to:
Appendix 2: Building Construction and Life Safety
Appendix 3: Center Administrative Staff Contact List
Appendix 4: Emergency Operation Center Designation

COMMUNICATION PLAN

1. During emergencies, this center uses primary and alternate means of communication;
    a. Landline telephone, cell phones, and the Regroup Mass communication platform are primary means of emergency communication. Email, and text messaging are alternate means for communication efforts; and
    b. Two-way radio communications are used where required to communicate with the local EMS during a regional emergency.
2. Internal Communication
    a. The Incident Commander is responsible for communicating the initial and ongoing situation status with the center's department heads and MP or designee.
    b. The MP or designee is responsible for communicating the status of any emergency to area/division leadership and appropriate corporate staff.
    c. Center staff attempt to use simple, precise language when communicating during an emergency. Codes are not used.
3. External Communication
    a. The Incident Commander is the key spokesperson for the center and:
        i. Notifies and communicates with regulatory and community agencies and resources regarding the center's occupancy, status, needs and ability to provide assistance;
        ii. Notifies/self-reports incidents involving fire, death, and/or serious bodily injury in accordance with federal and state guidelines.
        iii. Notifies the public relations department (Lori Mayer at 610-283-4995) who will handle radio/TV or other media inquiries, press releases or statements.
            1. NOTE: Center and regional employees do NOT communicate directly with the media; rather, all communications are handled by the public relations department. (Refer to Appendix 6.)

Refer to:
Appendix 5: Area Administrative Contact List
Appendix 6: Company Contacts
Emergency Notification Announcements

CRISIS PUBLIC RELATIONS: STAFF MEMBERS, VOLUNTEERS, CONTRACTORS, PHYSICIANS, FAMILY OF RESIDENTS AND COMMUNITY (INCLUDING OTHER LONG TERM CARE FACILITIES, AS APPOPRIATE)

1. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations.

COMMUNICATION WITH RESIDENTS, FAMILY MEMBERS AND OTHERS

2. This center uses the Genesis HealthCare CareLine as the emergency contact number (866-745-2273) as alternate communication in addition to primary telephone numbers for the residents' responsible parties and family members for contact during an emergency.

3. Based on direction from the Administrator/Incident Commander, residents, responsible parties and family members are notified as soon as possible when there is an emergency declaration at the center by center staff in person, via telephone, and through use of the Genesis CareLine. This communication includes patients who are included in census but outside of the center at the time of the emergency (i.e., at external physician appointments, dialysis, etc.). If the center determines additional alternate communication methods are needed, the Incident Commander works with company resources to obtain support, equipment and services.
4. If the center determines it has additional surge capacity (see below), local EMS and other long term care providers are notified of such capacity.
    a. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts, and to assist patients in receiving the care they need. In addition, while the HIPAA Privacy Rule is not suspended during an emergency, the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the privacy rule.
    b. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices.
    c. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures, and apply administrative, physical and technical safeguards of the HIPAA Security Rule to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy if possible, and disclosures are limited to the minimum necessary to accomplish the purpose.
    d. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

Refer to:
Appendix 7: Emergency Resources and Contacts
Appendix 8: Additional Resources

INTERNAL FUNCTIONS

THE CENTER TAKES ADVANTAGE OF LEAD-TIME BEFORE EMERGENCIES:

1. Staff will notify the Administrator or designee and DON of all potential emergency situations.
2. Keep a radio/television on at all times (if possible) and tuned to an emergency weather channel or other Emergency Alert System broadcaster.
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, emergency supplies, communication plans and appropriate contact information, with staff, visitors, volunteers and onsite contractors. Staff are monitored through use of the staffing schedules (updated as needed), and volunteers, visitors and others are monitored using the visitor log (typically kept in the reception area).
    a. Locate the emergency supplies; replenish if necessary. Refer to **Appendix 12: Emergency Supplies and Location of Critical Equipment**.
        i. The following equipment is typically available at this center: wheelchairs, walkers and canes, portable/folding chairs (for Staging Area), oxygen concentrators, IV poles, feeding pumps, suction machines, bedside commodes.
        ii. The following medical supplies are typically available at this center; first aid supplies, gauze, bandages, alcohol, triple antibiotic ointment, disposable gloves, eye protection, disposable gowns, surgical masks, BioMasks, N95 respirators, saline eyewash solution, incontinence products, barrier cream, sanitizing wipes, hand sanitizer, medications, medication cups/straws, shelf-stable nutritional supplements, food thickener, bladder catheter supplies, sterile pads, first aid tape, syringes, stretch gauze, elastic bandages, glycerin swabs, normal saline, and insulin supplies.
4. Remind staff to remain calm and in control, for organized response and to reassure the residents.
5. Clear corridors of obstructions.

DEPARTMENT HEAD EMERGENCY RESPONSIBILITIES:

1. Train personnel on department responsibilities;
2. Assign on-call responsibility for emergency management;
3. Provide support as directed by the Incident Commander;
4. Assure emergency duties are assigned;
5. Assign duties to staff based on physical capabilities and competencies;
6. Maintain a current list of all employees and their phone numbers;
7. Identify staff interested in volunteering to work in receiving facilities if evacuation is initiated;
8. Determine the minimal number and mix of employees necessary if an emergency is activated.
9. Notify the Administrator, DON, or designee of the potential staffing and supply needs; and
10. Conserve resources (e.g., water, linen, and supplies).

EMERGENCY PROCEDURE: TAKE COVER

1. It is the Incident Commander's responsibility to monitor all threatening situations and determine when the **Take Cover Procedure** is initiated. Situations involving risk to

residents, staff, and visitors due to events occurring inside and outside of the center are considered in the decision to **Take Cover**.

2. Upon making the decision to **Take Cover,** an announcement is broadcast over the center intercom system stating the following message:
    a. **"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."**
    b. Staff, if it is safe to do so, assist residents to Areas of Refuge identified in Appendix 2 of this EPP. If unsafe, staff takes immediate cover.
    c. Residents who use wheelchairs and cannot get into the Take Cover position are positioned with wheelchairs facing a wall with wheels locked, and covered with linens to help protect from flying debris (time permitting).
    d. Staff, residents and visitors (as they are able to), get into the Take Cover position (see below).


3. Emergency Job Tasks – Take Cover
    a. Administrator/Incident Commander
        i. Direct all individuals to Take Cover.
        ii. Be prepared to contact authorities if injuries and damages occur.
        iii. Direct everyone to remain in the refuge area until the danger has passed.
            1. **An "All Clear, Take Cover is over" message is then paged to signal the Take Cover situation has ended.** Afterwards, the Incident Commander accounts for residents, staff, and visitors.
    b. Nursing Staff
        i. Connect oxygen concentrators/tanks to residents requiring oxygen as needed.
        ii. Take first aid supplies/medical supplies to designated Area of Refuge, time permitting.
        iii. Relocate the residents to safe refuge and stay in close proximity of the residents while **taking cover**. Maintain transmission-based precautions as best as possible.
        iv. Close drapes, blinds, doors, and windows (time permitting).
4. Upon broadcast of the Take Cover announcement, all staff immediately discontinues tasks they are working on and begin implementing their **Take Cover** responsibilities.
    a. Immediately relocate residents and visitors to bathrooms or interior hallways (refer to Areas of Refuge, Appendix 2) away from all windows and doors. Staff closes all drapes, blinds, and doors.
    IMPORTANT NOTE: If residents, visitors, and staff are directed to Take Cover in a hallway having a door or window at the end of the corridor, attempt to keep a distance of 30 feet (30') away from the door or window.

b. Staff avoid areas with large ceiling spans. Small rooms or interior hallways away from windows and doors are suitable for **taking cover**.
c. Upon relocating all residents to a safe refuge, the staff stays in proximity of the residents while **taking cover** as well.
d. **Maintenance staff and Managers on Duty** should be prepared to activate Utility Shut-Off Procedures.
e. All *other* staff members immediately secure records, close drawers and cabinets, shut down electronic appliances, and report to the nearest Area of Refuge (refer to Appendix 2).
f. If a situation allows for advanced warning, residents, staff, and visitors will be re-located a designated area providing optimum refuge.
g. Upper floor occupants are moved to the basement or lowest level within the center.
h. Priority is given to evacuating the highest floor first.
i. Census is taken to account for all residents, staff, and visitors.
j. Upon issuance of the All Clear announcement, residents are taken back to their rooms.

Administrator (OR DESIGNEE) ALL EMERGENCIES:

1. Administrators are responsible for execution of Transfer Agreements and/or Memorandums of Understanding (MOU) for patient care and transportation. Updating your center's EPP ensures Divisional and Corporate support can access the Transfer Agreements or MOU's and activate those as you coordinate center emergency response.
    a. Where possible, centers attempt to transfer residents to Genesis-affiliated centers, as this allows for usage of existing databases and continuity of care.
    b. Administrators use Transfer Agreements and/or MOUs with non-affiliated centers, which are often mutual agreements, to arrange for patient care and services and evacuation transportation. (These agreements are activated after a decision has been made to evacuate.)
    c. Administrators activate this Emergency Preparedness Plan when necessary. If applicable, the *National Criteria for Evacuation Decision-Making in Nursing Homes* is reviewed with the management team to evaluate whether to evacuate or Shelter-in-Place. The availability and duration of emergency power is considered when making such determinations.
2. The Administrator/Designee is the Incident Commander and is responsible for activating and coordinating all activities related to the emergency.
    a. Only the Incident Commander, in collaboration with the MP and/or an authority with jurisdiction, can declare an evacuation.
3. The Administrator/Designee contacts the MP and directs internal and external communication as described above.
4. The Administrator/Designee contacts the local EMS and collaborates on integrated response, as appropriate.
5. The Administrator/Designee contacts the Ombudsman and communicates:
    a. How the residents will be sheltered;
    b. When/If the residents will be evacuated; and
    c. Where the residents will be sheltered.
6. The Administrator/Designee contacts the state licensing board.
7. The Administrator/Designee notifies the Medical Director and department heads.

8. The Administrator/Designee instructs staff to keep all doors closed in resident rooms, stairwells and functional rooms (storage, pantry, linen, etc.).
9. The Administrator/Designee instructs staff regarding suspension of non-essential services and procedures during emergencies.
10. The Administrator/Designee tracks the incident's progress and disseminates information to respective staff.
11. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers.
12. The Administrator/Designee establishes frequent communication with staff members, residents, and resident responsible parties.
13. The Administrator/Designee contacts vendors and others who may be needed for post-incident restoration and makes arrangements for services.
14. The Administrator/Designee completes NHICS Form 251, Center System Status Report to assess the center's damage.
15. The Administrator/Designee directs additional emergency documentation completion; refer to Appendices and Exhibits in this EPP.

Refer to Appendix 9: Transfer Agreements
Appendix 10: Short-term Evacuation Plan

Administrator (OR DESIGNEE) SHELTER-IN-PLACE (SIP): During emergencies the Administrator/Designee:

1. Meets with management team to discuss preparations for SIP.
2. Activates the center's SIP Plan as directed by area/divisional, regional, or corporate Leadership; and local authorities.
3. Notifies staff members, residents, and resident responsible parties of the decision to SIP.
4. Instructs individuals in the center to remain until it is safe to leave.
5. When it is safe, allows staff, volunteers, visitors, and vendors to communicate with their family members.
6. Oversees moves of residents to Areas of Refuge as necessary.

Administrator (OR DESIGNEE) EVACUATION: During emergencies the Administrator/Designee:

1. Activates the center's Evacuation Plan as directed by area, divisional, regional, or corporate leadership; or by local authorities. (Management team then notifies supervisors and staff.)
2. Meets with management team to finalize instructions for evacuation.
3. Coordinates evacuation efforts with local Emergency Management Agencies.
4. Notifies the following of the evacuation decision:
    a. The Genesis CareLine (866-745-2273) to determine bed availability;
    b. Residents and responsible parties of decision to evacuate. Communicates emergency phone numbers including alternate care center numbers;
    c. The Medical Director; and
    d. The receiving facility(ies) of the pending arrival.
5. Designates a staff member to monitor and complete the NHICS Master Resident Evacuation Tracking Log Form 255.
6. Notifies alternate care facilities of the pending arrival. Activates Transfer Agreements/MOU as necessary.

7. Secures the center and verifies all electronics and computers have been turned off and unplugged.
8. Approves shut-down procedures for non-essential utilities and designates appropriate personnel to implement shut-down.
9. Verifies emergency supplies for transport.
10. Initiates recovery and re-entry efforts when deemed safe.

SENDING CENTER: ADMINISTRATION TASK LIST

1. Schedule additional staff to coordinate transportation; consider and determine plans for cohorting patients, when applicable.
2. Work with MP to schedule transportation.
3. Update original evacuation report to reflect any changes; i.e., residents in hospital.
4. Review return plan with staff and ensure plan is followed.
5. Schedule additional staff to coordinate transportation.
6. Send supplies to receiving center as needed. Consider need to provide beds, wheelchairs, over bed tables, oxygen, food, water, bathing materials, linens, means for privacy, medical supplies and continence supplies.
7. Communicate daily with receiving center Administrator on return status.

RECEIVING CENTER: ADMINISTRATION TASK LIST

1. Verify all local emergency services are available prior to resident transport.
2. Contact center staff and ensure adequate staff is available to meet the needs of the residents; discuss and determine plans for cohorting patients when applicable.
3. Schedule staff to prepare the building for residents and ensure adequate supplies for each department are available.
4. Verify local vendors and contractors are available i.e. food and nutrition services, housekeeping/laundry, dialysis, physicians, pharmacy, oxygen, gas stations, x-ray and lab services.
5. Coordinate the return schedule with Senior Vice President of Operations and MP.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): ALL EMERGENCIES

1. During all emergencies nursing is responsible for:
    a. Coordinating resident care;
    b. Coordinating communication with medical providers;
    c. Printing and securing the following resident-specific documents:
        i. Admission Record (face sheet).
        ii. MARs;
        iii. TARs;
        iv. Most recent monthly order sheet;
        v. Care Plan;
        vi. Weight and VS Summary;
        vii. Most recent 7 days of nursing notes;
        viii. Most recent physician progress notes;
        ix. Behavior Monitoring Form;
        x. Skin integrity report; and

xi. Patient-specific medications, treatment and feeding supplies, including adaptive equipment, special needs items and preventive devices for falls and skin breakdown.

d. Obtaining additional clinical staff in collaboration with the Administrator and Human Resources;
e. Coordinating resident needs with food and nutrition services and materials management;
f. Notifying pharmacy services of pending evacuation and alert for need to provide back-up medications;
g. Communicating the status of care and resident conditions to the Administrator;
h. Accounting for and keep track of residents and staff;
i. Maintaining effective lines of communication with nursing staff members;
j. Preparing medications (one week supply if possible) for those residents going to alternate facilities, hospitals, or home;
k. Verifying all physician orders are current and have been obtained for residents.
l. Updating and printing resident/patient census reports;
m. Estimating the number of ambulatory and non-ambulatory residents/patients for transportation and assistance purposes. Identify residents on transmission-based precautions that require cohorting or segregation from other resident; and
n. Identifying residents with communication impairments, and associated planned interventions and updating resident care plans as necessary.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): EVACUATION TASK LIST

1. Designates Phase I and Phase II Evacuation Nurse Coordinators.
    a. Nurse Coordinator Phase I works to transfer the highest acuity residents first via ambulance if possible. Considers hospital transfers as appropriate.
    b. Nurse Coordinator Phase II works to transfer lower acuity residents via the most appropriate methods available. Phase II residents may be moved to a staging area prior to evacuation. Staff members are designated to each of the vehicles to assist and care for the residents during the transport. Identifies patients that may be cared for by family/friends and arranges discharge.
2. Groups the residents according to unit, acuity, and those on transmission-based precautions and assigns staff members accordingly.
3. Prepares the lists of residents and receiving location(s) so staff can prepare clothing, supplies, medications, and any other items.
4. Completes the *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient. This tracking includes patients that are counted in the resident census even if they are off-site at the time of the emergency.
5. Designates staff members to accompany each group.
6. Assists in coordinating transfer of all residents to alternate hospitals or other locations. Use *NHICS 255 Master Resident Evacuation Tracking Form.*
7. The Evacuation Nurse Coordinators or designees:
    a. Complete *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient noting patient-specific supplies and equipment.
    b. Collect patient-specific information (see above).
    c. Collect the supplies as noted on NHICS 260 and supervise load of medications, supplies and administration records to accompany transport vehicle:

i. A licensed nurse is assigned to safeguard controlled substances.
ii. If residents needing critical medications are deemed unsafe to carry their own medications, then a licensed nurse carries the medications.
iii. When necessary and appropriate, a separate cooler is provided for temperature-controlled medications.

d. Contact the DON of receiving center to inform him/her of the status of the evacuation.
e. Transfer residents from bed and transport in accordance with care plans.
f. If possible and time-permitting, inspect the residents for:
   i. Proper attire for the weather;
   ii. Identification (ID) wristbands (if applicable);
   iii. Assistive devices including hearing aids, dentures, glasses, and prosthesis.
g. Provide a change-of-shift (hand off) report. Include information regarding patients at risk for falls and elopement.
h. Supervise resident evacuation from the building and the resident flow to transportation.

SENDING CENTER: NURSING TASK LIST

1. Provide the *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
2. Pack resident medical records, supplies, clothing, necessary personal items and medications. Inventory sheets are completed if there is ample lead-time.
3. Prepare/pack any special needs equipment or supplies as necessary. (For example: special size Foley/ostomy supplies, enteral feed formula, oxygen).
4. Load residents with assistance from transport crew.
5. Give report and narcotics/controlled medications to transport nurse/crew.
6. Provide the resident records to transport crew.
7. Provide a method for resident identification either via use of wristbands or use of photo identification.
8. Provide resident identification.
   a. The sending center nursing team reports significant resident information to receiving center in a verbal or written hand-off report, including (wristbands may be used for this purpose):
      i. Code status/Advanced Directives
      ii. Potential for Fall Risk
      iii. Potential for Elopement Risk
      iv. Diagnoses
      v. Food, Medication and Other Allergies
      vi. Thickened liquid consistency
      vii. Diet consistency
      viii. NPO Status
      ix. Seizures
9. Provide medication management
   a. Medications are checked against the MARs to ensure all meds are accounted for per physician order before the residents are transported to the receiving center.
   b. Narcotics/controlled medications are separated and provided to the transport nurse who keeps control of the medications until arrival at the receiving center.

c. The transport nurse and DON or designee include the narcotic count sheet/MAR with each medication.

10. Provide resident special needs equipment.
    a. The DON/Designee uses the *NHICS 260 Individual Resident Evacuation Tracking Form* to identify special equipment or supplies needed during transport.
    b. Pressure relief devices for residents identified with specific wound needs.
    c. When possible, special equipment or supply needs (i.e., positioning devices, oxygen (see below) and means of securing oxygen, nebulizers, gel pads, special size colostomy bags) are loaded on the transport vehicle prior to the residents.
11. Provide oxygen needs to appropriate residents.
    a. Oxygen use is documented on the *NHICS 260 Individual Resident Evacuation Tracking Form*.
    b. Residents requiring oxygen are transported by wheelchair with the oxygen tank secured to the chair. Chair wheels are locked to prevent rolling during transport.
    c. Extra oxygen tanks are secured to prevent movement.
    d. Residents requiring oxygen may be transported separately due to limited number of wheelchair spaces on transporting vehicles.
12. Provide enteral feeding supplies to appropriate residents.
    a. The DON/Designee is responsible for ensuring enteral feeding formula and supplies are packed.
    b. Formula, tubing and syringes are collected, packed for transport, and labeled with the resident name(s).
    c. If support is necessary (i.e. inadequate formula on hand), the DON/Designee contacts the Regional Manager of Food and Nutrition Services for assistance.

TRANSPORTING CREW: NURSING TASK LIST

1. Find/Load first aid kit.
2. Ensure all transported supplies are labeled.
3. Inspect oxygen to ensure it is secured for transport.
4. Ensure transport team and residents have required PPE.
5. Upon arrival at the sending center, notify Administrator and DON and obtain a copy of *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
6. Assist with loading assigned residents.
7. Check actual residents loaded against *NHICS 255 Master Resident Evacuation Tracking Form* to ensure accuracy.
8. Check for critical medications and equipment: snacks/drinks; clothing and belongings; and associated administration records (MARs and TARs).
9. Take report from evacuating center nurse and take possession of narcotics.
10. As time allows, document resident condition on departure.
11. Provide care/services as necessary during transport and document such services.
12. Contact the receiving center periodically to coordinate arrival time.
13. Report to the nursing team at the receiving center upon arrival and transfer resident medications, belongings, documentation, and supplies.

TRANSPORTING CREW NURSING POLICY AND PROCEDURE

1. Oxygen.

a. The center uses *NHICS 260 Individual Resident Evacuation Tracking Form* to identify residents that require continuous or PRN oxygen. Residents with continuous or PRN oxygen needs are transported via wheelchair so the oxygen tank can be secured to the chair. During transport, the chair wheels are locked to prevent rolling. Residents using oxygen may be transported separately due to the limited number of wheelchairs spaces on transport vehicles.
b. Extra oxygen tanks are secured to prevent movement.
c. Guidance for the Safe Transportation of Medical Oxygen for Personal Use
    i. Vehicle operators take precautions to ensure medical oxygen for passengers' personal use is handled and transported safely.
    ii. For Transportation in the Passenger Area Task List/Instructions:
        1. Only transport oxygen in a cylinder maintained in accordance with the manufacturer's instructions. The manufacturer's instructions and precautions are usually printed on a label attached to the cylinder.
        2. Before boarding, inspect each cylinder to assure that it is free of cracks or leaks, including the area around valve and pressure relief device. Listen for leaks; do not load leaking cylinders. Visually inspect the cylinders for dents, gouges or pits. A dented, gouged, or pitted cylinder should not be transported.
        3. Limit the number of cylinders to be transported on board the vehicle to the extent practicable.
        4. If transportation arrangements allow, the vehicle operator considers limiting the number of passengers requiring medical oxygen.
        5. Cylinders used for medical oxygen are susceptible to valve damage if dropped. Handle these cylinders with care during loading and unloading operations. Never drag, roll or carry a cylinder by the valve or regulator.
        6. Do not handle oxygen cylinders or apparatus with hands or gloves contaminated with oil or grease.
        7. Secure each cylinder to prevent movement and leakage. "Secured" means the cylinder is not free to move when the vehicle is in motion. Each extra cylinder should be equipped with a valve protection cap.
        8. Oxygen cylinders or other medical support equipment are not stored or secured in the aisle. Make sure the seating of the passenger requiring oxygen does not restrict access to exits or use of the aisle.
        9. Since the release of oxygen from a cylinder could accelerate a fire, secure each cylinder away from sources of heat or potential sparks.
        10. Smoking or open flames (cigarette lighter or matches) are not permitted in the vehicle when medical oxygen is present.
        11. When the destination is reached, remove all cylinders from the vehicle as soon as possible.
    iii. For Transportation in the Cargo Compartment Task List:
        1. Place each cylinder in a box or crate or load and transport in an upright or horizontal position.
        2. Protect valves from damage, except when in use.
        3. Secure each cylinder against movement.

2. Narcotics/controlled medications.

a. When necessary, narcotics/controlled medications are transported from the sending center to the evacuation center.
b. All narcotics/controlled medications should have the count sheet/MAR attached to the medication.
c. A log listing the narcotics/controlled medications/MAR for each resident is sent to the receiving center. A copy is provided to the transporting nurse.
d. A nurse completes a narcotic count with the receiving center nurse upon arrival.
e. All narcotics/controlled medications should remain in the possession of a nurse during transport.

3. Illness or death enroute.
    a. If a resident/patient has a significant change in condition or expires during transport, the transporting vehicle diverts to the closest acute care center, if possible.
    b. If this is not possible, the transport crew alerts the receiving center and manages the patient situation until arrival.
4. Documentation.
    a. During transport, the transportation nurse/crew document resident conditions and status at the time of transfer and also documents medications administered, treatments given and any other information that is deemed pertinent.

NURSING: RECEIVING CENTER TASK LIST

1. On arrival take report from the transport nurse/crew and count narcotics/controlled medications.
2. Complete triage.
3. Pull original documents from the transport nursing documentation, make copies, and return original documentation to the sending center as soon as possible, and as appropriate.
    a. Give copies of the documentation from the sending center to medical records for retention to support continuity of care during the evacuation process.
4. Review MARs and TARs against documentation received from sending center to ensure all physician order changes were posted to these documents. Review other changes to identify orders for continuation.
5. Depending on appropriateness and availability, arrange for grief counselors to counsel evacuees.

NURSING: TRIAGE EVACUATION RECEIVING CENTER TASK LIST

1. If possible, set up stations for providing care as follows:
    a. Station I: Complete the resident admission assessment including:
        i. Vital signs with pain assessment
        ii. Evaluate presence of infections
        iii. Weight
        iv. Height
        v. Provide resident belongings to receiving nurse along with resident assessment information.
    b. Station II: Provide:
        i. Hydration
        ii. Snacks
    c. Station III:
        i. Transport resident and belongings to assigned room

ii. Provide as-needed personal care

NURSING: SHELTER-IN-PLACE TASK LIST

1. Assist in moving residents to Area of Refuge (if indicated) and frequently monitor their conditions.
2. Connect oxygen concentrators/tanks to residents requiring oxygen.
3. Take first aid supplies/medical supplies to designated safe areas and initiate treatment.
4. Be prepared to assist as needed at the direction of the Incident Commander.

NURSING: EXPANSION/SURGE OF RESIDENTS

1. Coordinate triage of casualties, if necessary.

Refer to Appendix 11: Triage of Casualties

MEDICAL DIRECTOR: ALL EMERGENCIES TASK LIST

1. If possible and appropriate, report to the center;
2. Provide assistance as appropriate, via telephone, electronically or in-person, during an external or internal emergency requiring medical evaluation and /or intervention and coordinate the activities of physicians as necessary;
3. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
4. The center only accepts admissions within its scope of care unless directed by a regulatory agency.
5. Triage casualties;
6. Obtain additional medical resources in collaboration with the SVP/VP of Medical Affairs or Regional Medical Director; and
7. Assist center with transfer decisions and emergency orders if attending physician cannot be reached.

HUMAN RESOURCES AND SCHEDULING: ALL EMERGENCIES TASK LIST

1. Human Resources /Benefits Designee and Scheduler are responsible for scheduling and assembling adequate staff in consultation with the Administrator/Designee:
    a. Maintain current information all center personnel and volunteers with addresses and phone numbers for contact purposes;
    b. Coordinate with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event that staff is needed in alternate locations;
    c. Update the department heads with results of attempts to obtain staff. Confirm expected availability as well as the number of family members joining the staff members;
    d. Coordinate, if necessary, transportation of the center staff to work;
    e. Monitor the length of time each employee works during the declared emergency and provide adequate time off to rest and recover. Time worked should not exceed sixteen (16) hours over a 24 hour period if possible;
    f. Identify areas where employees can rest and recover;
    g. If necessary, work with regional Human Resources staff to contact other Genesis centers to obtain additional staff.

FOOD AND NUTRITION SERVICES: ALL EMERGENCIES TASK LIST

1. The Dining Services Director or designee:
    a. Follows the Food and Nutrition Services Policies and Procedures, Food Service Emergency Plan and associated guidelines including a plan to obtain food and water in the event of an emergency;
    b. Obtains additional staff in collaboration with Human Resources;
    c. If power outage is likely, set refrigerators and freezers to the lowest setting to preserve items for the longest possible time period;
    d. Unplugs non-essential equipment;
    e. Obtains supplies of food and water for residents/patients and staff;
    f. Creates water supply:
        i. Fill tubs, pitchers, and as many containers as possible with water;
        ii. Bags as much ice as possible and stores bags in the freezers; and
        iii. If advanced warning is provided, purchases ice and stores in freezers.
    g. Determines the numbers of residents, visitors, volunteers, and employees for whom food service may need to be provided.
    h. Provides food service as appropriate and able. Refer to Exhibit 1 for Sample Emergency Menus.

FOOD AND NUTRITION SERVICES EMERGENCY EVACUATION GUIDELINES

1. The Dining Services Director/Designee:
    a. Coordinates food service with the center Incident Commander following the EPP.
        i. Provides adequate snacks and fluids for each vehicle transporting residents;
        ii. A sample snack menu, extended for consistency modified and Gluten-Free diets, has been developed for these purposes and may be customized as needed; and
        iii. All therapeutic diets are waived during an emergency with the exception of consistency-modified and Gluten-Free diets as allowed by state regulations.
    b. Packaged snacks and fluids (including thickened water) are provided in disposable containers or bags, if possible, with labeling for consistency-modified and Gluten-free (when appropriate).
    c. Gathers relevant vital resident and department records.
        i. Enteral feedings for residents are managed by nursing staff with support from the Dining Services Director/Designee.

SENDING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director or designee sends Food and Nutrition Services staff ahead to the receiving center(s) to prepare snacks and fluids for residents **on their arrival;**
2. Consult with the Regional Manager of Food and Nutrition directly to review plans for evacuation;
3. Dining Services Director makes plans for meals to be served prior to transport. (Note: Meals may be served inconsistently with the normal center schedule to ensure residents are prepared and fed at designated departure times);
4. Create/Print diet roster for distribution to receiving facilities;
5. Create/Print 2 tray card copies for each resident;
6. Prepare a simplified shelf-stable snacks and liquids master list. Include specific-consistency diets, thickened liquids, and disposable supplies (napkins, plastic cutlery).

7. Prepare and label snacks for consistency-altered diets (Dysphagia Advanced and Puree). A snack list identifying snacks for consistency-altered diets is included for transport.

RECEIVING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director and assigned staff arrive at the center in sufficient time to allow for inventory of food items to ensure nutrition needs of the residents.
2. The Dining Services Director/Designee prepares beverages and light snacks to be provided upon evacuated residents' arrival to the center. Include meals appropriate for consistency-altered diets and thickened liquids

REHABILITATION SERVICES: ALL EMERGENCIES TASK LIST

1. The Director of Rehab or designee:
    a. Assists with triage, transfer, or evacuation of residents;
    b. Obtains additional staff in collaboration with Human Resources; and
    c. Directs rehab staff to assist on the units as required.

MAINTENANCE SUPERVISOR: ALL EMERGENCIES TASK LIST

1. Gather emergency supplies. See Appendix 12: Emergency Supplies Checklist;
2. Evaluate the safety of the physical plant;
3. Coordinate emergency repairs;
4. Communicate the status of the center environment to the Administrator.
5. Make rounds of the center and grounds;
6. Secure potential flying debris (above, below, around, and in the center);
7. Check equipment for functionality:
    a. Monitor fuel supply for generator; and
    b. Check that equipment and utilities are functioning properly.
8. Prepare all vehicles for evacuation if needed;
    a. Check fuel, oil, and water levels for each vehicle;
    b. Move vehicles away from trees;
    c. Prepare maps/obtain directions with evacuation routes and alternate routes for each vehicle. A paper map with all routes should accompany each vehicle.;
    d. Load phone or other communication devices in each vehicle;
    e. Load first aid kit in each vehicle; and
    f. Identify storage space for medical and business records, medications, and equipment in each vehicle.
        i. Identify oxygen storage area, as needed, in each vehicle. Follow the guidelines for oxygen transport in vehicles.
9. Transporting Crew/Maintenance
    a. Service van as necessary to include air conditioning, oil, gas, tires, fire extinguisher, safety belts, etc. are all in good condition by completing the Pre-trip Vehicle Safety Inspection Checklist. Check transport supplies and load them into the vehicle;
    b. Identify route with maps for travel from evacuating center to receiving center and back to original center as appropriate;
    c. Identify van driver, licensed staff transporting evacuees, and schedule departure. Staff are made familiar with the use of safety devices in the vehicle;
    d. Bring money or purchase cards in the event supplies are needed during for the trip; and

e. Load communication devices.

Refer to Appendix 12: Emergency Supplies and Location of Critical Equipment

MAINTENANCE SUPERVISOR: EVACUATION TASK LIST

1. Secure the center and verify all electronics and computers have been turned off and unplugged;
2. Designate someone to stay behind, if deemed safe, to safeguard the center;
3. Activate shut-down procedures for non-essential utilities;
4. Work with responding emergency agencies on building security, traffic control, utility control, and elevator operations;
5. Make final rounds of the center and grounds;
6. Secure windows and other building openings; and
7. Pull shades and close all drapes.

MATERIALS MANAGEMENT (CENTRAL SUPPLY): ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain medical supplies and PPE;
2. Provide supplies and linens to the nursing units; and
3. Notify medical and medication suppliers of additional needs.

SOCIAL WORK: ALL EMERGENCIES TASK LIST

1. Provide support and crisis intervention services for residents, residents' families, and staff;
2. Notify responsible parties and residents, as directed by the Administrator/Incident Commander, of decisions to Shelter-in-Place/Evacuate and resident status;
3. Review and update Advanced Directives;
4. Manage resident discharges and placement, if possible, based on resident/responsible parties' requests;
5. Follow-up within 24 hours, if possible, to confirm care and services for discharged residents.

SENDING CENTER: SOCIAL SERVICES TASK LIST

1. Contact evacuated residents' families to let them know the residents' location;
2. Assist DON in supervising certified nursing assistants as they pack and inventory residents' belongings; and
3. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment and care plan accordingly.
    a. For residents experiencing adjustment difficulty, follow up as indicated.

RECEIVING CENTER: SOCIAL SERVICES TASK LIST

1. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment, and care plan accordingly.
2. Assist DON in supervising certified nursing assistants to ensure resident's personal belongings are made available to each resident and inventoried in accordance with established procedures;
3. Notify Responsible Parties of resident arrival/admission; and
4. Assess psychological/social needs to ensure needs and preferences are communicated to the interdisciplinary team.

a. Follow up with status call to Responsible Party as soon as possible following admission.

ADMISSIONS DEPARTMENT: ALL EMERGENCIES TASK LIST

1. Maintain a current list of residents;
2. Print face sheets if evacuation is possible;
3. Coordinate admissions with the DON/Administrator;
4. Assist social services with contacting responsible parties; and
5. Report available transportation and receiving center capacities to the Incident Commander.

ADMISSIONS DEPARTMENT: EVACUATION TASK LIST

1. Notify agencies with Center Transfer Agreements of the emergency situation and potential to evacuate;
2. Communicate resident information and status to the receiving center; and
3. Maintain a list that includes each resident name and the time/place of each resident's transfer.

BUSINESS OFFICE/PAYROLL: ALL EMERGENCIES TASK LIST

1. Manage payroll; and
2. Provide means to pay for food, supplies, and/or transportation.

BUSINESS OFFICE/PAYROLL: EVACUATION TASK LIST

1. The Cash Handler secures the following items for evacuation:
    a. Center petty cash;
    b. Resident trust fund (RTF);
    c. Petty cash;
    d. Resident trust check stock;
    e. Printed copy of most recent RTF Trial balances;
    f. Imprest checkbook;
    g. Payments to be deposited; and
    h. If applicable, purchase cards.
2. Turn off and unplug all computers; and
3. Take laptop(s) if applicable.

ENVIRONMENTAL SERVICES: ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain linen in the event of an emergency;
2. Secure:
    a. Linens;
    b. Blankets;
    c. Trash can liners;
    d. Mops;
    e. Rags;
    f. Buckets;
    g. Trash cans;
    h. Cleaning and disinfecting supplies; and
    i. Toilet paper.
3. Place emergency orders for supplies;
4. Clear corridors of any obstructions such as carts, wheelchairs, etc.;

5. Check equipment (wet/dry vacuums, etc.);
6. Unplug non-essential equipment; and
7. Maintain sanitation considering best practices for infection control.

LAUNDRY: ALL EMERGENCIES TASK LIST

1. Close all laundry chutes; and
2. Unplug non-essential equipment.

MEDICAL RECORDS: EVACUATION TASK LIST

1. Prepare resident medical records transport to the appropriate receiving facilities;
2. Assist nursing to obtain charting from each nursing station and provide them to the transporting nurse; and
3. In situations of planned evacuation to affiliated centers, centers follow a process to obtain/grant access to electronic medical records. Refer to the Planned Evacuation Process on for details.

RECEIVING CENTER: MEDICAL RECORDS

1. Place the Clinical Record at the appropriate nurse's station;
2. Make copies made of documentation from sending facilities, place the copies in a manila envelope marked "CONFIDENTIAL: Do Not Destroy". Place with the clinical record in the event of discharge of the resident. Send originals back to the sending center as soon as possible, and appropriate;
3. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices;
4. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures by applying administrative, physical and technical HIPAA Security Rule safeguards to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy and disclosures are limited to the minimum necessary to accomplish the purpose; and
5. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

SURGE CAPACITY

1. External disaster expansion guidelines:
    a. In the event of an external disaster, this center may be used by local hospitals and other health care facilities to care for additional patients as space/staff permit;
    b. Unplanned admissions from an external disaster are completed in collaboration with:
        i. External agencies;
        ii. Healthcare providers;
        iii. Administrator;
        iv. DON;
        v. Medical Director;
        vi. Admissions Coordinator;
        vii. Human Resources or Staffing Coordinator; and
        viii. The CareLine.
    c. The center only accepts admissions within its scope of care unless directed by the local health authorities or a regulatory agency.
    d. If the center team determines it is experiencing a healthcare surge, the following guidelines are used to assess, prepare, and mobilize to meet the need for increased patient care capacity:
        i. Transfer patients to other institutions in the region, state, or other states;
        ii. Group like-patient types together to maximize efficient delivery of patient care;
        iii. Convert single rooms to double rooms or double rooms to triple rooms, if possible;
        iv. Designate units or areas of the facility for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients;
        v. Use cots, beds, or other sleeping surfaces in flat space areas (e.g., cafeterias, recreation areas, lounges, lobbies) for noncritical patient care;
        vi. Beds should not be placed near windows, if possible and appropriate to the emergency, so as to avoid broken glass and protect patient privacy and security; and
        vii. Determine whether additional staff, including State or Federally designated health care professionals and volunteers, may be used to address surge needs.
    e. The center identifies areas and spaces that could be opened and/or converted for use as patient treatment areas, such as activity rooms, dining rooms, rooms with unlicensed beds, or other unused center space. Areas are selected based on the intensity of the incident and the anticipated number of healthcare surge patients the center may receive. The identified areas are cleared of excess furniture and equipment as needed.
2. Roles and Responsibilities
    a. The Director of Nursing/Resident Care Director and Admissions Director determine bed availability and admission placement in collaboration with CareLine;
    b. The Medical Director is notified and is responsible for emergency physician coverage, if necessary;
    c. The DON/Resident Care Director evaluates nurse staffing needs;

d. The Administrator/Designee and department heads are responsible for assuring adequate supplies and staff;
e. The Administrator/Designee contacts area leadership, the law department and regulatory agencies, as necessary to obtain waivers for additional capacity;

f. The Social Worker is responsible for notifying the residents' responsible parties of admission;
g. Center staff coordinates admission, identification, assessment and care planning for new residents following established operational, clinical, and admissions policies and procedures. Exception would be when suspended or waived by management and/or in consideration of CMS, state agency and other regulatory guidance; and
h. The center assumes responsibility for the care and services of residents admitted as the result of an emergency.

Refer to Appendix 13: Surge Capacity

EMERGENCY PHYSICIAN COVERAGE

The Medical Director is notified of all center-related emergencies having the potential for or currently requiring medical intervention.

DEPENDING ON THE CIRMCUMSTANCES AND TYPE OF EMERGENCY, IT IS THE MEDICAL DIRECTOR'S RESPONSIBILITY TO:

1. Provide on-site and/or offsite assistance during an external or internal emergency;
2. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
3. Triage casualties; and
4. Obtain additional medical resources in collaboration with the Vice President/Senior Vice President of Medical Affairs.

INTERRUPTION OF NORMAL OPERATIONS

The Incident Commander may suspend or relax policies and procedures during an emergency. These decisions and the associated potential consequences are considered carefully. In making these decisions, the Incident Commander prioritizes essential operations that must continue to prevent compromise of resident care. All significant departures from established policy and procedures and this EPP must be approved by the Incident Commander, Regional, Divisional, and Corporate leadership.

CAPACITY FOR DECEASED RESIDENTS

1. This center plans for the potential handling and holding of deceased individuals if support from local emergency responders or other community resources is not immediately available;
2. Human remains
   a. This center considers the following information in handling, processing, and storing human remains onsite on a temporary basis:
      i. The center's normal capacity, if any, to store deceased individuals; including refrigeration capacity available to store human remains safely and separated from emergency food supply;
      ii. Suitable areas on the center's periphery to store human remains without refrigeration;
      iii. Equipment (ice-making, etc.) or materials/supplies needed (storage bags for ice, deodorizers, body bags, heavy duty plastic wrap, personal protective equipment (PPE), tarps, pallets, etc.) to provide temporary storage of human remains; and
      iv. Ways to control and isolate temporary morgue provisions away from healthy center occupants (residents, staff, and visitors).
   b. The Incident Commander makes decisions and provides direction regarding temporary storage of human remains, and contacts support services and the local EMS for assistance.
3. Documentation
   a. The center documents information about deceased individuals on **NHICS Form 259: Master Center Casualty Report**.

RECOVERY AND RESTORATION

1. Post-emergency procedure
   a. Immediately following the emergency, when it is safe to do so, the Incident Commander undertakes the following actions:
      i. Coordinate recovery and restoration operations with area, division, region and corporate representatives, the Emergency Management Services (EMS), and other agencies with jurisdiction to restore normal operations.
      ii. Provide local authorities with a master list of displaced, injured, or dead and notify next of kin/responsible party. ***Refer to NHICS Form 259 Master Facility Casualty Fatality Report.***
      iii. Advise personnel to dispose of any food/supplies suspected to be or actually contaminated or spoiled.
   b. Inspection task list:
      i. When it is safe to do so, the Incident Commander and the Maintenance Director, with support services as necessary, perform an initial damage inspection. **NOTE: If there is concern of structural damage, center staff do not enter the building. The following precautions are taken to avoid injury and damage:**
         1. Open doors carefully.
         2. Avoid the use of open flame in the event of fuel leakage, dampened electrical equipment, or flammable materials;
         3. Watch for falling objects or downed electrical wires. Do not touch downed electrical wires or objects touched by downed wires;
         4. Stay away from windows and/or glassed areas;
         5. Take pictures and document damage; and
         6. Arrange for cleaning services, including removal/clean up of spilled medications, drugs, and other potentially harmful materials following center policies and procedures. (Refer to: Safety and Health P&P SH800.)
   c. When it is safe to do so, the Incident Commander and the Maintenance Director perform a utilities inspection. **The following precautions are taken to avoid injury and damage:**
      i. If a natural gas smell is noticed, open windows and doors, shut off main gas valve, leave premises, and contact the Utility Provider **IMMEDIATELY;**
      ii. If damage to wiring is suspected, do not use any appliances and shut off electrical power. Contact the Utility Provider and the contracted Electrical Contractor; and
      iii. If damage to plumbing is suspected, check water outlets and sewage lines. Shut off the main water valve if damage is observed. Contact the Utility Provider and contracted Plumbing Contractor.
   d. The Incident Commander reports all building, equipment, or utility damage to the MP;
   e. Upon notification from the proper authorities, center support services and/or utility providers the emergency has been terminated or de-escalated, the Administrator oversees the orderly return of residents and staff;

f. Before reoccupation of the building, a safety inspection of the center and surrounding areas, including the utilities delivery systems and HVAC units, is performed by the Incident Commander, the Maintenance Director, and regulatory agency(ies);
g. Recovery and restoration is managed in consideration of best practices for infection control, including:
    i. Frequent hand washing. If local water supply contaminated, use bottled water. If hands not visibly soiled – use alcohol-based hand rub;
    ii. In response to flooding or water damage and when possible, cleaning out damaged areas within 24 to 48 hours to prevent mold growth;
    iii. Cleaning, wearing rubber gloves, with a solution of approximately 1 cup bleach to each gallon of water, with open doors and windows for air circulation. (Bleach solution is not mixed with ammonia or other cleaners);
    iv. Use of dust masks during activities that may stir up mold spores or excessive dust.
    v. If applicable, following local officials' instructions for use of bottled water. If instructed to boil water, boiling for at least a full minute before using it to cook, clean or bathe;
    vi. Discarding all perishable food items that may have become contaminated or in contact with flood water including canned food;
    vii. Treating wounds in accordance with routine infection control practices;

    Note: Adapted from Becker's Infection Control and Clinical Quality, "APIC: 6 tips for infection prevention after a hurricane" written by Brian Zimmerman, 8/29/17.
h. After center reoccupation is considered safe, the Incident Commander and department leaders work to prepare the center to resume normal operations, and coordinate transportation and re-admission of residents;
i. After re-admission, the center re-establishes all essential services; and
j. After re-admission, the Incident Commander coordinates provision of crisis counseling for residents/patients, families, and staff as needed.

LOSS OF UTILITIES

1. Loss of electrical power
    a. Back-up Power/Generators: Emergency lighting/power is provided in conformance with center policies and the state's Department of Health policies to maintain temperatures, provide emergency lighting, as well as for fire detection and extinguishing systems and sewage and waste disposal. The ability to obtain and maintain generator power is a factor in whether to evacuate or Shelter-in-Place;
    b. The center follows multiple policies and procedures regarding infection control, hazardous waste, food handling and life safety that guide the center's sewage and waste control practices. The center will seek additional resources as necessary to meet sewage and waste disposal needs in accordance with current standards;
    c. If this center has a generator, the emergency generator system will be inspected weekly by appropriate service location staff and annually by a qualified outside contractor or more frequently if required by state regulation. If this center maintains an onsite fuel source to power the emergency generator(s), the center has contracted with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency.
    d. Service Delays:
        i. In the event electrical service is disrupted, flashlights are distributed throughout the center, prioritized as needed;
    e. Extended Loss: If power is lost and expected to be disrupted for an extended period of time, assistance is requested from local agencies.
        i. Center staff should consider the content of residents' personal refrigerators and advise residents accordingly;
        ii. In the absence of power for the call bell/light system the center uses bells or other methods to alert staff to their needs.
        iii. Loss of Utilities Alert:
            1. When appropriate and possible, the following announcement is made: **"Center Alert-We are activating Loss of Utilities protocols-(Describe loss of Power and Location). Please continue your duties and listen for further instructions."**
        iv. Provide instructions as necessary for the specific circumstances.
2. Air conditioning failure
    a. Notify HVAC Company and report problem;
    b. Monitor room temperatures. When the temperature of any resident/patient area reaches 81 degrees Fahrenheit for four (4) consecutive hours:
        i. Open doors;
        ii. Operate fans;
        iii. Notify the Administrator or designee and the Medical Director;
        iv. Make arrangements for transfer of residents/patients to other areas of the Center, or other facilities if necessary;
        v. Monitor residents'/patients' temperatures every four (4) hours;
        vi. Encourage fluids, begin intake and output records as necessary;
        vii. Relocate residents/patients who are at risk of hyperpyrexia/over-heated;
        viii. Observe residents/patients for symptoms of hyperpyrexia. Document findings.

c. The center follows protocols for addressing significant changes in condition for residents with symptoms of hyperpyrexia.

3. Heating failure
   a. Notify HVAC Company;
   b. If the outside temperature goes below 30 degrees Fahrenheit, drain plumbing and put antifreeze in the toilets and sinks;
   c. Monitor room temperatures. When the temperature inside the center remains at 65 degrees Fahrenheit, for four (4) consecutive hours:
      i. Obtain and distribute blankets, covering hands, feet, and heads;
      ii. Distribute warm soups, coffee, or tea to residents/patients;
      iii. Notify the Administrator, DON, or designees;
      iv. Notify the Medical Director;
      v. Monitor and chart resident/patient temperatures every four (4) hours;
      vi. Relocate residents/patients at high risk of hypothermia; and
      vii. Observe residents/patients for symptoms of hypothermia. Document findings.
   d. The center follows protocols for addressing significant changes in condition for residents with symptoms of hypothermia.
4. Interruption of telephone service
   a. Notify the telephone company and report disruption of service (use cellular or public telephone);
   b. Evaluate all phones and fax lines in the Center to determine the extent of the disruption; and
   c. During the disruption, the Incident Commander uses a cellular phone for emergent communication. Other available cell phones are used as needed with prioritization to avoid interruption to care and services.
5. Loss of water supply
   a. Notify the water division of the public utility department of the disruption of services;
   b. If the water department advises services will be resumed promptly, all residents/patients and service areas will be informed and instructed to refrain from turning on water taps until supply is re-established. Nursing services are responsible for advising residents/patients of the situation;
   c. If necessary, a minimum of the supply in hot water tanks and the emergency supply of water may be used. Contact may be made with the potable water supplier for additional water;
   d. In the event of a disaster in the immediate area creating prolonged and/or indefinite disruption of water supply to the center, the Incident Commander attempts to obtain water for residents/patients. If adequate water is not available, the Incident Commander proceeds with evacuation; and
   e. Prepare and handle disposal of human waste using supplies for containment and specific storage locations, and with use of PPE.

Refer to Appendix 14: Emergency Water Supply
Refer to Appendix 15: Utility Shut-Off Procedures

UTILITY, ELEVATOR & GENERATOR SYSTEM FAILURE

Failure	Contact	Action
Sewer drains backing up	Maintenance	Do not flush toilets or hoppers. Do not use equipment that sends water to drain. Be sure to turn off water except for drinking. If long-term outage expected, consider: Evacuation; Bath in a Bag; Accessible Portable Showers; and Accessible Portable Toilets
Water-sinks and toilets inoperative.	Maintenance	Use distilled or sterile water for drinking.
Fire sprinklers or alarm system inoperative.	Maintenance	Begin fire watch. Minimize fire hazards. NOTIFY LOCAL FIRE DEPARTMENT by calling 911
Water non–potable (not drinkable)	Maintenance	Water cannot be used for drinking, washing or cooking. Place "Non-Potable Water-Do Not Drink" signs at all drinking fountains and sinks. If a water shut-off valve is in place, turn off the water to the sink/drinking fountain. Use emergency water supply for drinking and cooking.
Elevator(s) out of service	Maintenance	Review fire and evacuation plans: modify plans if necessary. If people are trapped inside elevator, notify them help is on the way and call fire department. Notify elevator maintenance contractor.
Telephones	Maintenance	Use pay phones, cell phones, and runners as needed. Contact the phone company.
Electrical power (emergency generators working)	Maintenance	Ensure life support systems are on emergency power (red outlets). Distribute flashlights/glow sticks. Never plug generator into wall outlet. Keep generator dry. Allow generator to cool completely before refueling. Use only approved fuel containers. Monitor the generator for overheating. Always operate generators outdoors.
Generator and all electric systems failure	Maintenance Nursing	Use battery powered lighting (flashlights, etc.). Watch battery levels on all critical medical equipment. Implement transfer agreements for residents on critical medical equipment. Prepare center for evacuation
Nurse call system or resident alarms.	Maintenance Nursing	Establish visual resident monitoring rounds or surveillance. Call in additional staff if necessary.
Natural Gas outage or natural gas odor.	Maintenance	Open windows/ventilate area. Remove residents and employees from the area. Turn off gas equipment. Contact the gas company and the fire department.

BOMB THREAT

1. Center bomb threat guidelines for staff
   a. Do not panic or act in such a way that causes panic to residents, family members, or other employees;
   b. Do not hang up;
   c. Notify other employees;
   d. Have another employee contact 911 and alert authorities to threat;
   e. The following announcement is made: "**Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions.**";
   f. **Do not evacuate** the center until instructed to do so by the Incident Commander. This decision is generally based on advice from the police and/or fire department;
   g. Restrict access to the center;
   h. Close all doors; and
   i. Escort visitors and residents to resident rooms where they remain with doors closed until an all-clear is given.
2. If the bomb's location is mentioned in the threat:
   a. Immediately remove any residents, visitors and staff from the area;
   b. If you find an object out of the ordinary or appearing to be an explosive device, do not touch it and inform authorities of the object's location;
   c. Do not attempt to disarm, remove or disturb the potential explosive device; and
   d. Report all suspicious activities to investigating authorities.
3. Potential explosives
   a. **The center maintains a list of potential explosives to report to the fire/police departments. The potential explosives list:**
      i. Identifies oxygen storage locations;
      ii. Identifies fuel storage locations; and
      iii. Identifies locations of any other potential explosives in the center.

Refer to Appendix 16: Potential Explosives List

4. After the threat is received:
   a. As soon as possible after receiving the call, the receiver of the call documents all information relating to it, including the:
      1. Possible location and type of bomb;
      2. Time of detonation;
      3. Background noises (e.g., music, voices, etc.); and
      4. Voice quality (male/female), accents, or any speech impediments.
5. If a suspicious/explosive object is found:
   a. Immediately contact the Incident Commander. The Incident Commander then contacts law enforcement to immediately report the object's location. In the absence of immediate notification, center staff calls 911;
   b. Do not touch the object; and
   c. Follow the instructions of the bomb squad or local law enforcement officials who assume authority regarding object removal.

6. Law Enforcement and/or the Incident Commander initiates a partial or total evacuation as needed.
7. If a suspicious object is found without prior notification:
    a. Call 911;
    b. Report the exact location and description of the object;
    c. Follow any instructions given to you at this time by law enforcement officers; and
    d. Call Administrator, DON, or Designees.

BIOTERRORISM

1. Reporting requirements and contact information
    a. Any employee recognizing chemical or biological exposure symptoms immediately notifies the Administrator/Designee/Incident Commander;
    b. The Incident Commander immediately contacts 911 and area leadership;
    c. Restrict building entrance and exit until cleared by authorities;
    d. The Incident Commander contacts the Centers for Disease Control Bioterrorism Emergency Response Office at (770) 488-7100;
    e. Employees promptly evacuate all persons from the affected area as instructed by the Incident Commander; and
    f. As instructed by regulatory authorities, all building occupants remain on the premises until cleared and approved to exit.
2. Mail handling
    a. The center follows general mail handling guidelines, including:
        i. Opening all mail with a letter opener or method least likely to disturb contents;
        ii. Opening letters and packages with a minimum amount of movement; and
        iii. Center staff are advised not to blow into envelopes; or shake or pour out contents, and to keep hands away from nose and mouth while opening mail; and to wash hands after handling mail.
    b. Observing for suspicious envelopes or packages such as:
        i. Envelopes/packages with discoloration, strange odors or oily stains, powder or powder-like residue;
        ii. Protruding wires, aluminum foil, excessive tape or string;
        iii. Unusual weights for size, or lopsided or oddly shaped envelopes; and
        iv. Poorly typed or written addresses, no return address, incorrect titles, misspelling of common words, a postmark not matching the return address, and restrictions such as "personal" or "confidential."
3. In Handling Suspicious Mail, staff should:
    a. Stay calm and do not shake or empty contents of any suspicious package or letter;
    b. Keep hands away from mouth, nose, and eyes;
    c. Isolate package or letter and not carry or show to others, and cover gently with clothing, paper, inverted trash can; and
    d. Not try to clean up any spills or walk through any spilled material;
    e. Alert others in area and leave area, closing all doors;
    f. Wash hands with soap and water;
    g. Notify supervisor/designated responder who in turn calls 911, local FBI Field Office, area, division, region and corporate leadership;
    h. Not allow anyone to enter the room until proper authorities arrive; and
    i. List all people who were in the room or area when the package or letter was recognized. Give the list to the health and law enforcement officials.
4. Potential agents
    a. Diseases with recognized bioterrorist potential and the agents responsible for them are described in Table 1. (Note: The Center for Disease Control does not prioritize these agents in any order of importance or likelihood of use.)

Table 1. Most Common Chemical and Biological Agent Used in Terrorist Attacks

Chemical Agents	Effects	Onset
Nerve Agents Tabun Sarin Soman GF, VX	Contraction of the pupils of eyes Watery discharge from nose Labored or difficult breathing Convulsions	Seconds to minutes
Blister Agents (Vesicants) Mustard Lewisite Phosgene Oxime	Skin redness Blisters Eye Irritation Blindness Labored or difficult breathing Coughing	Minutes to hours
Blood Agents Hydrocyanic Acid Cyanogen Chloride Arsine Methyl Isocyanate	Panting Convulsions Loss of consciousness Breathing stops - usually temporary in nature	Minutes
Choking Agents Phosgene Chlorine Ammonia	Tightness in the chest Coughing Labored or difficult breathing	Minutes to hours

Biological Agents	Effects Of Inhalation	Time From Exposure Until Symptoms Appear	Contagious?/Treatment
Anthrax	Fever Headache Fatigue Labored or difficult breathing Death if untreated	1 to 5 days	Not contagious, but spores can survive outside host for years. Treat with IV antibiotics for 30 days. Can also use vaccination which is effective only if begun before symptoms appear.
Botulism	Blurred vision Eyes sensitive to light Difficulty speaking Progressive paralysis Respiratory failure	1 to 5 days	Not contagious. Treat with supportive therapy. Antitoxin available from CDC.
Hemorrhagic Fever	High fever Low blood pressure Bleeding from mucous membranes Organ failure Death	4 to 21 days	Contagious: spread through body fluids. Treat with supportive therapy. Ribavirin for some viruses.
Plague	Fever Chills Headache Nausea Vomiting Pneumonia Septicemia/blood poisoning Death	2 to 3 days	Highly contagious by aerosol/droplet route. Medications available - Should be given within 8 to 24 hours of time symptoms begin.
Smallpox	Fever Severe fatigue Headache Backache Abdominal pain Blister-like skin lesions Death - 20 to 30% of those infected	7 to 17 days	Highly contagious by aerosol route or contact with pox scabs. Symptomatic treatment. Vaccine available through CDC.

NUCLEAR, RADIATION, OR HAZARDOUS CHEMICAL FALLOUT

1. In the event of a nuclear, radiation, or hazardous chemical fallout:
    a. Notify Administrator or designee;
    b. Contact the local health department or police if there is the belief exposure has occurred;
    c. Tune radio to the local emergency broadcast station;
    d. Alert center residents/patients, staff, and visitors and keep them informed of new developments. The following announcement is made:
        i. **"Center Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."** Provide instructions as needed.
    e. Close all doors, windows, and drapes;
    f. Move residents/patients to the hallways and close the fire doors;
    g. In the event of hazardous chemical fallout, seal all openings to the outside air and block all outside air intakes;
    h. Reassure residents/patients, visitors, and staff;
    i. Evaluate the need to restrict entrance into the center in collaboration with Area leadership, division, region, state and local authorities;
    j. Follow the direction of state and local authorities; and
    k. If directed by local authorities, evacuate residents/patients per location Evacuation Plan.

    Note: Facilities located in a Nuclear Emergency Planning Zone should follow the plan developed for their location.

FIRE EMERGENCY GUIDELINES

1. This center monitors potential fire risk. Any unsafe condition is reported to a supervisor immediately so corrective measures can be taken promptly.
2. In the event of a fire:
    a. Extinguishers: Fire extinguishers are used in accordance with instructions.
    b. Transport: Residents are transported to a safe area;
    c. Staff Assignments: One person is assigned to wait outside the building to direct the fire department personnel to the area of the fire;
    d. Evacuation: Residents are evacuated as necessary and according to the Evacuation Plan;
    e. Staff ensure the Fire Lane is clear for emergency personnel and vehicles;
    f. Staff use the census log, staff census/schedule, and visitor log to account for staff, residents and visitors;
    g. Staff relocate wheeled equipment during fire or other emergency; and
    h. Report fire incidents, death or serious bodily injury by phone to the state agency and others as required by state guidelines.
3. Fire response and announcement:
    a. Upon discovering fire or smoke, center staff:
        i. Remove residents from immediate danger according to evacuation guidelines
        ii. Make the following announcement:
            1. **"Center Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."**
        iii. Implement the R.A.C.E. program:
            1. **Rescue** Remove residents to at least 20 ft. from the threatened area, preferably on the opposite side of the closest fire door.
            2. **Alarm** Activate the closest fire alarm. Even though automatic alarms may be activated, contact the fire department by calling 911.
            3. **Confine** After removing endangered residents, close the door(s) of the threatened room or area. Close smoke/fire doors behind you as you go.
            4. **Extinguish/Evacuate** Assess the fire threat to either attempt to extinguish the fire or evacuate residents from the affected station. If the area is evacuated, check that all smoke/fire doors are properly closed. Block the bottom of the doors with sheets or towels to slow smoke penetration into the unaffected areas.
4. Fighting the fire:
    a. **Call 911 for all fires;** and
    b. If the fire is small, it may be extinguished by smothering (covering) with sheets or clothes, or by using a portable fire extinguisher.
        i. Fire extinguishers are used only if the fire is small and there is no threat of endangering the user or other individuals;
        ii. When using a portable extinguisher, staff are instructed to follow the "PASS" protocol: Pull, Aim, Squeeze, and Sweep:
            1. **Pull** the fire extinguisher pin;
            2. **Aim** the nozzle at the base of the flame;
            3. **Squeeze** the handle; and

4. **Sweep** the fire extinguisher back and forth at the base of the flame.

iii. Staff are advised to make **one** attempt to extinguish a fire with a fire extinguisher. If first attempt is unsuccessful, staff should confine the fire area and evacuate the residents and staff.

SPECIAL CARE UNIT/RESIDENTS FIRE PROCEDURE:

Vent units, dialysis units, dementia units, bariatric patients, and hospice patients are subject to special consideration during a fire emergency due to a locked unit and acuity. Due to this consideration, this center has special procedures for addressing these specific patients' safety needs, as documented in Appendix 17.

Refer to Appendix 17: Special Care Unit Fire Procedure

AUTOMATIC SPRINKLER OR ALARM SHUT-OFF

When it becomes necessary to shut off the automatic sprinkler or fire alarm system in the building for any reason, it is the duty and responsibility of the Administrator/Designee to:

Inform the Fire Department that the sprinkler or alarm system has been shut off, the reasons for system shut off, and the approximate length of time the system will be off.

Designate personnel to serve on fire watch for the period the sprinkler or alarm system is shut off.

Fire watch personnel tour the center at least every hour to check for fire or conditions that could result in fire. (The center follows local fire regulations requiring more frequent rounds to the extent that such regulations exist.)

Refer to:

Appendix 18: Fire Sprinkler Shut-Off Procedures
Appendix 19: Fire Alarm Reset Procedures

SECURITY PLAN

This center has established a security plan to help protect the safety of residents/patients, staff, and visitors.

1. Exterior building security
    a. This center has a schedule for locking/unlocking of exterior doors during nighttime hours, including persons responsible; and
    b. This center follows a schedule to inspect outdoor lighting adequacy.
2. Interior building security
    a. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection.
    b. This center's security plan includes a schedule to inspect indoor lighting adequacy.
    c. The center's plan also contemplates resident-specific security needs, including:
        i. Security measures for special units;
        ii. Risk for resident elopement;
        iii. Use of Electronic alarms systems; and
        iv. Communication call bells.
3. Administrative controls for security
    a. The center follows the communications protocols established in Section V of this plan as needed to address security issues.
    b. The center's security plan describes the check-in procedures for visitors.

Refer to Appendix 20: Security Plan

INTERNAL OR EXTERNAL DISTURBANCES

1. For disturbances within the center, staff are advised to:
    a. Approach the individual causing the disturbance (subject) and attempt to calm them down;
    b. If the individual cannot be quieted, politely ask the subject to leave the center;
    c. Call the police department for assistance if the subject does not cooperate; and
    d. If the subject attempts to leave after the call is made, do not attempt to detain him/her. Call the police back and inform them of the current situation.
2. Under the influence
    a. To protect the center, residents, visitors and personnel from being injured or offended by individuals under the influence of alcohol or narcotics, staff are advised to:
        i. Inform the individual of your intention to call them a cab and have them leave the property;
        ii. If the individual refuses to leave, call the police department; and
        iii. If the individual is an employee, immediately notify their supervisor and Administrator.
3. External disturbances
    a. Anyone detecting a civil disturbance or potential civil disturbance during normal business hours reports the situation to the Administrator and/or, after normal business hours, to the Manager on Duty (Incident Commander) who:
        i. Assesses the situation (location of the disturbance, what the disturbers are doing, how many are there, etc.);
        ii. Reports the situation to the police department immediately by dialing 911 and requesting assistance;
        iii. Instructs staff to lock all building doors and windows and close all blinds and curtains in resident rooms;
        iv. Instructs staff to move residents into their rooms and away from exterior windows and close room doors;
        v. Instructs visitors to stay in the resident room(s);
        vi. Monitors building access at all entrances to identify non-authorized persons attempting to enter the center. Unauthorized access/attempts at access to the center are immediately reported to 911;
        vii. Relinquishes control of the situation, if established, to the police department/EMS upon their arrival; and
        viii. When the disturbance has subsided or has been controlled, the Incident Commander surveys the affected areas and determine the need for additional assistance.

HOSTAGE SITUATION

1. If a hostage situation is identified, staff are advised to:
    a. Immediately call 911 and explain the situation to the police and provide specifics such as the:
        i. Subject's name or identifying information;
        ii. Victim(s);
        iii. Exact Location; and
        iv. Known or suspected weapon(s),
2. Notify Administrator or designee as soon as possible and activate the Emergency Plan;
3. The following announcement is made: "**Security Alert-We are activating Hostage protocols- We have a Hostage situation (Location). Please listen for further instructions.**" Provide further instructions as needed;
4. Evacuate the affected area per the location's Evacuation Plan, attempt to isolate the subject, and secure the perimeter;
5. Remain calm; follow the subject's directions;
6. If the subject is talking: listen; do not argue;
7. Avoid heroics: be aware not to make sudden movements; and don't crowd the subject; and
8. Be prepared to respond to law enforcement personnel regarding your observations and any additional information you may have involving the subject or victim.

ELOPEMENT: MISSING RESIDENT/PATIENT

1. If a resident/patient is discovered missing:
    a. Communicate internal notification of missing resident/patient. The following announcement is made: **"Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.**;
    b. Begin a coordinated search throughout the building; search every room in the Center;
    c. Search immediate grounds, supply flashlights and associated supplies; and
    d. If the resident/patient is not found, the charge nurse/supervisor should:
        i. Notify the Administrator and DON or designees;
        ii. Call 911 and report the missing resident/patient;
        iii. Notify responsible family member;
        iv. Notify the resident's/patient's physician;
        v. Notify the appropriate state and local agencies; and
        vi. Supply resident's/patient's picture to police, etc.

Refer to Appendix 21: Elopement Drill Documentation Form

SEVERE WEATHER/NATURAL DISASTER

1. **TORNADOES**
   a. Tornadoes are violent local storms extending to the ground with whirling winds reaching 300 mph. Spawned from powerful thunderstorms, tornadoes can uproot trees, damage buildings, and turn harmless objects into deadly missiles in a matter of seconds. Damage paths can be in excess of one mile wide and 50 miles long. Tornadoes can occur in any state but occur more frequently in the Midwest, Southeast, and Southwest, with little or no warning.
      i. Tornado Watch – Atmospheric conditions are right for tornadoes to potentially develop. Be ready to take shelter. Stay tuned to radio and television stations for additional information. NOTE: Multi-floor centers consider relocating non-ambulatory and dependent residents from the higher floors to the lowest floor.
      ii. Tornado Warning – A tornado has been sighted in the area or is indicated by radar. Take cover immediately.
   b. Based on the results of the hazard vulnerability analysis, if this center is at risk for tornado, the center:
      i. Consults Emergency Management officials regarding the tornado warning system;
      ii. Monitors local media and alerts for tornado watches and warnings;
      iii. Has established procedures to inform personnel when tornado warnings are posted and considers the need for spotters to be responsible for looking out for approaching storms;
      iv. Educates staff on Areas of Refuge identified in Appendix 2;
      v. Considers the amount of space needed during a tornado, including consideration adults each generally require about six square feet of space and nursing home residents may require more space;
      vi. Identifies Areas of Refuge considering the best protection in a tornado is usually an underground area. If an underground area is not available, consider:
         1. Small interior rooms on the lowest floor without windows;
         2. Hallways on the lowest floor away from doors and windows;
         3. Rooms constructed with reinforced concrete, brick, or block with no windows or heavy concrete floor or roof system overhead; and
         4. Protected areas away from doors and windows. **Note: Auditoriums, cafeterias, and gymnasiums covered with flat, wide-span roofs are not considered safe.**
      vii. Makes plans for evacuating personnel away from lightweight modular offices or mobile home buildings. These structures offer no protection from tornadoes;
      viii. Conducts periodic tornado drills; and
      ix. Reviews the **Take Cover** Procedure and instructs affected individuals to **Take Cover** inside the center in a safe area if necessary.
   c. Emergency procedure: Tornado Watch
      i. The following announcement is made in the event of a Tornado Watch: **"Medical Alert. We are activating severe weather protocols. A tornado watch has been issued for this area** effective until _____ (*time watch*

ends). A **tornado watch** means current weather conditions may produce a tornado. Close all draperies and blinds throughout the center and await further instructions. Please continue with your regular activities."

ii. The above message is repeated several times after the first announcement, and then approximately hourly until the **watch** has terminated;
iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover procedures (described above);
v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position.
    1. The Incident Commander monitors weather alerts on radio and television.
vi. Staff closes all window drapes and blinds;
vii. Staff distributes flashlights, towels, and blankets to staff and residents;
viii. First aid and medical supplies are secured and taken to central area for refuge;
ix. Staff secures outside furniture, trash cans, etc.;
x. After the **Tornado Watch** has been cancelled and the Incident Commander has determined the dangerous situation has passed, an announcement is made: **"All Clear, Repeat, All Clear"**; and
xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

d. Emergency procedure: Tornado Warning
    i. The following announcement is made in the event of a Tornado Warning: "**Medical Alert. We are activating severe weather protocols. A tornado warning** has been issued for our area. Immediately implement Take Cover procedures. Repeating—a **tornado warning** has been issued for our area. Immediately implement Take Cover procedures." ;
    ii. The above message is repeated several times after the first announcement and then hourly until the **warning** has terminated;
    iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
    iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover/Evacuation procedures (described above);
    v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position;
    vi. The Incident Commander monitors weather alerts on radio and television;
    vii. First aid and medical supplies are secured and taken to central area for refuge;
    viii. Upon hearing this announcement, all personnel follow the Shelter-in-Place/Take Cover procedures to provide for the safety of the residents, visitors, and themselves;
    ix. After the Tornado warning is over and the Incident Commander has determined the dangerous situation has passed, am **"All Clear, Repeat, All Clear"** announcement is made to inform affected parties that the **Take Cover** situation has ended;
    x. Upon issuance of the All Clear announcement, residents are taken back to their rooms; and

xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

EARTHQUAKE PROCEDURE

Earthquake: An earthquake is a sudden, rapid shaking of the ground caused by the breaking and shifting of rock beneath the Earth's surface. This shaking can cause buildings and bridges to collapse; disrupt gas, electric, and phone service; and sometimes trigger landslides, avalanches, flash floods, fires, and huge, destructive ocean waves (tsunamis). Buildings with foundations resting on unconsolidated landfill, old waterways, or other unstable soil are most at risk. Buildings or trailers and manufactured homes not tied to a reinforced foundation anchored to the ground are also at risk since they can be shaken off their mountings during an earthquake. Earthquakes can occur at any time of the year.

Hazards Associated with Earthquakes: When an earthquake occurs in a populated area, it may cause deaths, injuries and extensive property damage. Ground movement during an earthquake is seldom the direct cause of death or injury. Most earthquake-related injuries result initially from collapsing walls, flying glass, and falling objects, or from people trying to move more than a few feet during the shaking. Some of the damage in earthquakes is predictable and preventable.

Aftershocks: Aftershocks are smaller earthquakes following the main shock and can cause further damage to weakened buildings. Aftershocks can occur in the first hours, days, weeks, or even months after the quake. Some earthquakes are actually foreshocks, and a larger earthquake might occur.

1. The following hazards ARE considered if an earthquake may have caused structural damage to the center:
    a. Water system breaks: may flood basement areas;
    b. Exposure to pathogens from sanitary sewer system breaks;
    c. Exposed and energized electrical wiring;
    d. Exposures to airborne smoke and dust (asbestos, silica, etc.);
    e. Exposure to blood borne pathogens;
    f. Exposure to hazardous materials (ammonia, battery acid, leaking fuel, etc.);
    g. Natural gas leaks creating flammable and toxic environment;
    h. Structural instability;
    i. Insufficient oxygen;
    j. Confined spaces;
    k. Slip, trip or fall hazards from holes, protruding rebar, etc.;
    l. Falling objects;
    m. Fire;
    n. Sharp objects such as glass and debris;
    o. Secondary collapse from aftershock, vibration and explosions;
    p. Unfamiliar surroundings;
    q. Adverse weather conditions; and/or
    r. Noise from equipment (generators/heavy machines)
2. In planning considerations for earthquakes, the center:

a. Completes the HVA and determines the probability of an earthquake;
b. Consults with Emergency Management officials regarding earthquake preparedness and response expectations;
c. Identifies safe areas in the center; for example, under a sturdy tables or desks, against interior walls away from windows, bookcases, or tall furniture, considering that the shorter distance the center's occupants need to move to safety, the less likely occupants will be injured;
d. Secures furniture, appliances and other large items in accordance with applicable requirements to help comply with safety compliance and reduce potential damage and injury;
e. Uses NHICS Form 251, Center Systems Status Report, to assess the center following an earthquake;
f. The findings from NHICS Form 251 assist the Incident Commander in determining if the center needs to be evacuated or if occupants can shelter-in-place following the initial earthquake;
g. Trains staff, residents, and families on immediate response procedures to an earthquake including the steps to evacuate or shelter-in-place;
h. Conducts drills to prepare staff and residents for earthquakes;
i. Tracks costs associated with the earthquake's damage;
j. Identifies primary and secondary communications systems;
k. Prepares to address the psychological impact an earthquake can have on residents and staff; and
l. If an immediate peril is identified like a gas leak, uncontrolled fire, or threat of building collapse, the center may immediately evacuate in accordance with the **Evacuation Procedures described in Internal Responsibilities.**

FLOOD/FLASH FLOOD/DAM FAILURE

Flood Watch: An announced Flood Watch indicates local flooding is possible. To the extent practicable, the center team listens to the local radio and television stations for information and prepares to evacuate.
Flood Warning: An announced Flood Warning indicates flooding is already occurring or will occur soon. The center team takes precautions immediately after being made aware of this warning. Center teams prepare to move to higher ground and evacuate.

1. Planning considerations for floods:
    a. The risk of flood is assessed in the Appendix 1: Hazard Vulnerability Assessment. If flood is a probable risk, the center:
        i. Considers purchasing a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup, and staff listens for flood watches and warnings;
        ii. Reviews the local community's emergency plans and becomes familiar with the planned evacuation routes and areas of higher ground;

iii. Inspects onsite areas potentially subject to flooding and onsite areas to which records and equipment could be moved making plans to move records and equipment as needed;
iv. Reviews the center insurance coverage for flooding;
v. Undertakes flood proofing measures, as necessary. These measures include:
1. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings;
2. Installing watertight doors;
3. Constructing movable floodwalls; and
4. Installing pumps to remove flood waters.

b. Note: The center may undertake other emergency flood proofing measures generally less expensive than those listed above but require substantial advance warning. They include:
i. Building walls with sandbags;
ii. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil; and/or
iii. Constructing a single wall by stacking small beams or planks on top of each other.

c. The center evaluates the need for backup systems, such as:
i. Portable pumps to remove flood water;
ii. Alternate power sources such as generators or gasoline-powered pumps; and
iii. Battery-powered emergency lighting.

2. Emergency procedure: flooding general procedures
a. In the event of an expected flood, the following announcement is made:
i. **"Medical Alert-We are activating severe weather protocols. A flood/flash flood watch or warning has been issued for this area effective until _____ (*time watch ends*).** A **flood watch** means that current weather conditions may produce flooding. A **flood warning** indicates flooding is occurring in the area. Please await further instructions." The center provides additional instructions as known and necessary.
ii. Administrator and DON are notified if not on the premises;
b. Center staff accounts for all residents and staff members;
c. Center management staff convene together for a briefing and instruction;
d. The Incident Commander activates this plan to manage the incident. (The most qualified staff member on duty at the time assumes the Incident Commander position);
e. The Incident Commander decides whether to flood proof (see above) or evacuate based on geographical location and history of flooding of the center as well as the results of the evacuation analysis discussed above. If evacuation is necessary, the evacuation processes described above are followed; and
f. The situation is only deemed "under control" after the local authorities have concluded emergency operations and the Incident Commander has declared the situation "safe."

3. **EMERGENCY JOB TASKS: FLOODING**
4. Administrator/Incident Commander:
i. Determine to flood proof the center or evacuate;

ii. If decision is to evacuate, use the evacuation procedures described above; and
iii. Account for residents, staff, and visitors.

b. All Staff/Management:
   i. Assist with flood proofing the center if necessary.

HURRICANES, TROPICAL STORMS AND FLOODING

This center consults with Emergency Management Office to determine flood zone and hurricane evacuation zones, and monitors flood watches and warnings. (Note: Wind damage from a hurricane can necessitate evacuation even if there is no threat of flooding from the storm surge.)
If hurricane or tropical storm warnings are issued for the area, the center team makes plans to protect outside equipment and structures, and follows guidance from the EMS regarding evacuation and other precautions. The center also makes and implements plans to protect windows, such as by use of permanent storm shutters or installation of window covers.
The center also considers and implements backup systems as needed, such as portable pumps to remove flood water and alternate power sources, such as generators or gasoline-powered pumps.

1. Hurricane and tropical storm threat and watch center procedures
   a. Local authorities issue a ***"Watch"*** when a hurricane or tropical storm is expected to hit within 36 hours. The center then makes the following announcement is:
      i. **"Medical Alert: We are activating severe weather protocols. A hurricane/tropical storm watch has been issued for this area effective until _____ (*time watch ends*)."**
   b. After the announcement, each department leaders contacts their staff and creates a schedule of employees to work during the emergency. Staff is scheduled to work:
      i. Before the storm strikes;
      ii. During the storm; and
      iii. After the storm.
   c. The Incident Commander alerts alternate care facilities and transportation providers of the potential evacuation; and
   d. The Incident Commander and center team considers resident acuity/status, infection control precautions in determining transportation needs. (Refer to the procedures above regarding Shelter-in-Place or Evacuation.)

PANDEMIC INFLUENZA

EPIDEMIC GENERAL STATEMENT

The leadership team (Administrator, DON/Resident Care Director, and Center Medical Director) complete the **Epidemic Preparedness Checklist.** If there is an outbreak in the center, the leadership team directs activities.

EPIDEMIC GUIDELINES

1. When an epidemic is declared, follow instructions from clinical leadership to implement the following:
    a. If a severe staffing shortage is apparent, deploy alternative staffing and implement altered standards of care;
    b. Implement use of the **Daily Symptom Screening Form** for all new admissions, re-admissions, staff, visitors, and vendors; and
    c. Make provisions to accommodate overcrowding.
2. **Refer to:**
    a. Epidemic Preparedness Checklist
    b. Influenza Preparedness Plan PowerPoint (on Central)
    c. Altered Standards of Care
    d. Daily Symptom Screening Form
    e. Outbreak Intervention Tiers for Influenza and Gastroenteritis (on Central)

3. General guidelines
    a. Residents with symptoms of or confirmed with targeted epidemic illness should remain in their rooms. Limit transport to medically necessary purposes;
    b. Place a sign stating "Stop-See Nurse Before Entering/For Instructions" on the door;
    c. If there is a widespread outbreak of residents with targeted epidemic illness, or symptoms of influenza, use existing partitions (smoke doors, separate floors) to establish restricted entrance areas in the building furthest away from common areas used by residents and staff;
    d. Label the area as "Stop-See Nurse Before Entering/For Instructions" on the entrances to the area;
    e. Allow serial use of N95 disposable respirators within this area to conserve respirators/masks if the respirator/mask supply is in question;
    f. Place a surgical mask on residents with influenza or other respiratory illness symptoms who are required to be moved out of the restricted area or their rooms;
    g. Instruct visitors:
        i. To limit movements within the building;
        ii. On limiting hand contact with surfaces in the center; perform hand hygiene after surface contact;
        iii. On respiratory hygiene/cough etiquette; and
        iv. On hand hygiene before entering and when leaving the resident room and with any resident contact.
    h. Perform hand hygiene immediately after removing mask or respirator or any PPE;
    i. Treat all excretions, secretions and body fluids as potentially infectious; and

j. Wash hands with soap and water if hands visibly soiled or caring for resident with C. diff or any gastrointestinal infection or use an alcohol-based hand gel.

EMERGING INFECTIOUS DISEASES

1. Definition: Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:
    a. New infections resulting from changes or evolution of existing organisms;
    b. Known infections spreading to new geographic areas or populations;
    c. Previously unrecognized infections appearing in areas undergoing ecologic transformation; and
    d. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

2. General Preparedness for Emergent Infectious Diseases (EID)
    a. Center leadership will be vigilant and stay informed about Emerging Infectious Diseases (EID) with the assistance of Corporate and Divisional Clinical leaders. They will keep Divisional administrative and clinical leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
3. Local Threat
    a. Once notified by the public health authorities at either the federal, state and/or local level the EID is likely to or already has spread to the center's community, the center activates specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities;
    b. The center's Infection Preventionist (IP), with assistance from the National Infection Prevention and Control Team as needed, researches the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies;
    c. Based on the specific disease threat, the center reviews and revises internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated;
    d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing;
    e. If EID is spreading through an airborne route, then the center activates its respiratory protection plan (refer to GHC Policy and Procedure SH408 Respiratory Protection Program) to ensure employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure;
    f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information;
    g. Brief contractors and other relevant stakeholders on the center's policies and procedures related to minimizing exposure risks to residents;
    h. Post signs regarding hand hygiene and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the center along with the instruction that anyone who is sick must not enter the building; and

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the center, screening for exposure risk and signs and symptoms may be done, if possible, prior to admission of a new resident and/or allowing new staff persons to report to work.

4. Self-screening:
    a. Staff will be educated on the center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
        i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health;
        ii. Precautionary removal of employees who report an actual or suspected exposure to the EID;
        iii. Self-screening for symptoms prior to reporting to work; and
        iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
5. Self-isolation:
    a. In the event there are confirmed cases of the EID in the local community, the center may consider closing the center to new admissions, and limiting visitors based on the advice of local public health authorities.
6. Environmental cleaning: The center follows current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
    a. Engineering controls: The center uses appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.
7. Instructions to manage suspected case(s) in the care center:
    a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation/precaution room and notify local public health authorities;
    b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible. Resident to wear mask during the transfer;
    c. If the suspected infectious person requires care while awaiting transfer, follow center policies for isolation/precaution procedures, including all recommended PPE for staff at risk of exposure;
    d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE;
    e. If feasible, ask the isolated resident to wear a mask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated resident unless it advised otherwise by public health authorities;
    f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation/precaution room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC;

g. Implement isolation/transmission-based precautions (TBP) procedures in the center (isolation/TBP rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities; and
h. Activate quarantine (separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

ARMED INTRUDER GENERAL GUIDELINES

In situations in which there is lead-in time to a potential armed intruder violence threat against the center, the center management team discusses actions to be taken by the center and questions to ask the intruder.

1. During an armed intruder event, the center follows steps, when possible, staff will determine which of the "Four Outs" will be the best for their survival:
    a. "Get Out": Identifying current residents, visitors and staff for potential exit from the center. Individuals will proceed to exit the building until they find a safe place. (This is the best choice if staff can safely do so.);
    b. "Lock Out": Identifying if residents, visitors and staff could be protected by potentially locking them in the center, preventing entry by the intruder. Individuals will get behind a locked or barricaded door. This action is the next best choice and if it is safe to do so, the best way to protect residents from becoming a victim;
    c. "Hide Out": Identifying current residents, visitors, staff and locations for potential concealment within the center. Staff will hide in inconspicuous places in the center. Staff can help residents by hiding them in plain sight (e.g. Put extra linens on a resident's bed when the resident is bed-ridden; or
    d. "Take Out": Establishing a plan to stop the armed intruder's activities. Staff will use diversions and weapons of opportunity to take out the Armed Intruder. When considering a takeout plan, if there are several people, use diversions and make a plan to gang up on the Armed Intruder.
2. In addition, a staff member calls 911 when safe to do so. Gives the 911 operator specific details to aid in law enforcement's response to the event. Uses a center phone even if just to leave an open line to the 911 operator;
3. The fire alarm is not pulled/activated; and
4. Refer to the Armed Intruder Training and associated Armed Intruder Table Top Exercise for more information on the center's plan and practices used to manage these emergencies.

WINTER STORMS

Background
Winter storms are often an underestimated threat. For the frail elderly, the single greatest threat posed by winter is the loss of body heat. Normal aging is accompanied by a decline in the ability to thermo-regulate. Chronic ailments and acute injuries exasperate the ability to self-regulate body temperature. In fact, fifty percent of cold-related injuries happen to individuals over the age of 60.

1. Preparing for the Storm
    a. Before the snow begins:
        i. All departments must inventory existing supplies and order low supplies prior to snowfall;
        ii. Generator fuel must be checked and generator test run. If your generator uses diesel or propane, the tank should never fall below ½ tank fill level at any time; and
        iii. Snow blower fuel must be checked and test run.
    b. After snow has started to fall:
        i. Parking lot entrance, fire lane and all facility exits must be kept clear;
        ii. Fire hydrants are to be kept accessible at all times; and
        iii. Areas for ambulances and supply vehicles take priority over parking areas.
2. Winter Hazard Communication
    a. The National Weather Service issues outlooks, watches, warnings, and advisories regarding potentially hazardous winter weather:
        i. Outlook: this is essentially a forecast, informing the public winter storm conditions are possible in a 2 to5 day timeframe. Actions at this time are to monitor local media for weather condition updates;
        ii. Advisory: winter weather conditions are expected and could cause significant inconvenience and could potentially create hazardous conditions. However, if one is prepared and cautious, advisory conditions should not be life threatening;
        iii. Watch: winter storm conditions are possible within a 36 to 48-hour window. Begin preparations; and
        iv. Warning: potentially hazardous winter weather is occurring or will occur in 24 hours.
3. Wind Chill
    a. Wind chill can be a significant problem. Exposure to cold can lead to frostbite or hypothermia. The elderly are highly susceptible. Regardless of whether the temperature is 32F or -32F, cold has the same effect. Wind chill is not the actual air temperature, but is the impact of the combination of wind and cold upon exposed skin. Moving air conducts heat away from the body faster.

Wind Chill Chart

Adapted from the National Weather Service, Originally Published 11/01/01.

Temperature across top, wind speed down left side.

Calm	40	35	30	25	20	15	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	36	31	25	19	13	7	1	-5	-11	-16	-22	-28	-34	-40	-46	-52	-57	-63
10	34	27	21	15	9	3	-4	-10	-16	-22	-28	-35	-41	-47	-53	-59	-66	-72
15	32	25	19	13	6	0	-7	-13	-19	-26	-32	-39	-45	-51	-58	-64	-71	-77
20	30	24	17	11	4	-2	-9	-15	-22	-29	-35	-42	-48	-55	-61	-68	-74	-81
25	29	23	16	9	3	-4	-11	-17	-24	-31	-37	-44	-51	-58	-64	-71	-78	-84
30	28	22	15	8	1	-5	-12	-19	-26	-33	-39	-46	-53	-60	-67	-73	-80	-87
35	28	21	14	7	0	-7	-14	-21	-27	-34	-41	-48	-55	-62	-69	-76	-82	-89
40	27	20	13	6	-1	-8	-15	-22	-29	-36	-43	-50	-57	-64	-71	-78	-84	-97
45	26	19	12	5	-2	-9	-16	-23	-30	-37	-44	-51	-58	-65	-72	-79	-86	-93
50	26	19	12	4	-3	-10	-17	-24	-31	-38	-45	-52	-60	-67	-74	-81	-88	-95
55	25	18	11	4	-3	-11	-18	-25	-32	-39	-46	-54	-61	-68	-75	-82	-89	-97
60	25	17	10	3	-4	-11	-19	-26	-33	-40	-48	-55	-62	-69	-76	-84	-91	-98

Frostbite Times

30 Minutes

10 Minutes

5 Minutes

1. Response to wind chill
    a. To ensure residents do not suffer from exposure to cold, consider the following:
        i. Providing extra attention to residents who wander or are at risk for elopement;
        ii. Clothing in loose-fitting layers and an insulated head covering, even indoors;
        iii. Attempt to ensure that residents remain dry;
        iv. Should a person succumb to cold, warming the person slowly, starting with the body core. Do not start warming with the arms and legs, as this will drive cold blood toward the heart which can trigger heart failure. Change the resident into warm, dry clothing and then cover them with a blanket. Avoiding providing alcohol, coffee, or any other hot beverage or food. Discuss administration of medications with the attending provider;
        v. Providing high calorie foods and snacks for staff and residents;
        vi. Providing extra blankets. (If possible, hypo-allergenic blankets should be used. Residents who wish to use their own wool blankets or quilts with other natural fibers should be allowed to do so, but they should not be allowed to share these items as other residents may be allergic to the natural fibers); and
        vii. Monitoring residents and increasing hydration activities; increased clothing and use of blankets may increase sweating. Dry air associated with extremely cold weather may also lead to residents dehydrating faster.

2. If the heating system suffers a significant mechanical failure during cold weather, consider evacuation;
3. Residents on medical oxygen should be given alternate safe means of staying warm and should be kept away from any potential source of ignition; and
4. Evacuation under icing conditions is not a good idea. Be prepared to shelter in place in winter.

Refer to Loss of Utilities Heating Failure if center heat is compromised.

1135 WAIVERS

1. In the event a major disaster or public health emergency is declared by the Secretary, the facility reserves the right to request a waiver in accordance with section 1135 of the Social Security Act, and by which certain statutory requirements and or services may be modified or waived during the duration of the emergency;
2. Under the waiver the role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials is such that sufficient services and healthcare items will be provided to the maximum extent feasible and in part, modifies requirements that physicians and other healthcare professional hold licenses in the State in which they provide services if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area).

VOLUNTEERS

The Center may use volunteers in an emergency or other emergency staffing strategies as necessary to provide for the care and treatment of patients. The Center collaborates with the local Emergency Management Services and state or federally designated health care professionals to address surge needs during an emergency. Involvement of volunteers in management of emergencies is addressed in this EPP.

1. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers;
2. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations;
3. Staff are monitored through use of the staffing schedules (updated as needed).
4. Volunteers, visitors, and others are monitored using the visitor log (typically kept in the reception area);
5. The center maintains current information all center personnel and volunteers with addresses and phone numbers for contact purposes; and
6. The Incident Commander/designee coordinates with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event staff is needed in alternate locations. Trained volunteers are permitted to transport, move and assist residents if necessary.

Refer to Exhibit 8. NHICS Form 523, Volunteer Staff Registration.

ANNUAL REVIEW AND SIGN-OFF

1. The Safety Excellence Team and the Administrator reviews and approves this manual and associated appendices and supporting documentation:
    a. Prior to implementation;
    b. After regulatory updates;
    c. If new hazards are identified or existing hazards change;
    d. After tests, drills, or exercises, if issues requiring corrective action have been identified;
    e. After actual disasters/emergency responses;
    f. After infrastructure changes;
    g. At each update or revision; and
    h. At least annually.
2. Staff Training
    a. All staff are trained and demonstrate competency during orientation and annually with materials based on this Emergency Preparedness Plan and corresponding policies and procedures. The center maintains electronic and/or written documentation of training. Administrators must ensure training is completed as required.
3. Staff Testing: Exercises, Drills and Simulations
    a. This center conducts internal and external training exercises, drills, and simulations **at least annually and in accordance with applicable local, state, and federal guidelines**. This training is discussed further in the center's Emergency Preparedness Compliance Guide.
        i. This center participates in full-scale, community-based exercise or, when a community-based exercise is not accessible, an individual, facility-based exercise.
        ii. This center conducts an additional exercise that may include, but is not limited to the following:
            1. a second full-scale community-based exercise or individual,
            2. a facility-based full scale exercise, or
            3. a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.
        iii. If this center has experienced an actual natural or man-made emergency requiring activation of the emergency plan, the center will not need to participate in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the event; and
        iv. The center documents completion of these activities. This documentation includes an analysis of the center's response to the exercise and emergency events, and revises this Emergency Preparedness Plan as needed.
    b. Exercises, drills, and simulations are used to practice emergency procedures and to identify concerns prior to a crisis or disaster situation;
    c. Drill evaluation are be conducted on different levels of management within the center;
    d. Drill evaluations are not confined to routine fire or evacuation drills;

e. Drill evaluations are used to verify planning, response, and recovery programs are in place for the center;
f. Outside resources, including local emergency responders/support services, are invited to periodically participate in, observe, and evaluate internal exercises, drills, and simulations; and
g. Exercises, drills, and simulations are documented to include:
    i. Who participated;
    ii. Concerns identified;
    iii. Corrective actions taken to correct deficient areas; and
    iv. Reports of such activities are retained within the center per state and federal regulations.

Refer to:
Appendix 24: Annual Review and Sign-off

STATE AND LOCAL REQUIREMENTS

The center may be required to follow more stringent state and local regulations than guided within this manual. As such, additional regulations are analyzed and complied with as necessary.

Refer to:
Appendix 25: State and Local Requirements

POLICIES AND PROCEDURES LINKS

Corporate Policies and Procedures
Emergency Preparedness
Emergency Preparedness: Evacuation and Waivers
Emergency Preparedness: Medical Records
Emergency Preparedness: Shelter in Place
Emergency Preparedness: Supplies
Significant Events Reporting

Food and Nutrition Services Procedures
Food Service Emergency Plan (P&P 6.3)
Food Service Emergency Procedures (P&P 6.4)

Omnicare LTC Pharmacy Services
LTC Facilities Receiving Pharmacy Products and Services from Pharmacy
Relocation of Residents or Pharmacy Services During an Emergency or Disaster

Center Operations
OPS100 Accidents/Incidents
OPS142 Transfer Agreements
OPS161 Facility Assessment
OPS164 Utilization of Outside Resources during an Emergency

Preventative Maintenance Policies and Procedures
Emergency Generators

Safety and Health Policies and Procedures
SH100 Safety Management Program
SH601 Personal Protective Equipment
SH602 Personal Protective Equipment: Assessment of
SH604 Procurement and Distribution of Respirators: Airborne Illness

FEDERAL DEFICIENCIES (ETAG) CROSSWALK

Provided as reference. **Users are strongly encouraged to refer to Genesis Central for up to date policies and procedures and to search for key words within this document and on Central for additional information.**

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0001	Establishment of the Emergency Program	Corporate P & P 1.22, Emergency Preparedness	Completed EPP (Full Plan) Completed EP Compliance Guide Appendices
E-0004	Development Maintain EP Program	Same as above	Same as above
E-0006	Maintain and Annual EP Updates	Same as above	Same as above
E-0007	EP Program Population	Center Operations P & P OPS 161 Facility Assessment	EPP Appendix 23. Description of Center Patient/Resident Population
E-0009	Process for EP Collaboration	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	References to collaboration throughout EPP
E-0013	Development of EP Policies and Procedures	Refer to Links Above	Refer to Links Above
E-0015	Subsistence Needs for Staff and Patients	Refer to Links Above	References throughout EPP
E-0018	Procedures for Tracking of Staff and Patients	Corporate P & P 1.22, Emergency Preparedness	Refer to Exhibit 3 and Exhibit 7 NHICS Forms 255 and 252 and references to these forms in the EPP
E-0020	Policies and Procedures including evacuation	Refer to Links Above	References to Evacuation throughout EPP
E-0022	Policies and Procedures for Sheltering	Corporate P & P 1.31, Emergency Preparedness: Sheltering in Place	References to Sheltering in Place in EPP
E-0023	Policies and Procedures for Medical Documents	Corporate P & P 1.30, Emergency Preparedness: Medical Records	Refer to Section LL, Receiving Center: Medical Records

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0024	Policies and Procedures for Volunteers	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Refer to Section XXIX. Volunteers and Exhibit 8, N HICS Form 523, Volunteer Staff Registration
E-0025	Arrangement with Other Facilities	Center Operations P & P OPS142 Transfer Agreements and OPS 164 Utilization of Outside Resources During an Emergency	Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0026	Roles under a Waiver Declared by the Secretary	Center Operations P & P OPS163 Utilization of Outside Resources during an Emergency	Refer to Section XXVIII. 1135 WAIVERS
E-0029	Development of Communication Plan	Corporate P & P 1.22, Emergency Preparedness	Refer to section V. COMMUNICATION PLAN and associated exhibits
E-0030	Names and Contact Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Appendix 3: Center Administrative/Staff Contact List
E-0031	Emergency Contact Information	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Appendix 7: Emergency Resources and Contacts
E-0032	Primary/Alternate Means of Communication	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN
E-0033	Methods of Sharing Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN and Appendix 7: Emergency Resources and Contacts as well as references to evacuation and medical records throughout the EPP

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0034	Sharing Information on Occupancy/Needs	Corporate P & P 1.22, Emergency Preparedness, Center Operations P & P OPS 142 Transfer Agreements	Refer to Section VII, SURGE CAPACITY and Appendix 13, Surge Capacity, and Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0035	LTC and ICF/IID Family Notifications	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. Communication Plan and Section III. General Guidelines, D. Notification of Plan
E-0036	Emergency Prep Training and Testing	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0037	Emergency Prep Training Program	Corporate P & P 1.22, Emergency Preparedness	Vital Learn Reports and Completed Attestations; refer to Emergency Preparedness Compliance Guide
E-0039	Emergency Prep Testing Requirements	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0041	LTC Emergency Power	Preventative Maintenance P & P 2.0, Emergency Generators	Refer to Section XII, Loss of Utilities, Appendix 2, Building Construction and Safety, and Appendix 15, Utility Shut Off Procedures
E-0042	Integrated Health Systems	Not Applicable	Not Applicable

PLAIN LANGUAGE EMERGENCY NOTIFICATION SCRIPT

TAKE COVER

"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."

"All Clear, Take Cover is over" is then paged to signal the Take Cover situation has ended.

LOSS OF UTILITIES

"Facility Alert-We are activating Loss of Utilities protocols- (Describe loss of Power and Location). Please continue your duties and listen for further instructions."

BOMB THREAT

"Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions."

NUCLEAR, CHEMICAL, OR RADIATION FALLOUT

"Facility Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."

FIRE

"Facility Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."

INTERNAL OR EXTERNAL DISTURBANCE

"Security Alert- We have a disturbance (Location). Please listen for further instructions."

HOSTAGE/ARMED INTRUDER SITUATION

"Security Alert-We are activating Hostage/Armed Intruder protocols- We have a Hostage/Armed Intruder situation (Location). Please listen for further instructions."

ELOPEMENT

"Medical Alert-We are activating Missing Resident protocols- The Resident was last seen (location)."

TORNADO WATCH

"Medical Alert-We are activating severe weather protocols- A tornado watch has been issued for this area effective until _____ (time watch ends)." (Repeated after five (5) minutes and then hourly until the watch has terminated.)

TORNADO WARNING

"Medical Alert-We are activating severe weather protocols- A tornado warning has been issued for our area. Immediately implement Take Cover procedures. Repeating—a tornado warning has been issued for our area. Immediately implement Take Cover procedures." (Repeated after five (5) minutes and then hourly until the warning has terminated)

FLOOD WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- A flood/flash flood watch or warning has been issued for this area effective until _____ (time watch ends)."

HURRICANE WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- a hurricane/tropical storm watch has been issued for this area effective until _____ (time watch ends)."

GENERAL ALL CLEAR ANNOUNCEMENT

"All Clear, Repeat, All Clear"

Emergency Preparedness Plan (EPP) List of Appendices

- Appendix 1: Hazard Vulnerability Analysis (HVA)
- Appendix 2: Building Construction and Life Safety
- Appendix 3: Center Administrative/Staff Contact List
- Appendix 4: Emergency Operation Center Designation
- Appendix 5: Area Administrative Staff Contact List
- Appendix 6: Company Contacts
- Appendix 7: Emergency Resources and Contacts
- Appendix 8: Additional Resources
- Appendix 9: Transfer Agreements
- Appendix 10: Short-term Evacuation Plan
- Appendix 11: Triage of Casualties
- Appendix 12: Emergency Supplies and Location of Critical Equipment
- Appendix 13: Surge Capacity
- Appendix 14: Emergency Water Supply
- Appendix 15: Utility Shut-off Procedures
- Appendix 16: Potential Explosives List
- Appendix 17: Special Care Unit Fire Procedure
- Appendix 18: Fire Sprinkler Shut-Down Procedures
- Appendix 19: Fire Alarm Reset Procedures
- Appendix 20: Security Plan
- Appendix 21: Elopement Drill Documentation Form
- Appendix 22: Succession Plan
- Appendix 23: Description of Center Patient/Resident Population
- Appendix 24: Annual Review and Sign-Off
- Appendix 25: State and Local Requirements
- Appendix 26: Insertions from Compliance Guide Completed Tasks

Appendix 1: Hazard Vulnerability Analysis (HVA)

Instructions
Evaluate each event type using the hazard specific scale, using an all-hazards approach that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address a wide spectrum of emergencies/disasters.

Event Type
This column includes the event, risk or disaster you are assessing. Additional events may be added and evaluated in the Assessment; use the blank lines for these items.

Probability
Rate the probability of the risk occurring on a scale of zero (event will not occur) to 3 (event is very likely to occur). To rate the probability of an event occurring, at a minimum consider the known risk of the event occurring based on historical data and manufacturer/vendor statistics.

- Scale: How often has the event occurred within the last year to 10 years?
  - There is no likelihood of this event occurring in this setting/area (i.e., volcano). = score of 0 (no additional entries are required for this event type)
  - Event has not occurred in the past 10 years = score of 1
  - Event occurs every 3 to 10 years = score of 2
  - Event occurs approximately every 1 to 3 years = score of 3

Note: The Probability of human events (i.e., workplace violence, mass casualties) can never be assessed with a probability score of 0. These types of events have the score of 0 identified as N/A in the HVA.

Risk
Rate the associated risk of each event to patients and staff, property, finances (such as the cost to replace, cost of repair, time to recover and the potential interruption or inability to provide services). Input the highest associated score.

- Scale: If the event occurs will it result in:
  - A threat to human health, safety or life? Could the event result in significant injury or death? Score = 5
  - Property Damage? Score = 4
  - Economic Loss or Legal Ramifications? Will employees be able to report to work? Will patients be able to get to the center? Would the center be at risk for fines, penalties, or other legal interventions? Score = 3
  - Systems Failure? Score = 2
  - Loss of Community Trust or Goodwill? Score = 1

Preparedness
Rate the center's level of preparedness for the event.

- Scale: If the event occurs the center is:
  - Well prepared: the center has a current plan, the staff is aware of the plan and has participated in drills, back-up systems are available = score of 1
  - Partially prepared: the center has a plan, with current documents and contracts. Staff may require additional training or drills, center may need back-up systems = score of 2

- Not Prepared: the center does not have a plan at all, or only has a plan, and has not trained the staff or collected associated documents and contracts, and does not have back-up systems = Score of 3

Using the HVA

For each row, Multiply the Probability score by the sum of the Risk and Preparedness scores from all columns, enter score Review and highlight the events types with highest Hazard Vulnerability (HV) scores. These events pose the greatest risks to the center, and are carefully considered and prepared for as the center completes the rest of the appendices in the EPP, and associated training and drills.

Hazard Vulnerability Assessment

Center Name Keene Center Business Unit #: _____ Date: 11/1/22

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			HV SCORE
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	←*Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
HURRICANE		X			X							X	
TORNADO		X			X							X	
SEVERE THUNDERSTORM	X				X							X	
SNOWFALL	X				X							X	
BLIZZARD	X				X							X	
ICE STORM		X			X							X	
EARTHQUAKE		X			X							X	
TIDAL WAVE				X					X		X		
EXTREME TEMPERATURES		X				X						X	
DROUGHT				X		X						X	
FLOOD, EXTERNAL			X		X							X	
WILD FIRE			X								X		
LANDSLIDE			X								X		
VOLCANO				X									
PANDEMIC				N/A	X						X		
ELECTRICAL FAILURE		X			X							X	
GENERATOR FAILURE		X			X							X	
TRANSPORTATION FAILURE		X			X						X		
FUEL SHORTAGE		X			X						X		
NATURAL GAS FAILURE		X			X							X	
SEWER FAILURE		X			X							X	
STEAM FAILURE		X			X								
FIRE ALARM FAILURE		X			X							X	
COMMUNICATION FAILURE		X			X						X		

VENT TYPE	PROBABILITY				RI					PREPAREDNESS			TOT
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	← *Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
MEDICAL VACUUM FAILURE				N/A			X				X		
HVAC FAILURE		X									X		
INFORMATION SYSTEM		X					X				X		
FIRE, INTERNAL			X			X					X		
FLOOD, INTERNAL			X			X					X		
HAZMAT, INTERNAL			X			X					X		
MASS CASUALTY – TRAUMA			X	N/A	X						X		
MASS CASUALTY – MEDICAL			X	N/A		X					X		
MASS CASUALTY – HAZMAT			X	N/A	X						X		
HAZMAT EXPOSURE			X	N/A	X						X		
TERRORISM – BIOLOGICAL			X	N/A	X						X		
TERRORISM – CHEMICAL			X	N/A	X						X		
HOSTAGE SITUATION			X	N/A	X						X		
CIVIL DISTURBANCE (RIOT)			X	N/A		X					X		
LABOR ACTION			X	N/A		X					X		
BOMB THREAT			X	N/A	X						X		
WORKPLACE VIOLENCE			X	N/A	X						X		
DOMESTIC VIOLENCE			X	N/A	X						X		
BUILDING BREAK-IN			X	N/A		X					X		
AUTO BREAK-IN			X	N/A			X				X		
MEDICATION THEFT			X	N/A			X				X		
ASSAULTS (OUTSIDE)			X	N/A					X		X		
ELOPEMENT		X		N/A	X							X	
KIDNAPPING			X	N/A	X						X		

Appendix 2: Building Construction and Life Safety

Instructions: Enter information as prompted.

A. Building Construction Type/Year Built (refer to Life Safety Survey for details): Masonry / Brick 1978

B. Have additions been constructed? Yes X No

1. If additions have been constructed, in what year(s)?

_____

C. Number of Stories: 3

D. Number of Buildings: 1

E. Number of Beds: 106

F. Approximate Number of Staff per Shift: 1st = 45, 2nd=20, 3rd=12

G. Fire Alarm System –
Name of Monitoring Service: Direct link to Keene Fire

H. Generator Vendor Name: Power Up

Generator Vendor Phone Number: 603-657-9080/ 866-420-4906

1. Type, phase and voltage of generator: Kohler 3 phase 102-208
2. Areas of the building supplied by emergency power: Complete building coverage
3. Fuel Type: Diesel
4. Fuel Capacity: 1278 gallons
5. Fuel Duration: 102-142 hours 4-6 days
6. Fuel Tank above or below ground level?: Above Ground
7. How/When is generator tested?: Weekly under partial load
8. Is generator above projected flood level?: Yes, except if local dam is breached.

I. Is the building constructed to withstand hurricanes or high winds? X Yes No
If Yes:
   1. What is the highest category of hurricane or wind speed that the building can withstand? 150 miles per hour
   2. What is the highest category of hurricane or wind speed that the center roof can withstand 100 miles per hour
   3. Is the center in a flood plain? **X** Yes No
   4. If the center is in a hurricane zone, is a storm surge expected? Yes **X** No

J. General description of resident/patient population:
Rehab and long term care residents and patients. Medical conditions vary. Ambulatory and non ambulatory residents with a changing resident population.

For the safety of building occupants, the Emergency Preparedness Leadership Team identifies the best available refuge areas in the center. Many buildings contain rooms or areas designed to offer some degree of protection from all but the most extreme tornadoes and winds. In buildings without specific rooms designed and constructed to serve as safe rooms, the goal should be to select the **best available refuge areas** - the areas that will provide the greatest degree of protection.

In general, the **best available refuge areas** meet the following criteria:

- **Interior rooms.** Rooms without an exterior wall or window are less likely to be penetrated by windborne debris. Examples include resident bathrooms, small office areas without windows, janitor closets, clean and soiled utility rooms, pantry storage rooms, medication rooms, basement rooms and corridors, central supply rooms, center restrooms, staff locker rooms, and closets.
- **Location below ground or at ground level.** Upper floors are more vulnerable to wind damage.
- **No glass in the room.** Typically, windows and glass doors are extremely vulnerable to high wind pressures and the impact of windborne debris.
- **Reinforced concrete or reinforced masonry walls.** Reinforced walls are much more resistant to wind pressures and debris impact, but can fail if the roof deck is blown away.
- **Strong connections between walls and roof and walls and foundation.** Walls and roofs are better able to resist wind forces when they are securely anchored to the building foundation.
- **Short roof spans.** Roofs with spans of less than 25 feet are less likely to be lifted up and torn off by high winds.
- **Long central corridors** often qualify as the best available refuge areas. In addition to having desirable structural characteristics (e.g., short roof spans, minimal glass area, and interior locations), corridors usually are long enough to provide the required amount of refuge area space and can be quickly reached by building occupants. **If a corridor is chosen, marking the high wind area of refuge boundaries at least 30 feet from a glass door or window is advisable**, as well as educating staff to keep occupants within the boundaries and to close all doors leading to the corridor during a high wind event.

*Note: The best available refuge areas do **not** ensure the safety or survival of their occupants. They are simply the areas of a building in which survival is most likely.*

If the center is unsure whether a particular location is appropriate to use as a high wind area of refuge, the Team refers to Federal Emergency Management Agency FEMA's Best Available Refuge Area Checklist to evaluate appropriate areas of refuge

Part B: Refuge Areas

List all areas of refuge according to the guidelines above and mark these areas on the center floor plan:

1. 1st floor conference room.
2. Hallways- 1st floor
3. Library- Concern Glass
4. Main Dining Room 1st floor- Concern Glass
5. Rehab Therapy Room- Concern Glass
6. Beauty Salon- No Glass
7. Recreation Therapy Room- Concern Glass
8. Staff Lunch Room- Inside location no glass.
9. 2nd & 3rd Floor Day Lounge- Concern Glass
10. Inside Hallway Main Floor
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

an emergency (e.g. incident commander, public information officer, patient liaison, etc.). For example, a Facility Incident Commander may be the Administrator. Also, a unit manager may be the facility's identified person as the Safety Officer.

NOTE: INSERT LIST OF ALL STAFF CONTACT LIST HERE: INCLUDE ALL STAFF, PHYSICIANS, LOCAL LTC FACILITIES AND VOLUNTEERS. REVIEW AND UPDATE AS NEEDED.

Appendix 4: Emergency Operation Center Designation

In the event of an emergency/disaster, the center must have 2 areas identified from which the emergency would be managed. The location should have internet and phone access, as well as access to emergency supplies and this EPP, if possible.

The Emergency Operation Center (EOC) will be located in:

1st floor Conference Room

The secondary Emergency Operation Center (EOC) will be located in:

Administrator's Office

Appendix 5: Area Administrative Staff Contact List

INSTRUCTIONS: Fill in the necessary contact information below. Contact as needed based on this EPP.

Area:	Name	Contact Number
Sr. VP Operations	Shayne Hutchinson	(304) 419-5057
Sr. VP Medical Affairs	Carolyn Blackman	(401) 479-4144
SVP Clinical Operations	Julie Britton	(215) 803-5644
MP/RED, Operations	Teale Howe	(603) 571-0279
VP/Director of Clinical Ops	Tina Osborn	(978) 602-0092
Clinical Quality Specialist	Audrey Kerin	(802) 323-6714
	Kristen Marois	(603) 325-8345
VP Property Management	Perry Valentine	(610) 806-2602
Director of Employee Safety	Cynthia Fleming	(603) 387-9380
Region Property Manager	Mike Lenoch	(603) 315-0565
Region/Area HR Manager	Jessica Foley	(603) 686-4396
OmniCare Pharmacy		

CareLine: 1 (866) 745-2273

Appendix 6: Company Contacts

Corporate Office	Genesis HealthCare, 101 E State St., Kennett Square, PA 19348	
Executive Chairman	David Harrington	david.harrington1@genesishcc.com
EVP & CFO	Orrin Feingold	orrin.feingold@genesishcc.com
EVP & COO	Melissa Powell	melissa.powell4@genesishcc.com
SVP Human Resources	Brandon Poole	brandon.poole@genesishcc.com
SVP Medical Affairs	John Loome	410-494-7671
SVP & CIO	Joe Montgomery	610-716-7439
EVP	Michael Sherman	610-864-9751
SVP Spend Management and Support Services	David Bertha	610-247-8822
VP Compliance	Maria Suarez	505-468-2384
IT Help Desk	Help Desk Rep.	800-580-3655
Director, Risk & Insurance Services	Janice Burnap	505-259-1913
GHC Claims & Litigation	Bette Pfeiffer	610-925-2415 610-925-2419 (FAX)

*Communication with media is guided by division Business development leaders. Refer to Crisis Communication Contacts on Central for details.

Appendix 7: Emergency Resources and Contacts

Instructions: Enter information into the table as prompted below. Emergencies involving fire, death or serious injury are reported in accordance with state and federal guidelines. Other reporting and engagement is completed as needed during an emergency.

COUNTY/LOCAL Emergency Management Agencies

County:	Cheshire
Contact/Title:	Herb Stephens, Area Director of Winchester
Address:	1 Richmond Rd
City, State Zip	Winchester, NH 03470
Phone Number:	603-355-0858

State Emergency Management Agency

State:	**New Hampshire**
Contact/Title:	Department of Safety
Address:	33 Hazen Drive
City, State Zip	Concord, NH 03305
Phone Number:	603-271-2231

Federal Emergency Management Agency (FEMA)

Region:	United States
Contact/Title:	Department of Homeland Security
Address:	99 High St.
City, State Zip	Boston, MA 02110
Phone Number:	877-336-2734

COMMUNITY RESOURCES CONTACTS:

Agency:	**Name:**	**Phone:**
County Health Department	Eileen Fernandez	603-354-5454 x2130
LTC Ombudsman	Fleurette Grenier	603-271-4375
State Licensing and Certification Agency	NH Board of Nursing	603-271-2823
County DHHR Office	DHHR- Keene	603-357-3510
Poison Control Center	Northern New England	800-222-1222
Tribal Contact		
Other		

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

Appendix 8: Additional Resources

Use this form to maintain contact information for emergency support services.

NHICS FORM 258 | CENTER RESOURCE DIRECTORY

	CONTACT (COMPANY/AGENCY/NAME)	**PHONE NUMBER** - PRIMARY	**PHONE NUMBER** - SECONDARY	**E-MAIL**	**FAX / WEBSITE**
Agency for Toxic Substances and Disease Registry (ATSDR)	Poison Control	800-232-4636	770-488-7100		www.aapcc.org
Ambulance/EMS	911	911			
American Red Cross	Keene Chapter	603-352-3210			www.redcross.org
Biohazard Waste Company	Stericycle	866-783-7422			www.stericycle.com
Buses	Delano Company	603-399-4371			
Cab, City	Adventure Taxi	603-355-1484			www.advlimo.com
Emergency Management Agency	FEMA	877-336-2734			www.fema.gov
CDC		800-232-4636			www.cdc.org
Clinics	Dartmouth Hitchcock	603-354-5420			www.dartmouth-hitchcock.org
Coroner/Medical Examiner	Cheshire County Coroner	603-271-1235			
Dispatcher - 911	911	911			
Emergency Operations Center (EOC), Local	Keene Dispatch Center	603-357-9861			
Emergency Operations Center (EOC), State	NH Dept of Safety	603-271-2231			
Engineers:					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
HVAC	HVAC	Granite State Plumb	603-529-3322		
Mechanical	Mechanical	Pappas Contracting	603-313-7107	603-380-5252	
Structural	Structural				
Environmental Protection Agency (EPA)	Environmental Protection Agency	NH Dept of Environmental services	603-271-3500		
Epidemiologist	Epidemiologist	NH Dept of Health	603-624-6466		
Family	Family	*SEE FAMILY CONTACT LIST*			
Fire Department	Fire Department	Keene Fire Department	603-209-1742		
Food Service	Food Service	Sysco	508-285-1000		
Fuel	Fuel	Cheshire Oil	603-352-0001		
Funeral Homes/Mortuary Services	Funeral Homes/Mortuary Services	Foley Funeral	(603) 352-0341		
Generators	Generators	Power up Generator	866-420-4906	603-657-9080	
HazMat Team	HazMat Team	Keene Fire Dept.	911		
Health Department, Local	Health Department, Local	Keene Health Dept.	603-357-9836		
Heavy Equipment (e.g., Backhoes, etc.)	Heavy Equipment (e.g., Backhoes, etc.)	Holmes Construction	603-231-3242		
Home Repair/Construction Supplies:	Home Repair/Construction Supplies:	Home Depot	603-355-2113		

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Hospitals:	Cheshire Medical Center	603-354-5400			www.**cheshire-med**.com
Hotel	Best Western				bestwestern.com/Official
Housing, Temporary					
Ice, Commercial	Sysco	508-285-1000			
Laboratory Response Network					
Laundry/Linen Service	People's Linen	(603) 352-2038			peopleslinen.com
Law Enforcement:	Keene Police Dept.	603-352-2222			www.keenepd.org
City Police	Keene Police Dept.	603-352-2222			www.keenepd.org
County Sherriff					
Highway Patrol	NH state police	603-271-1162			
Licensing & Certification District Office	Michael Fleming	(603) 271-9499			https://www.dhhs.nh.gov/contactus/index.htm
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:	Keene Center	603-357-3800			
Media:	WMUR Channel 9				
Print	Keene Sentinel	603-352-1234			
Radio					
Radio					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
TV					
TV					
TV					
Medical Gases					
Medical Supply	Medline	800-633-5463	603-320-2926		
Medication, Distributor:	OMNICARE	603-625-6406			www.omnicare.com
Moving Company:					
Pharmacy, Commercial:	OMNICARE	603-625-6406			www.omnicare.com
Poison Control Center	Northern NE Poison Center				https://www.nnepc.org/
Portable Toilets					
Radios:	Keene Center/Langdon Place	357-3800			
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds	Joerns	800-826-0270			joerns.com

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Biomedical Devices	Medline	1-800-633-54 63			www.medline.com
Medical Devices	Medline	1-800-633-54 63			www.medline.com
Oxygen Devices					
Radios					
Restoration Services (e.g., Service Master)					
Road Conditions	*CALTRANS*	*1-800-427-7623*			
Salvation Army					
Shelter Sites					
Staff	*SEE STAFF CONTACT LIST*				
Surge Facilities	Listed with Administrator				
Trucks:					
Refrigeration	Sysco	508-285-1000			
Towing					
Utilities:					
Gas	Liberty Utilities	603-209-2586			
Power	Eversource	800-662-7764			www.eversource.com
Sewage	Keene Water dept.	(603) 352-6550			https://keenetx.com/departments/utilities
Telephone					
Water					
Ventilators					
Water Vendor – Potable, Portable Shower/Portable Toilet	Sysco	See above			
Other:					

Appendix 9: Transfer Agreement

Use this form to document every transfer agreement for transportation and reception of residents (e.g. other Long-Term Care Centers, Hospitals, and Ambulance Companies). **Reminder: Execute at least one agreement with a Long Term Care Center more than 50 miles away.**

Type of Service:	Hospital
Name:	Cheshire Medical
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Ambulance/Transport
Name:	Diluzio
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Long Term Care Facility
Name:	Langdon Place of Keene
Address:	126 Arch Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-3902

Type of Service:	Long Term Care Facilty
Name:	298 Westwood
Address:	Main Street
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 352-7311

Type of Service:	Long Term Care Facility
Name:	Pleasant View Center
Address:	239 Pleasant Street
City, State, Zip	Concord, NH 03301
Phone Number:	(603) 226-6561

Type of Service:	Long Term Care Facility & Evacuation Center
Name:	Applewood Rehabilitation Center
Address:	8 Snow Road
City, State, Zip	Winchester, NH 03470
Phone Number:	(603) 239-6355

Type of Service:	Long Term Care Facility
Name:	Cedar Crest
Address:	91 Maple Avenue
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 358-3384

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Appendix 10: Short-Term Evacuation Plan

Enter the information requested below. Describe the center's plan for short-term evacuation procedures. Consider custody issues for patients in specialty care units, accountability process for visitors and vendors, maintaining clear approach areas for emergency equipment and personnel, and a communication plan when developing these procedures.

Short-term evacuation will be used if immediate evacuation of the center is needed for safety considerations (e.g. the structural integrity of the building is compromised or there is an active fire in the center). Employees, staff, and residents will gather at established meeting spaces outside the center. Choose gathering points away from where emergency personnel will be responding to the center. Plan to use cell phones to communicate the short-term evacuation activation to the MP, transportation services, short-term evacuation site, and the long-term evacuation sites to indicate a long-term evacuation is possible. Plan for no re-entry to the building until it is determined it is safe to do so.

(Note: While areas such as school gymnasiums and churches are not good evacuation sites for a long-term evacuation, they may be used if the structural integrity of the center is compromised. If it is determined a long-term evacuation is necessary, follow the center's plan for evacuation using the short-term evacuation area as the sending center.)

PLAN: Designate area of short-term evacuation site for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients.

Meeting Place 1: Cedarcrest

Meeting Place 2: _____

Transportation Services: Deluzio, Adventure Limousine

Potential Locations: Local stop over location agreement with Cedarcrest on Maple St.

Additional Information:

_____

_____

_____

Appendix : Triage of Casualties (update 1/15/2017)

Instructions:

In the event of an internal or external disaster resulting in injuries, all casualties will be triaged using the priority Mass Casualty criteria and tags identified below. The Director of Nursing and Medical Director or designees will coordinate the process in collaboration with emergency personnel. Where appropriate, victims from external disasters will be triaged at the ambulance entrance.

Priority 1 Immediate (Red): Serious, but salvageable life threatening injury/illness

Victims with life-threatening injuries or illness (such as head injuries, severe burns, severe bleeding, heart-attack, breathing-impaired, internal injuries) are assigned a priority 1 or "Red" Triage tag code (meaning first priority for treatment and transportation).

Priority 2 Secondary (Yellow): Moderate to serious injury/illness (not immediately life-threatening)

Victims with potentially serious (but not immediately life-threatening) injuries (such as fractures) are assigned a priority 2 or "Yellow" (meaning second priority for treatment and transportation) Triage tag code.

Priority 3 Delayed (Green): 2 types

- Victims who are not seriously injured, are quickly triaged and tagged as "walking wounded", and a priority 3 or "green" classification (meaning delayed treatment/transportation). Generally, the walking wounded are escorted to a staging area out of the "hot zone" to await delayed evaluation and transportation.
- Delayed also includes those victims with critical and potentially fatal injuries or illness, indicating no immediate treatment or transportation.

Priority 4 Deceased (Black):

Victims who are found to be clearly deceased at the scene with no vital signs and/or obviously fatal injuries are classified as deceased or priority 4 (Black) in the triage coding system.

Planned Triage Locations

After triage, casualties will be moved to the following locations for treatment, evaluation, and transportation, as appropriate:

Priority 1: Library holding area
Priority 2: Library holding area and rehab department
Priority 3: Dining room-due to its size and location
Priority 4: Unit lounge or holding area on first floor

Appendix 12: Emergency Supplies and Location of Critical Equipment

Instructions: *Enter the location of emergency supplies; add additional items as necessary.*

ITEM	LOCATION
Radio (transistor) weather / radio alert	reception
Flashlight / Glow Sticks (extra batteries and bulbs)	nursing units
Self-stick tags for identification purposes	nursing units
Basic tool kit (hammer, pliers, screwdriver(s), knife, etc.)	***maintenance department***
Shovel(s)	maintenance dept and shed
Drinking water supply per contract	dietary
Disposable eating equipment	dietary
Food, emergency supply	dietary
Waterless hand cleaner	medical storage
Respirators, gowns, gloves and masks	medical storage
Linens, blankets, adequate in case of power failure	laundry dept
Emergency first-aid kit	nursing
Trash Bags	laundry
Log or tablet to list residents/patients/employees leaving the Center	reception & nursing
Incontinent supplies (briefs), disposable wash cloths	medical storage
Room thermometers	maintenance
Blood pressure cuffs	nursing
Stethoscopes	nursing
Mass Casualty Tags (red, yellow, green, blue, black)	
Policy and procedure manuals	online
Personal protective equipment	nursing
MSDS	maintenance
Master keys	

FIRE EXTINGUISHERS	LOCATION
1st floor	dining room, kitchen, utility hall, reception, rehab, activities
2nd floor	near oxygen room, north and south ends
3rd floor	across from nurses station, north and south ends

Appendix 13: Surge Capacity

Instructions: Enter information into the table as prompted below.

This analysis assists the center in determining the maximum number of patients that may be accommodated if the center is asked to expand services through the local EMS or to meet the terms of a Memorandum of Understanding (MOU) with another provider.

Location	Number of Possible Additional Beds (Based on 70 Sq. Ft./Bed)	Priority Level of the Area (from least desirable to most (Scale: 1 – 10)	Comments (Ex: Possible Isolation Area or Specialty Area)
Private Rooms Which Can Accept Additional Beds	N/A-0		
Semi-Private Rooms Which Can Accept Additional Beds	N/A-0		
Additional Bed Space Dining Rooms	1st floor DR =10	10	
Additional Bed Space Activities Room	remove table=5	5	
Additional Bed Space Rehab Gym	move tables =4	5	
Additional Bed Space Corridor Ends			
Additional Bed Space Lounge Area			
Additional Bed Space Specialty Areas (Ex: Dementia Unit)	Library=4	10	
Additional Bed Space Other Areas			
Other	Conference room=3	8	
Total Additional Beds (Surge Capacity)	26		

Appendix 14: Emergency Water Supply

Instructions: Enter information into the table as prompted below.

1. Potable Water Contract Information

Company: Garelick Farms

Address: Farm Road

City: Boston

State: MA

Zip: 02010

Contact Person: _____

2. Emergency Water Supply

The center may prioritize use of water for activities as follows:

i. Drinking
ii. Medicating
iii. Dietary use
iv. Personal hygiene
v. Waste water (mopping)

The Red Cross, FEMA and USGS recommend an emergency supply of one gallon of water per person, per day. The center has calculated this need as follows:

- Total bed capacity = 106 + 80 Total approximate expected staff per day = 186 Total people
- Total people X 3 days = 558 gallons of water

The center's water source amounts and locations are as follows (enter applicable amounts and sites:

a. Primary

i. _____ gallons bottled water. Location(s): _____

ii. _____ gallons water in barrels. Location(s): _____

iii. _____ gallons in ice machine(s) Location(s): _____

iv. TOTAL: _____ gallons*

(*Note: should meet or exceed gallons calculated in # 2, Above)

b. Secondary

i. _____gallons in water heaters. Location: _____

ii. _____gallons in toilet tanks.

iii. _____gallons in other _____. Location: _____

iv. _____gallons in other _____. Location: _____

Appendix 15: Utility Shut-O Procedures

In the event of utility disruption, call the Administrator and Maintenance Director immediately. The Administrator or designee will be responsible for notifying the appropriate state agencies, as required. Enter the information required below.

Utility Shut-Off Locations

1. Water: Boiler Room
2. Electricity: Electrical Room
3. Gas: Electrical Room
4. Heat: Boiler Room
5. Fire Sprinkler System: Boiler Room
6. Oxygen Room: 2nd floor, 3rd floor
7. Oxygen Manifold Shutoff: Not applicable

Generator/Battery System

The generator may be used in emergency situations.

Generator Location: Outside building to East

Extra Fuel Storage Location: N/A

Location of generator Start Up Procedures: Electrical Room

In an emergency situation, the following individuals have the authority to "shut off" the utilities:

Administrator, Maintenance Director, Incident Commander, Maintenance Assistant

---

Use diagrams and instructions on the shut off values, utility controls to explain and use each utility shut-off.

For centers that maintains an onsite fuel source to power the emergency generator(s), insert the contract with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency. (INSERT CONTRACT FOLLOWING THIS PAGE.)

Appendix 16: Potential Explosives List

Instructions: Enter all potential explosives and current location.

ITEM	LOCATION
Oxygen Storage	2nd and 3rd floor
Generator Fuel	outside building to the east
Gasoline/additional fuel	storage shed outside maintenance (metal shed)
Chemical Closet	Maintenance Department

Appendix 17: Special Care Unit Fire Procedure

The purpose of this section is to plan for the safety of Specialty Care Unit (SCU) residents in case of a fire or fire drill. Insert the required information below. *Due to the profile of the SCU residents, procedures may vary from routine center policy.*

In case of a fire or fire drill in any other zone in the building (outside of the SCU):

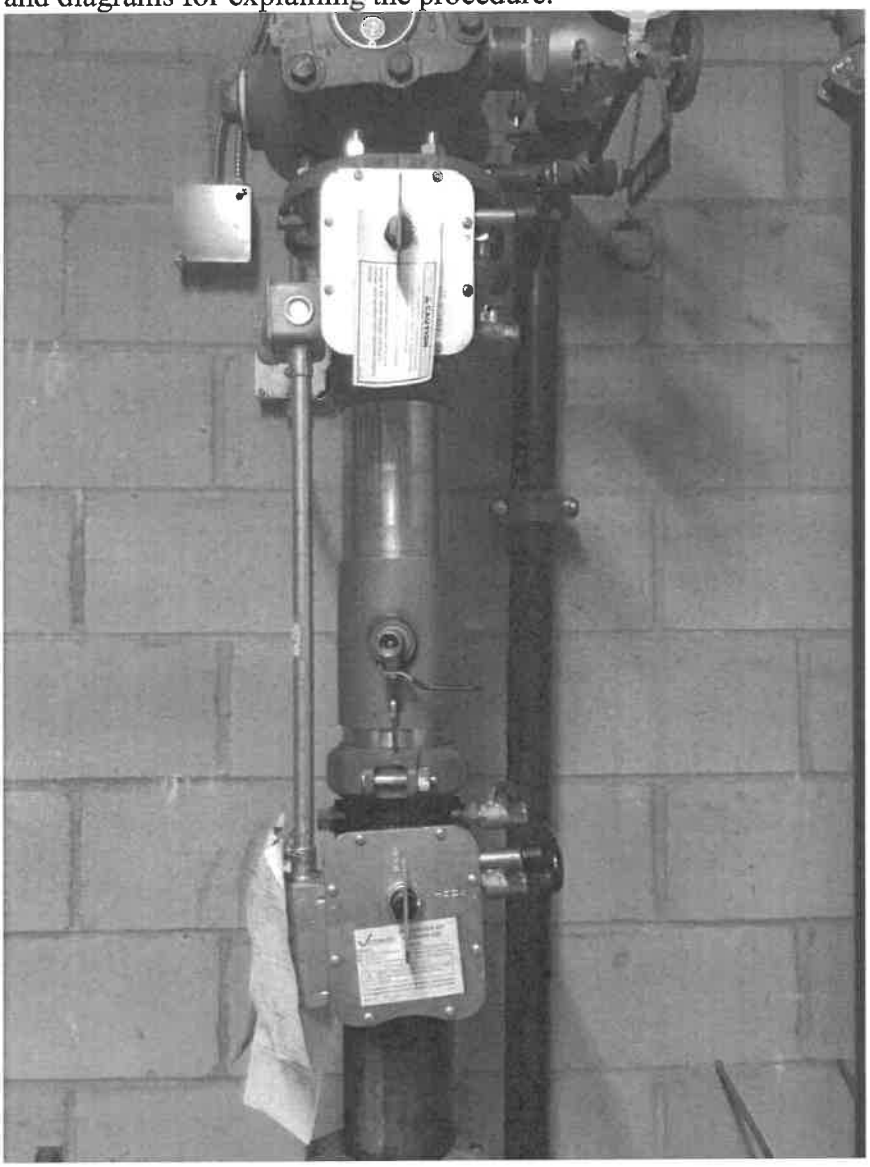
- All SCU residents who are not in bed will be kept together in a specific area.
- SCU staff close all doors in the unit and stay with SCU residents.
- Any residents who are in bed will remain in bed with the room door closed until all clear.

If fire or fire drill is in the SCU:

- SCU staff close all doors to rooms.
- SCU staff move residents past fire doors to safe area.
- SCU staff remain with the SCU residents until all clear.
- If residents are in bed, staff move residents potentially in immediate danger to safe area.

Appendix 18: Fire Sprinkler System Shut-Off Procedures

Instructions: Insert the center's fire sprinkler system's shut-off procedures using pictures and diagrams for explaining the procedure.



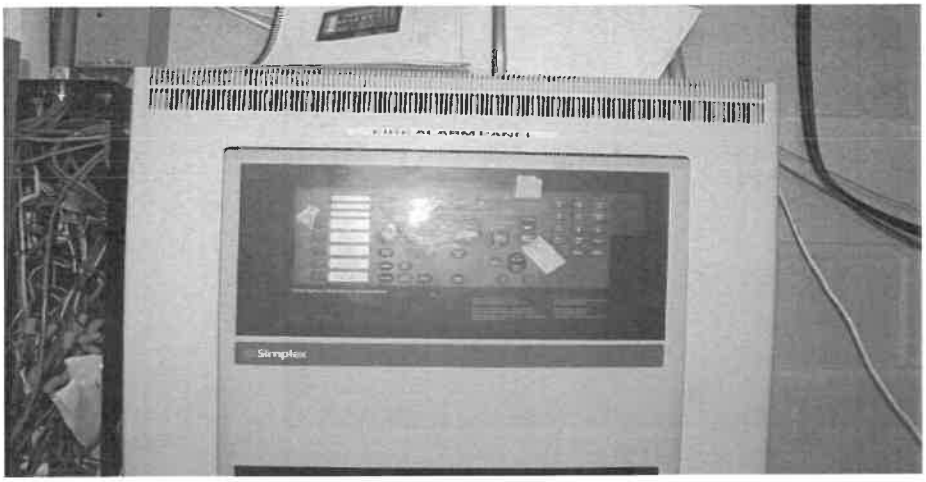
Appendix 19: Fire Alarm Reset Procedures

Insert the center's fire alarm shut-off procedures. Use pictures and/or diagrams to help provide a detailed explanation.

Main Fire Alarm Panel inside the electrical room.
Fire Dept and Maintenance Staff use only to silence, reset and maintain/acknowledge the fire alarm and emergency condition.

If fire alarm is activated, due to malfunction or fire, the fire department will reset and shut off.

Reset procedure:
Silence Alarm, Hit Reset in manual controls.



Appendix 20: Security Plan

This form is used to describe the center's plan for access and perimeter security. Instructions: Enter the location of entrances and exits and the security plan for each in the table below.

Entrance/ Exit Location	Used by/ Purpose	Restricted access (Keypad/ lock)		Frequency of entry code change	Type of alarm system	Current signs on door?	Locked/ Open Days/Times		Lighting Evaluation *	Comments and/or Corrective Actions
		YES	NO							
Example: Kitchen Backdoor (by ramp)	*Employees to take out trash; supply vendors.*	*Y*		*Monthly, Qtrly*	*Wander-guard, Watch Mate, IBI, or Catchall.*	*Marked as exit, no sign on outside of door*	*Daily*	*5:00 a.m. – 8:00 p.m.*	*Adequate*	
Main Entrance	employees, visitors	Y		As needed	wanderguard	Exit	daily	8am-6 pm	adequate	
utility hall-1st floor, house keeping, central supply, kitchen	exit only		N	N/A	None	None	interior open daily		adequate	
2nd and 3rd floor stairs-north & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
2nd and 3rd floor stairs-central	employees	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor-North & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor dining room	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	

Appendix 20: Security Plan

Lighting Evaluation: When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting and remove brush or debris to eliminate shadowed areas.

Interior Building Security:

Describe what the center has in place for stairwell protection (if applicable). Included in the description may be door security alarms/keypads, persons responsible for updating/changing entry codes, CCTV cameras and how the system is monitored, or other systems used for stairwell protection.

Front door live video monitoring that is on 24/7 that may be viewed at the 2nd Floor nursing station when staff are present

Front Doors are electronically locked at 9:30 PM and reopen electronically at 5:30 AM. Other exterior doors are locked and secured after hours. Most exterior doors and stairwell doors are secured via magnetic locks tied into our Secure Care wandering system. All Magnetic doors release with an audible local alarm sounding if appropriate pressure is applied for 15 seconds.

Lighting Adequacy- When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting to eliminate shadowed or dark areas.

Describe the check-in procedures for visitors and how identification badges for employees and/or visitors being used.

All employees have identification badges that they are required to wear while on duty. Visitors are strongly encouraged to sign in at the front entrance sign-in Log.

Appendix 20: Security Plan

Describe how the following are used for Resident-Specific Security:

Security measures for special units.

No special units.

- Resident Elopement Wander Guards.
- Electronic alarms systems such as door alarms.
- Communication call bells.

Wanderguard system, locked doors with keypad entry after 6pm.

Wander system near elevators, center stairs, at front door and all 1st floor exits. Tap bells and hand bells.

Communication call bells.

Visitor Log Protocol.

All visitors are screened and checked in at the reception desk upon arrival.

Appendix 21 :LOPEMENT DRILL DOCUN NTATION FORM

Drill Date and Time:_____ Unit:_____

Check all that apply:

____ Nurse alerts all staff of missing resident with plain, simple language. For example, "Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.

____ Each unit sends a person to the unit that announced the code to learn the name and description of the missing resident.

____ A person is designated as the House Person in Charge (HPIC) of the search. The HPIC coordinates the search so that the in-house and outside searches occur at the same time.

____ Each unit charge nurse directs in-house staff to search room to room and all potential areas of the Center: resident rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen, bathrooms, dayrooms/lounges, courtyards, and employee lounges.

____ HPIC assures all areas/floors of the building are searched.

____ During open kitchen hours, dietary staff search the kitchen and related areas, including walk-in refrigerators/freezers.

____ During closed kitchen hours, the HPIC assigns a staff member to search the kitchen and related areas.

____ HPIC sends two staff members outside to search the grounds.

____ Outside searchers go out the front door (or door designated by HPIC), one to the left and one to the rig search the building perimeter and grounds, and meet at the back door.

____ If one does not arrive at the back door, the other staff member proceeds to that staff member in case help was needed.

____ Both staff members return into the building together.

____ All unit, kitchen, and grounds search findings are reported to the HPIC immediately.

____ Staff are able to verbalize what to do if resident is not located by the end of the search.

____ Staff are able to verbalize documentation and follow-up requirements.

Comments:

Plan of Correction (if indicated):

Signature of Person Conducting Drill:_____

Appendix 22: Succession Plan

During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.

When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. In the absence of the Administrator, The Director of Nursing (DON) acts as the Incident Commander. In the absence of the Administrator and DON, the following team members act as the Incident Commanders, in priority order.

Administrator Name: Patrick Lyons

DON Name: Brandice French

Incident Commanders in absence of Administrator and DON:

Name and Title: Daniel Birmingham

Name and Title: Amanda Stubbs

Name and Title: Melanie Lucius

Appendix 23. Description of Center Patient/Resident Population (Insert from or Refer to Center Facility Assessment. See OPS 161, Facility Assessment for details.)

Appendix 24: Annual Review and Sign-Off

This EPP has been reviewed, with changes noted, and approved by the Safety Committee and Administrator:

Safety Committee Chairman Name: Daniel Birmingham

Safety Committee Chairman Signature and Date: _____

Administrator Name: Patrick Lyons

Administrator Signature and Date: _____

Appendix 25: State and Local Requirements

If your state/county/city/municipality has more stringent requirements, enter those requirements below, or insert reference materials. Contact your local EMS for information.

Appendix 26. Insertions from Compliance Guide Completed Tasks

Instructions: After this page, insert the following completed documents from the Emergency Preparedness Compliance Guide:

1. **Resident Council Minutes indicating dates/times of presentations of the EPP.**
2. **Contact with Local Emergency Management Services (EMS) Form.**
3. **Community-Based Drill After Action Report**
4. **Training Acknowledgement Forms (Staff)**
5. **Tabletop Exercise**

Exhibit 1: Food and trition Services – Sample Emergenc; enu, Level 1: No Power

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bu
	3/4 cup	Cold Cereal	Cold Cereal, Moistened	Cream of Wheat or Rice 1/2 cup	Cream of Rice 1/2 cup
	1/4 cup	Cottage Cheese	Cottage Cheese	Puree Cottage Cheese 1/2 #10 scoop	Cottage Cheese
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1-1/2 cup	Beef Stew, Cnd	Beef Stew, Cnd, Ground	Puree Beef Stew, Cnd	GF Peanut Butter & Jelly Sandwich 1 each
	1/2 cup	Seasoned Green Beans	Seasoned Green Beans	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Tuna Salad Sandwich	Plain Tuna Salad on Wheat	Puree Tuna Salad,Puree Bread 1 serving	GF Tuna Salad Sandwich
	1/2 cup	Seasoned Beets	Seasoned Beets	Puree Seasoned Beets 1 #8 scoop	Seasoned Beets
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1/4 cup	Scrambled Egg	Scrambled Egg	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1 each	Roasted Chicken	Roasted Chicken,Grd, Moistened 1 #12 scoop	Puree Roasted Chicken 1 #12 scoop	Roasted Chicken
	1/2 cup	Mashed Potatoes	Mashed Potatoes	Mashed Potatoes	Fresh Mashed Potatoes
	1/2 cup	Scalloped Tomatoes	Scalloped Tomatoes	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Ice Cream/Pudding	Smooth Ice Cream/Pudding	Smooth Ice Cream/Pudding	GF Pudding
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	3/4 cup	Soup, Cnd	Puree Soup, Cnd	Puree Soup, Cnd	
	2 packet	Saltines			
	1 each	Grilled Cheese Sandwich	Grilled Cheese Sandwich,No Crust	Puree Grilled Cheese Sandwich 1 serving	GF Grilled Cheese Sandwich
	1/2 cup	Three Bean Salad	Plain Three Bean Salad	Puree Three Bean Salad 1 #8 scoop	Fresh Three Bean Salad
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1 each	Hard Cooked Egg	Scrambled Egg 1/2 cup	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg 1/2 cup
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	2 ounce	Baked Ham	Baked Ham,Grd,Moistened	Puree Baked Ham 1 #12 scoop	Baked Ham
	1/2 cup	Sweet Potatoes	Sweet Potatoes	*Puree Sweet Potatoes 1 #10 scoop	Sweet Potatoes
	1/2 cup	Wax Beans	Chopped Wax Beans	Puree Wax Beans 1 #10 scoop	Wax Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Sliced Meat Sandwich	Sliced Meat Sandwich, Ground, Moistened	Puree Sliced Meat Sandwich	GF Sliced Meat Sandwich
	1 packet	Mustard	Mustard	Mustard	Mustard
	1/2 cup	Baked Beans	Mashed Baked Beans	Puree Baked Beans 1 #10 scoop	Seasoned Green Beans
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered

Exhibit 2. Sample Emergency Snack M

Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
2 each	*Assorted Cookies	*Puree Sugar Cookies 1 #16 scoop	*Puree Sugar Cookies 1 #16 scoop	GF Cookies
1 each	Chocolate Cream Cookie (S)	Choc. Cream Cookies (S)	Puree Choc. Cream Cookies 1 #16 scoop	GF Cookies
1 each	Oatmeal Crème Cookie (S)	Oatmeal Crème Cookie (S)	Puree Oatmeal Crème Cookie 1 #16 scoop	GF Cookies
1 packet	*Graham Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
4 each	Vanilla Wafers	Puree Vanilla Wafers 1 #24 scoop	Puree Vanilla Wafers 1 #24 scoop	GF Cookies
1 ounce	Cheese Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
1 ounce	Cheese Puffs	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1 ounce	Pretzels (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
4 packet	Saltines (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1/2 cup	Applesauce	Applesauce	Applesauce	Applesauce
1/2 cup	Mandarin Oranges	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Mandarin Oranges
1/2 cup	Peaches	Peaches	Puree Peaches 1 #10 scoop	Peaches
1/2 cup	Pears	Pears	Puree Pears 1 #10 scoop	Pears
1/2 cup	Pineapple Tidbits	Crushed Pineapple	Puree Pineapple 1 #10 scoop	Pineapple Tidbits
1 each	Fresh Apple	Applesauce 1/2 cup	Applesauce 1/2 cup	Fresh Apple
1 each	Banana	Chopped Banana 1/2 cup	Mashed Banana 1/2 cup	Banana
1/2 cup	Cantaloupe	Soft Chopped Cantaloupe 1/2 cup	Puree Cantaloupe 1 #10 scoop	Cantaloupe
1/2 cup	Grapes	Applesauce	Applesauce	Grapes
1 each	Fresh Orange	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Fresh Orange
1/2 cup	Watermelon	Chopped Watermelon 1/2 cup	Puree Watermelon 1 #10 scoop	Watermelon
1/2 cup	Apple Juice	Apple Juice	Apple Juice	Apple Juice
1/2 cup	Orange Juice	Orange Juice	Orange Juice	Orange Juice
1/2 cup	Cranberry Juice	Cranberry Juice	Cranberry Juice	Cranberry Juice
1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
1/2 cup	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt
1/2 cup	Smooth Pudding	Smooth Pudding	Smooth Pudding	GF Pudding

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 255 | MASTER RESIDENT EVACUATION TRACKING FORM

1. INCIDENT NAME:		2. FACILITY NAME:	
3. DATE PREPARED:		4. RESIDENT TRACKING MANAGER:	

5. RESIDENT EVACUATION INFORMATION

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				MEDICAL RECORD #:	
DISPOSITION	MODE OF TRANSPORTATION	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/TRANSPORT CO.)	MED RECORD SENT:	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					MD/FAMILY NOTIFIED:	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

6. CERTIFYING OFFICER:		7. DATE/TIME SUBMITTED:	

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: OPERATIONS BRANCH
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER LEADER

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Exhibit 3
Revised October 1, 2022

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 260 | INDIVIDUAL RESIDENT EVACUATION TRACKING FORM

1. FACILITY NAME:		2. DATE:	
3. UNIT:			
4. RESIDENT NAME:		5. AGE:	
6. MEDICAL RECORD #:		7. SIGNIFICANT MEDICAL HISTORY:	
8. ATTENDING PHYSICIAN:			
9. FACILITY NOTIFIED:	☐ YES ☐ NO	CONTACT INFORMATION:	_____

10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY):

☐ HOSPITAL BED ☐ GURNEY ☐ WHEEL CHAIR ☐ AMBULATORY ☐ SPECIAL MATTRESS	☐ IV PUMPS ☐ OXYGEN ☐ VENTILATOR ☐ BLOOD GLUCOSE MONITOR ☐ RESPIRATORY EQUIPMENT	☐ SERVICE ANIMAL ☐ G TUBE PUMP ☐ MONITOR ☐ OTHER ☐ OTHER	☐ FOLEY CATHETER ☐ OTHER ☐ OTHER ☐ OTHER ☐ OTHER

ISOLATION:	☐ YES ☐ NO	TYPE:	_____

11. DEPARTMENT LOCATION			
ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD SENT:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG SENT:	☐ YES ☐ NO		
BELONGINGS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
VALUABLES:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
MEDICATIONS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		

12. ARRIVING LOCATION			
ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD RECEIVED:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG RECEIVED:	☐ YES ☐ NO		
BELONGINGS RECEIVED:	☐ YES ☐ NO		
VALUABLES RECEIVED:	☐ YES ☐ NO		
MEDICATIONS RECEIVED:	☐ YES ☐ NO		

13. SPECIAL CONSIDERATIONS			
TIME TO STAGING AREA:		TIME DEPARTING TO RECEIVING FACILITY:	
DESTINATION:		ARRIVAL TIME:	
TRANSPORTATION:	☐ AMBULANCE UNIT ☐ HELICOPTER ☐ BUS ☐ OTHER: _____		
ID BAND CONFIRMED:	☐ YES ☐ NO	ID BAND CONFIRMED BY:	

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: OPERATIONS SECTION – ADMIT/TRANSFER & DISCHARGE UNIT
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING

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Exhibit 5: **NHICS FORM 251: CENTER STATUS REPORT**

1. INCIDENT NAME:		2. CENTER NAME:	Keene Center		
3. DATE PREPARED:		4. TIME PREPARED :		5. OPERATIONAL PERIOD:	

SYSTEM STATUS CHECKLIST		
COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
FAX	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/PATIENT RECORDS/TIME CARD SYSTEM/INTRANET, ETC.)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NURSE CALL SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PAGING – PUBLIC ADDRESS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RADIO EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SATELLITE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM – CELL	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
VIDEO-TELEVISION-INTERNET-CABLE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
CAMPUS ROADWAYS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FIRE DETECTION/SUPPRESSION SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FOOD PREPARATION EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ICE MACHINES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
LAUNDRY/LINEN SERVICE EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RESIDENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
PHARMACY SERVICES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
DIETARY SERVICES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
DOOR LOCKDOWN SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SURVEILLANCE CAMERAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELECTRICAL POWER-PRIMARY SERVICE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SANITATION SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NATURAL GAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
AIR COMPRESSOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ELECTRICAL POWER, BACKUP GENERATOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELEVATORS/ESCALATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HAZARDOUS WASTE CONTAINMENT SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OXYGEN	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PNEUMATIC TUBE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STEAM BOILER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SUMP PUMP	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WELL WATER SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER HEATER AND CIRCULATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

Exhibit 6: NHICS FORM 259 | MASTER CENTER CASUALTY/FATALITY REPORT

1. INCIDENT NAME:		2. CENTER NAME:	
3. DATE/TIME PREPARED:		4. OPERATIONAL PERIOD DATE/TIME:	
5. REPORTED CASUALTY/FATALITY			
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME
RESIDENT NAME:		MEDICAL RECORD #:	
INJURY	TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME

Exhibit 7: NHICS FORM 252 | SECTION PERSONNEL TIME SHEET (STAFF TRACKING SHEET)

6. FACILITY NAME:	Keene Center		
7. FROM DATE/TIME:		**8. TO DATE/TIME:**	
9. SECTION:		**10. TEAM LEADER:**	

11. TIME RECORD

#	EMPLOYEE (E)/VOLUNTEER (V) NAME (PLEASE PRINT)	E/V	EMPLOYEE NUMBER	NHICS ASSIGNMENT/ RESPONSE FUNCTION	DATE/TIME IN	DATE/TIME OUT	SIGNATURE	TOTAL HOURS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

1. CERTIFYING OFFICER:		**2. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY, INCLUDING VOLUNTEERS

NHICS 252

Exhibit 8: NHICS FORM 253 | VOLUNTEER STAFF REGISTRATION

12. FACILITY NAME:	Keene Center					
13. FROM DATE/TIME:		14. TO DATE/TIME:				
15. REGISTRATION						
NAME (LAST NAME, FIRST NAME)	**ADDRESS** (INCLUDE CITY, STATE, ZIP)	**SOCIAL SECURITY NUMBER**	**TELEPHONE**	**CERTIFICATION/ LICENSURE & NUMBER**	**REFERENCE CHECK**	**SECTION ASSIGNMENT**
16. CERTIFYING OFFICER:		17. DATE/TIME SUBMITTED:				

Exhibit 9. EPIDEMIC PREPAREDNESS CHECKLIST

	Person Responsible	Date Completed
Planning and Decision Making		
Administrator/Executive Director is responsible for preparedness planning		
Create a multidisciplinary planning committee to include administration, medical director, nursing, reception, environmental, and others as needed; meet a minimum of monthly to evaluate your plan		
Incorporate epidemic preparedness into your Emergency Preparedness plan		
Develop plan to ensure that patient identification is on all patients/residents		
Complete the Emergency Numbers and Contacts List (refer to *Emergency Preparedness Plan: Attachment C*) ➢ **Include local, regional, or state emergency preparedness groups**		
Prepare updated employee contact list		
Ensure Test Kit is available, as indicated (i.e., Influenza)		
Communications		
Designate a person who will be responsible for **daily monitoring of updates (i.e., GHC Flu page)** and internal communications to staff, patients, and responsible parties		
Establish a system for communication with patients and families		
Maintain a list or database for patients' regular clinic, physician, or dialysis appointments in order to cancel non-essential appointments		
Education		
The Nurse Practice Educator/Practice Development Specialist or designee is responsible for coordinating education		
In-service all staff on Emergency Preparedness *(*may also refer to *Influenza Preparedness PowerPoint, if applicable)*		
In-service staff on infection control procedures and precautions, respiratory hygiene/cough etiquette		
Infection Control		
Post signage (Respiratory Hygiene/Cough Etiquette, Hand Hygiene, visitor sign in reception area)		
Implement respiratory hygiene/cough etiquette throughout the facility, as necessary		
Develop a plan for cohorting patients ➢ Discuss with VPMA and CQS if facility will confine all affected patients to one area, close off wings that are affected, or just confine sick patients and their roommates to their rooms		
Implement surveillance of targeted epidemic illness cases in the facility per Infection Control policies		
Collect information on: ➢ Incoming patients – confirmed or suspected targeted epidemic cases ➢ Number of new cases of targeted epidemic illness within the facility		
Report confirmed or suspected cases of targeted epidemic illness to the VPMA		
General Staff Management		
Develop plan for 100% vaccination of staff, if applicable; Administrator/ED and/or DON/RCD will have a personal conversation with staff who decline vaccination		
In collaboration with Area leadership, develop plan for 30% absenteeism; submit plan to MP		

	Person Responsible	Date Completed
➢ Number and categories of personnel needed to keep facility open or take patient overload ➢ Conduct a daily assessment of staffing status (refer to *Daily Review Form*) ➢ Develop plan for work/rest schedule as needed (i.e., place to sleep when extended work hours are necessary)		
Avoid floating staff if possible		
Educate staff to self-assess and report symptoms that they may be having before reporting to work		
Educate staff to develop a child care plan for school closings		
Review guidelines for Altered Standards of Care		
Discuss with staff the possibility of helping with essential patient care at times of severe staffing shortages		
Sick Staff		
Follow protocols for sick staff: ➢ Employees who develop symptoms during work hours should be sent home ➢ Employees who have been ill but are recovered may provide care to patients		
Alternative Staff		
If needed discuss use of alternative staff with SVP, VPMA and VPCO. Develop plan for use of employees not usually involved in patient care to perform basic patient care with supervision (Refer to *Alternative Staff Guidelines*)		
Influx of Infectious Patients		
Develop plan for patients requiring hospitalization ➢ Patient transport ➢ Lists of hospitals with contact information		
Develop plan to accommodate overcrowding and to ensure that an inflow of infectious patients does not overstretch the facility's resources ➢ Capacity of facility ➢ Number of empty beds/cots ➢ Patient care equipment ➢ Availability of treatment options ➢ Availability of vaccine and antiviral drugs ➢ Staffing resources		
Develop strategies to aid hospitals by admitting non-influenza patients not affected		
Environment		
Address whether adequate storage is available for additional supplies, e.g., water, food, medical supplies		
Make arrangements for additional storage, if needed		
Store adequate supplies/equipment (located in appropriate areas of building)		
For droplet precautions, position beds are at least three feet apart if setting up alternate bed areas		
Food Service		
Provide emergency food and disposable supplies are maintained		
Maintain hard copy of resident roster from Tray Trakker		
Develop staffing plans for full-day shifts (12 to 16 hours)		

Exhibit 10. DAILY SYMPTOM SCREENING FORM

INSTRUCTIONS: Use this form during an outbreak to screen **all** new admissions, re-admissions, staff, visitors, and vendors for symptoms of the illness before reporting to duty. Fill in specific symptoms monitored in the associated columns below. If staff report with symptoms meeting the clinical criteria, recommend follow-up treatment and send them home. (Note: this form may be modified based on specific outbreak.)

Name of Screener

Title

			Symptoms				**Status**		
Date	**Name**	**Time**	**Temperature**	______	______	______	**OK to work/visit**	**Exclude from duty/visit**	**Screener initials**
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Temperature <100°F, OK to work/visit.

Temperature >100°F with any of above symptoms, exclude from duty/visit.

Exhibit 11. ALTERED STANDARDS OF CARE (ASC) FOR EPIDEMIC/PANDEMIC

In most cases, the order to use ASC will be initiated by state authorities. Following a declaration by the Governor that there is an emergency which is detrimental to the public health, the DPH/HHSD may order adherence to ASC priorities and protocols.

Principles for Allocation of Limited Resources and ASC Protocols

Priority for limited medical resources and ASC protocols will be based upon the allocation of scarce resources to maximize the number of lives saved. This allocation will be:

1. Determined on the basis of the best available medical information, clinical knowledge, and clinical judgment;
2. Implemented in a manner that provides equitable treatment of any individual or group of individuals based on the best available medical information, clinical knowledge, and clinical judgment;
3. Implemented without discrimination or regard to sex, sexual orientation, race, religion, ethnicity, disability, age, income, or insurance status.

ASC protocols will recognize:

- Any changes in practices necessary to provide care under conditions of scarce resources or overwhelming demand for care
- An expanded scope of practice for health care providers
- The use of alternate care sites, at facilities other than health care facilities
- Reasonable, practical standards for documentation of delivery of care

Individual Rights

Civil liberties and patients' rights will be protected to the greatest extent possible; however, it is recognized that the protection of the public health may require limitations on these liberties and rights during an epidemic.

Provider Liability

Health care providers who provide care in accordance with the priorities and ASC protocols, including care provided outside of their scope of practice or scope of license, will be considered to have provided care at the level at which the average, prudent provider in a given community would practice.

Priority Activities for ASC

The term "altered standards" has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation. It could also mean changing who provides various kinds of care or changing privacy and confidentially protections temporarily.

Because there are no nationally defined altered standards of care, Genesis HealthCare has established the priorities listed below. However, state/federal authorities are in the process of developing altered standards of care which may supersede Genesis priorities.

Nursing:

- Basic personal hygiene
- Use of hospital gowns for residents as opposed to personal clothing to reduce laundry
- Turning
- Toileting
- Feeding
- Medication Pass
- Critical documentation only – fever, change in condition, incidents

Housekeeping:

- Focus on high-touch surfaces such as tabletops, side rails, door knobs, telephones, time clocks, faucets, etc.

Dietary:

- Minimum nutritional requirements for three meals a day
- Therapeutic diets will be evaluated on an individual basis
- Essential documentation only

Social Services:

- Limit activities to current pandemic issues
- Essential documentation only

Laundry:

- Additional shifts may be needed to handled increased demands

Maintenance:

- Suspend preventive maintenance activities to reallocate resources

Recreation Services:

- Suspend activities to reallocate resources

Admissions:

- Limited to only those associated with the epidemic
- Consider marketing personnel reallocation to local centers

Business Office, Human Resources, Central Supply, Medical Records, Clerical Functions:

- Limit to essential functions only to reallocate resources

Survey & Certification
Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

Not Started	In Progress	Completed	Tasks
			• **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			• **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).

			• **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *
			- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
			- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
			- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
			- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:
			  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel
			  - An adequate supply of potable water (recommended amounts vary by population and location)
			  - A description of the amounts and types of food in supply
			  - Maintaining extra pharmacy stocks of common medications
			  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
			- Identifying and assigning staff who are responsible for each task
			- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days
			- Contract established with multiple vendors for supplies and transportation
			- Develop a plan for addressing emergency financial needs and providing security

			• **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: * - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees. - Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established - Adequate food supply and logistical support for transporting food is described.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- The amounts of water to be transported and logistical support is described. - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation - Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff. - Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - It is described whether staff family can shelter at the facility and evacuate.
			• **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *
			• **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			• **Facility Reentry Plan**: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			• **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
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Survey & Certification
Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			• **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			• **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: - Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. - Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.
			• **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.
			• **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			• **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - Encourage family participation
			• **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes
			• **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			• **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: - Exercises or drills must be conducted at least semi-annually - Corrective actions should be taken on any deficiency identified
			• **Loss of Resident's Personal Effects:** Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

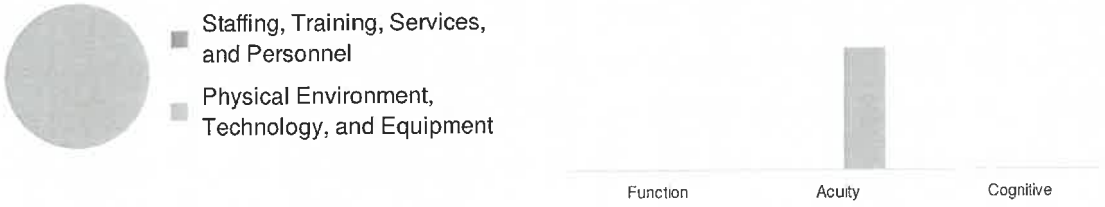
Facility Assessment

Keene Center

305051: Keene Center - 55070, Keene, NH

Keene Center
NAME

Insufficiencies by Category & Type



1
INSUFFICIENT CATEGORIES

3
ACTION/PLAN IN PLACE

Dec 1, 2022 - Dec 22, 2022

Last Activity: Dec 26, 2022

ADC: 98

Licensed Beds: 106

I. Resident Population Profile - Dec 2, 2021 - Dec 1, 2022

Admissions/Stays Summary

	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Number of Admissions/Stays in Past Year	329	100	N/A
Number of Admissions/Stays ending in Community Discharge	111	33.7	Low
Number of Admissions/Stays ending in Death	46	14	Very High
Number of Admissions/Stays ending in Hospitalization	76	23.1	Low
Number of Admissions/Stays ending in Other Discharge	8	2.4	Low
Number of Ongoing Stays	88	26.7	N/A
Number of Short Stays (Less than 100 days)	189	57.4	Low
Number of Short Stays 1-14 Days	68	36	N/A
Number of Short Stays 1-30 Days	133	70.4	N/A
Number of Short Stays 1-60 Days	170	89.9	N/A
Number of Short Stays 1-90 Days	186	98.4	N/A
Number of Long Stays (100 days or more)	114	34.7	High

Number of Post-acute Admissions/Stays	302	91.8	High

A. Function, Mobility, & Physical Disabilities

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Global Function (Barthel) Index			
ADL Function Low	168	51.1	Low
ADL Function Moderate	31	9.4	Very Low
ADL Function High	92	28	High
Activities of Daily Living (ADL) - Assistance Required: 1 Person			
Daily Care (excluding Bathing)	269	81.8	High
Bed Mobility	114	34.7	Low
Transfer	134	40.7	High
Walk in Room	94	28.6	Low
Toilet Use	153	46.5	High
Eating	172	52.3	High
Bathing	191	58.1	Very Low
Dressing	183	55.6	Low
Hygiene/Grooming	194	59	Low
Activities of Daily Living (ADL) - Assistance Required. 2+ Persons			
Daily Care (excluding Bathing)	165	50.2	High
Bed Mobility	145	44.1	High
Transfer	100	30.4	Low
Walk in Room	3	0.9	Low

Toilet Use	115	35	High
Eating	2	0.6	High
Bathing	75	22.8	High
Dressing	89	27.1	High
Hygiene/Grooming	73	22.2	High
Mobility			
Independently Ambulatory (No Assistive Device)	0	0	N/A
Independently Ambulatory (With Assistive Device)	1	0.3	N/A
Ambulation with Assistance (No Assistive Device)	23	7	N/A
Ambulation with Assistance (With Assistive Device)	122	37.1	N/A
In Chair All or Most of Time	197	59.9	N/A
With Contractures	165	50.2	Very High
Physically Restrained	1	0.3	High

Rehabilitative Services (for those receiving therapy)	Avg. Number of Days	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Speech-Language Pathology and Audiology Services	2.2	33	10	High
Occupational Therapy	3.3	217	66	High
Physical Therapy	2.8	177	53.8	Low
Respiratory Therapy	1.7	30	9.1	High
Psychological Therapy	1	1	0.3	N/A
Recreational Therapy	1	1	0.3	Very Low

1. Types of care required- Admissions tea ncluding IDT and hospital screener review potential ad sions and the services/equipment/staffing required to care for the resident. Center has a high population of residents that require ADL assistance. This includes bathing, dressing, grooming and toileting. High incidence of mobility assistance with device and mechanical lift. Types of care provided but not limited to - Skilled nursing care, long term care, advanced care planning, palliative care and veteran care. Supporting residents, families and caregivers throughout the continuum of their time with Keene Center. The Center creates an atmosphere similar to home building relationships for residents, family members and staff. Community partnering has been modified since the presence of COVID 19 and the need to modify the types of ways our center collaborates and connects with the community. Strive to deliver care that is culturally religiously and ethnically competent/sensitive. Embrace/welcome all who enter.

2. Services required- Center collaborates with rehabilitative services located on site - PT/OT/ST (via tele visit and proctor). Through collaboration residents are evaluated for developing plans for the resident to restore function and or maintain highest level of self performance. Health drive provides dental, podiatry opthamology and audiology services. Residents have the option of community based services as well. US Labs/Trident provide the lab services, x-ray and EKG services. Medi Telecare provides the mental health services. Omnicare provides the services pertaining to pharmacy and therapeutic oversight of medication regimes. Lincare is the provider for oxygen needs and respiratory therapy. HCS Inc. of Keene is the primary provider of Hospice service in the Center, however Compassus and Bayada are available options for residents as well. The Center provides infusion therapy around the clock with supplies from Omnicare. Wound care / pressure relieving / reducing Joerns. G-tube nutritional services - consultation with dietician / PCP. Partnership with the VA for veterans. Due to the ongoing requirements surround Covid 19 and the changing guidance surrounding testing, vaccines and isolation the senior leadership respond to the arising needs and adapt the training/ education.

3. Staff/Personal required- Center employs a full senior leadership team overseeing each department. Nurses, LNA, medical records, Director of nurses, NPE, ICP, Unit Managers, CRC, Skin Lead make up the clinical team. SSD director, and Admissions director back each other up in their respected areas. Recreation department- Full time activity director, two full time assistants and a bus driver for the center 1-2 days a week. Dietary and Housekeeping services are contracted with Health Care Service Group. Dietary-FSS, Dietician (8 hours weekly), cooks, and diet aides. Housekeeping and Laundry- Director, laundress, and housekeepers. Maintenance Department- Full time director and full time assistant. Rehabilitation team is contracted through- Genesis Rehabilitation group. PT/OT/ST. Genesis Physician Service- Medical director and a part time NP to transition to a full time NP first of 2023.

4. Staff Competency- New clinical staff complete competencies on hire, and annually. When a new treatment modality is introduced training is provided. Gaps in performance are identified and further education is provided to elevate performance.

5. Physical plant environment required- Center has 53 resident rooms (semi private) with beds. Rooms are duel certified to accommodate for placement of SNF customers throughout the center. Full kitchen, Main dining room and a family room on each resident floor that serves as a dining room/recreation location for residents that require physical assistance/supervision when dining. Center has a vented, and approved oxygen storage room. External generator that runs dedicated outlets (identified with red face plates) Laundry room is equipped with three washers, and three gas dryers. Therapy room is equipped with various pieces of equipment for treatment modalities. Center has one storage pod for equipment storage. Extra rehab equipment- wheelchairs, walkers, splints, wedges, ect. are stored in the rehab room closet.. A small shed is located behind the building with excess rehab equipment, wheel chairs and supplies.

6. Medical and non-medical Center has a shared bus that is stored at a sister facility. The bus is shared with other buildings. The town of Keene has two ambulances, Diluzio and adventure limousine provide transportation to residents. Current transportation needs in the state of NH is in a state wide spread shortage. This has impacted the ability to schedule appointments, and the lack of follow through with transportation showing up as well as delayed transports from hospital to center. VA has a bus and they assist with scheduling appointments and booking transportation.

7. Health information technology resources required- Center uses PCC for the EMR. PCC is also the technology used for MAR/TAR. Sister centers also use PCC which would support center professionals wish access to view the EMR remotely. Nursing using E-Mar for medication administration and has a back up system for when the computer system is offline. POC is LNA documentation, SWIFT skin documentation, and Rehab optima for rehab documentation.

B. Acuity-Diseases, Conditions, & Treatments

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Acuity Index			
Acuity Index Low	121	36.8	Low
Acuity Index Moderate	149	45.3	High
Acuity Index High	59	17.9	High

Cancer			
Cancer	41	12.5	Very High
Heart/Circulation			
Heart Failure (CHF)	69	21	High
Peripheral Vascular Disease (PVD)	50	15.2	High
Gastrointestinal			
Cirrhosis	8	2.4	Very High
Gastroesophageal Reflux Disease (GERD) or Ulcer	128	38.9	Very High
Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease	6	1.8	Very High
Genitourinary			
Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)	95	28.9	Very High
Neurogenic Bladder	27	8.2	Very High
Obstructive Uropathy	1	0.3	Low
Infections			
Multidrug-resistant Organism	2	0.6	Low
Pneumonia	13	4	Low
Septicemia	14	4.3	High
Tuberculosis	0	0	None
Urinary Tract Infection (UTI)	21	6.4	Low
Viral Hepatitis	1	0.3	Low
Wound Infection	2	0.6	High
Metabolic			
Diabetes	128	38.9	High

Arthritis	116	35.3	Very High
Osteoporosis	46	14	Very High
Hip Fracture	23	7	High
Other Fracture	43	13.1	Very High
Neurological			
Alzheimer's	21	6.4	High
Aphasia	7	2.1	High
Cerebral Palsy	3	0.9	High
Cerebrovascular Accident (CVA, TIA) Stroke	43	13.1	High
Non-Alzheimer's Dementia	80	24.3	High
Hemiplegia or Hemiparesis	32	9.7	High
Paraplegia	9	2.7	Very High
Quadraplegia	5	1.5	High
Multiple Sclerosis	9	2.7	Very High
Huntington's Disease	0	0	None
Parkinson's	16	4.9	High
Tourette's	0	0	None
Seizure Disorder or Epilepsy	28	8.5	High
Traumatic Brain Injury	3	0.9	High
Nutritional			
Malnutrition	47	14.3	Very High

Anxiety Disorder	104	31.6	High
Depression	150	45.6	High
Manic Depression	16	4.9	High
Psychotic Disorder	11	3.3	High
Schizophrenia	7	2.1	Low
Post Traumatic Stress Disorder (PTSD)	3	0.9	High
Pulmonary			
Asthma, COPD, or Chronic Lung Disease	104	31.6	Very High
Respiratory Failure	45	13.7	Very High
Vision			
Cataracts, Glaucoma, or Macular Degeneration	38	11.6	Very High
Conditions			
Dehydrated	2	0.6	High
Swallowing Difficulty	49	14.9	Very High
Pain Frequency (Frequent or Almost Constant)	37	11.2	Low
Fever	4	1.2	Low
Vomiting	9	2.7	High
Internal Bleeding	10	3	Very High
Falls with Injuries	30	9.1	High
Falls Since Admission or Prior Assessment	53	16.1	High
One or More Unhealed Pressure Ulcers/Injuries	40	12.2	High
Shortness of Breath When Sitting	35	10.6	High

Unplanned Significant Weight Loss	25	7.6	High
Unplanned Significant Weight Gain	10	3	Low
Current Tobacco Use	6	1.8	Low
Treatments			
Chemotherapy	1	0.3	Low
Radiation	0	0	None
Oxygen	82	24.9	High
Suctioning	0	0	None
Tracheostomy	1	0.3	High
Invasive Mechanical Ventilator (ventilator or respirator)	0	0	None
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	8	2.4	High
IV Medications	4	1.2	Low
Transfusions	2	0.6	Very High
Dialysis	4	1.2	Low
Isolation	8	2.4	Very High
Parenteral/IV Feeding	3	0.9	High
Feeding Tube	4	1.2	Low
Mechanically Altered Diet	62	18.8	Low
Indwelling Catheter	46	14	High
External Catheter	3	0.9	High
Ostomy (urostomy, ileostomy, colostomy)	6	1.8	Low

Intermittent Catheterization	2	0.6	High
Urinary Toileting Program	0	0	None
Bowel Toileting Program	0	0	None
Injections	147	44.7	Very Low
Influenza Immunization	63	19.1	Low
Pneumococcal Immunization	59	17.9	Very Low
Medications			
Insulin	54	16.4	N/A
Psychoactive Medications	189	57.4	N/A
Antipsychotic Medications	29	8.8	N/A
Antianxiety Medications (anxiolytics)	36	10.9	N/A
Antidepressant Medications	168	51.1	N/A
Hypnotic Medications	2	0.6	N/A
Anticoagulant	89	27.1	N/A
Antibiotics	61	18.5	N/A
Diuretic	107	32.5	N/A

B.1. Acuity - Frequency of Potentially High-Risk Treatments

IV antibiotics	More than 6
IV fluids	1-5
IV other medications	1-5
PICC line	1-5
Surgical drains	1-5
Anticoagulation - INR monitoring	More than 6
Nebulizer Treatments	More than

Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	1-5
Bariatrics	1-5

B.2. Acuity - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable) Center provides a vast variety of care with higher prevalence of the following: Renal diseases, GI conditions, cardiac/ circulatory conditions including vascular, musculoskeletal- arthritis, and metabolic prevalence-diabetes. Neurological conditions include-TIA, CVA, and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Nutritional conditions- malnutrition, Psychosocial conditions- center has a high prevalence of depression, anxiety and PTSD. Pulmonary conditions with high prevalence include Asthma, COPD, and chronic lung disease. Sensory conditions including visual ailments have a high prevalence at the center. Other conditions with a high incidence include pain frequency, falls preadmission/post admission. Treatments- oxygen therapy, CPAP/BiPAP, IV Medications, mechanically altered diet, indwelling catheter, ostomy, injections- including insulin and immunizations. High prevalence of Psychoactive medication- predominantly antidepressants. Anticoagulant.

2. Services require (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other services outlined in the center functions- rehab, ancillary services, hospice, vision, dental, podiatry, mental health services, lab services, O2 etc. The center utilizes Third Eye for after hours/on call physicians. As well as with new equipment and PRN education.

3. Staff/Personal required- center has agreements/partnership with supporting services. Omnicare, Linecare, Joerns, GRS/powerback, GPS-Medical director/NP services. Staffing is linked to occupancy. Acuity is factored into overall staffing patterns, and modified as census goes up or down. .

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided.

5. Physical plant environment required - external generator runs the entire building. Central air conditioning units cool all common areas, and individual units are placed in the resident rooms, offices and common areas in Spring and removed in the Fall.

6. Medical and non-medical equipment required- Each unit is equipped with mechanical lifts and variety of sized slings. The shower rooms on each floor are equipped with a shower and whirlpool tub. Bladder scanner for use on both floors. The center has partnerships with various venders that provide equipment for the care of residents- Omnicare IV pumps, enteral feeding pumps. Linecare CPAP/BiPAP, medication carts that are serviced by Omnicare, the omnicell in the medication room for emergency/back up medications, nebulizer machines/O2 concentrators. Joerns wound vacs and specialty sleeping surfaces. The kitchen uses a Robo coupe machine to prepare mechanically altered textures. Keene Center has a facility bus for outings that is shared with three other homes.

7. Health information technology resources required- such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC in the EMR for center. Additional supporting technology such as programs like SWIFT for wound care and Omniview for pharmacy, POC and Rehab Optima.

C. Cognitive, Mental, & Behavioral Status

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Interviewable	239	72.6	Very Low
Memory Impaired on BIMS	58	17.6	High
Orientation Impaired on BIMS	97	29.5	Low
Recall Impaired on BIMS	86	26.1	High
Understanding Impaired	28	8.5	High
Decision Making Impaired	90	27.4	Very High

With Intellectual Disability or Developmental Disability	3	0.9	Very High
Dementia: Non-Alzheimer's or Alzheimer's Disease	82	24.9	Low
Wandering	25	7.6	Very High
Psychotic Symptoms	18	5.5	High
With Behavioral Health Care Needs	71	21.6	High
Resident Behavior Impacted Resident Care	10	3	High
Resident Behavior Impacted Others	3	0.9	High
Potential For Self Harm	0	0	None
Hearing Impaired	30	9.1	High
Speech Impaired	33	10	High
Vision Impaired	7	2.1	Low
Comatose	0	0	None

C.1. Cognitive - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable). Center provides a vast variety of care with higher prevalence of following: Cognitive diagnosis/conditions impacting cognition include - TIA, CVA and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Psychosocial conditions- Center has a high prevalence of depression, anxiety and PTSD. Sensory conditions including visual ailments have a high prevalence at Center. other conditions with a high incidence include pain frequency, falls pre-admission/post admission. High prevalence of Psychoactive medication- predominantly antidepressants.

2. Services required (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other service as outlined in center functions- rehab, ancillary services, hospices, vision, dental, podiatry, mental health services, lab services, O2 etc. Center utilizes Third Eye for after hours/on call physicians. Person centered care drives individual care planning, what matters to the resident supports the cognitive and mental health needs of the resident. The recreation team develop programs in collaboration with the residents.

3. Linecare, Joerns, GRS/powerback, GPS- Medical director/NP services. Meditelicare provides specialized mental health services, including medication reviews, talk therapy, in-service education on special topics.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing with services proficiency with services required and provided. Special ongoing training includes specialized dementia training, trauma informed care and topics that target techniques to care for those with cognitive/mental behavior health conditions.

5. Physical plant environment required- Secure care system at main entry, emergency doors and elevators. Center does not use bed/chair alarms. Center does have removable stop signs used for various rooms including resident rooms as a deterrent for wandering residents entering another persons room.

6. Medical and non-medical equipment required- Center has devices for music, animatronic pets and weighted babies available that provide comfort for various levels of cognitive conditions. Keene Center has a facilities bus for outings that is shared with three other homes. Pocket

7. Health information technology resources required- IPAD or similar device for virtual visits. PCC is EMR.

D. Cultural, Ethnic, & Religious Factors

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Age			
Age less than 65	35	10.6	Low
Age 65 to 94	270	82.1	High
Age 95 or greater	24	7.3	High
Race/Ethnicity			
American Indian or Alaska Native	1	0.3	High
Asian	0	0	None
Black or African American	1	0.3	Low
Hispanic or Latino	1	0.3	Low
Native Hawaiian or Other Pacific Islander	0	0	None
White	325	98.8	Very High
PASRR			
PASRR level II indicates serious mental illness and/or intellectual disability or related condition	10	3	High
Other			
Male	133	40.4	High
Married	111	33.7	High
Need/Want Interpreter	0	0	None
Life Expectancy less than 6 Months	28	8.5	High
Receiving Hospice Care	27	8.2	High

D.1. Cultural - Activities, Services, & Places

Spiritual/Religious Services

Catholic

Other Christian

Other faith or world religion

Holiday Services

Christian holidays

Jewish Holidays

Accommodations for Worship

Time of day (e.g. sunrise, early AM, late afternoon, evening)

Noise (e.g. silence, quiet room)

Furniture (e.g. comfort for sitting, kneeling)

Media (e.g. books, videos, music)

Equipment (e.g. TV, CD player, etc.

Objects and/or icons (e.g. art, statues, votives, etc.)

Other accommodations

Places of Worship

Non-Christian spiritual setting

Other setting

Spiritual Counseling

Non-denominational

Priest

Minister

End of life counseling/visitation

Spiritual Reading/Study

Other sacred texts

D.2. Cultural - Food & Nutrition

Diet

Vegetarian

Sugar-free

Dairy

Dairy substitutes (e.g. soy)

Protein preferences (e.g. beef, pork, fowl, fish, vegetarian)

Other diet

Meal Time

Early (e.g. breakfast, coffee)

Mid-afternoon

Evening

Religious/Holiday Meals

None

D.3. Cultural - Daily Routine

Daily Routine Accommodations

Clothing and cosmetics (e.g. religious garments, jewelry, makeup, oils)

Gender preferences (e.g. same gender personal care providers)

Outside visitors (family, friends, partners, significant relations)

Place and times for privacy

Access to outdoors

Waking time

Bed time

Other daily routine accommodations

D.4. Cultural - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable): Center serves individuals from a vast group of religious affiliations. Center provides a vast variety of care with higher prevalence in the age groups 65 to 94. The Center does have customers in the younger and older age group as well. Our Center community is predominantly white, but have provided service to a diverse population. This includes the individual preferences of the resident- rise and bed time, when and what to eat, what to wear, how to spend their time, how they want to be addressed as well as other personal preferences. Our culinary team and recreation team collaborate to provide enriching experiences including multidenominational services and activities. The dietician supports the team regarding religious and cultural needs being met through nutritional services.

2. Services required- through assessment process, Center is able to determine specific services required by those in our care. Spiritual services include Catholic, Christian and nondenominational. The Center works with the resident/customer to ascertain the spiritual connection they require and seek partnership with community partners. Resident Council helps drive the nature of service desired.

3. Staff/Personnel required- The recreation, dietary and social service team collaborate with the residents to identify what matters to them, the frequency and types of spiritual/religious services, food and cultural preferences. Local clergy and religious leaders, volunteers and community groups.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided, including the importance of what matters to the resident.

5. Physical plant environment required - Space for worship, and spiritual services to accommodate large and small groups.

6. Medical and non-medical equipment required- center has a shared bus. PA system is available for use to project sound quality for all listeners. A podium is also available for those presenting.

7. Health information technology resources required- such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC is the EMR for the Center where care teams complete assessments and collect information specific to the resident and their spiritual/religious and cultural needs.

Supporting Documents

No records were found

II. Staffing, Training, Services & Personnel

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No
Eating	Sufficient	Sufficient	Sufficient	No
Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Not Applicable	Not Applicable	Not Applicable	No
Rehabilitative Services (for those receiving therapy)				

Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

Staffing and scheduling systems- Daily discussions regarding staffing on each of the floors/units. The unit managers provide updates on resident needs. The scheduler will make staffing adjustments based on census and acuity. Scheduler and clinical team meet daily/weekly for labor meetings to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted services are also evaluated by the IDT to develop plans to ensure services are provided during the identified gaps. During outbreak status and closing congregate activities/meals staffing is evaluated to determine adjustments that are required. Center has primary assignments with floaters that cover primary days off. In the event we have an outbreak of COVID 19 center will consult regional support team to develop staffing plan based on current guidance for staff to return to work. Caregivers collaborate via hey team leader, huddles, staff meetings and 1:1 to determine changes to work loads and assignments. All senior leaders with licenses support direct care staff and partner to ensure adequate numbers for safety and quality.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annually, and with identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff. Training is conducted through a variety of modalities. These include vital learn programs through online programming, education boards, and live education. Nursing competencies are conducted on hire and annually.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes, or process creation to impact overall quality of care and efficiency of process.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams complete analysis of data. Data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards, etc. evaluate improvement and development of PIPs/IA.

3. Corrective actions-QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance.

B. Acuity-Diseases, Conditions, & Treatments

■0 □0 ■0 □3 ■0 □0 Y-1 N-38

Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	In Progress	Sufficient	No
Nutritional	Sufficient	In Progress	Sufficient	Yes
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	In Progress	Sufficient	No
Pulmonary	Sufficient	Sufficient	Sufficient	No
Cataracts, Glaucoma, or Macular Degeneration	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	Sufficient	No
Radiation	Sufficient	Sufficient	Sufficient	No
Oxygen	Sufficient	Sufficient	Sufficient	No

Suctioning	Sufficient	Sufficient	Sufficient	No
Tracheostomy	Not Applicable	Not Applicable	Not Applicable	No
Invasive Mechanical Ventilator (ventilator or respirator)	Not Applicable	Not Applicable	Not Applicable	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Not Applicable	Not Applicable	Not Applicable	No
Dialysis	Not Applicable	Not Applicable	Not Applicable	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	Sufficient	Sufficient	Sufficient	No
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No
Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No

Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Our strategic business plan includes current clinical capabilities as well as identified opportunities in the market. The labor team evaluate capacity and competence of staff and needed training/competencies needed to provide the service. Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing and the acuity in the center.

2. Staff training and competency program- NPE spear heads the staff training and competence program. Through collaboration with IDT program is modified to meet the current needs/acuity. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborates with direct care staff to evaluate assignments and needed adjustments. Staff utilize the Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process. When new service opportunities present through market analysis with community partners staffing patterns/sufficiency is evaluated from the perspective of the proposed new service.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly with adhoc meetings throughout the month as needed. As part of the SBP and the QAPI service gaps are identified and PIP/IA are developed.

2. Business- SBP/market analysis and Safety Excellence Improvement activities and PIPs are identified.

3. Corrective actions- QAPI team members present minutes and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet gaps in performance.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □1	■0 □0	Y-0 N-11

Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	In Progress	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Sufficient	Sufficient	Sufficient	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted service are also evaluated by the IDT to develop plan to ensure services are provided during identified gaps.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals are included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments to communicate needs, suggestions for process changes or process creation to impact overall quality of care and efficiency of process. Direct staff assignments are never left "vacant" Keene Center fills all direct care assignments if uncovered by a primary or alternate with clinical leadership or licensed individual.

C.2. Cognitive - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to out QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams compete analysis of data (data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the team identification of Opportunities for

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet gaps in performance. The Hey Team Leader program provides a vehicle of feedback and efficient process to implement corrective action. Competency of staff while "in progress" a dedicated action plan may or may not be developed. Keene Center provided leaders with the option of completing the LNA program to increase the " all hands on deck" approach.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■ 0 □ 0	■ 0 □ 0	■ 0 □ 0	Y-1 N-10
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No

D. Cultural, Ethnic, & Religious Factors

Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	Yes
Other	Not Applicable	Not Applicable	Not Applicable	No

D.1. Cultural - Sufficiency Analysis Summary

1. Staffing and schedules systems- Understanding the unique needs of each resident and their preference provides the guide for determining capacity and competence of staff. This includes seeking support services which include but not limited to clergy, religious groups, LGBT/inclusion groups.

2. Staff training and competency program- [redacted] spear heads the staff training and competence progr[redacted] Programs such as Trauma informed care.

3. A review of staff assignments and systems for coordination and continuity of care for residents within and across staff assignments- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions and the process or creation to impact overall quality of care and efficiency of process. Being sensitive to matters to the customer- for example no male caregivers, does not take showers, or is a night owl.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Keene Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvements activities and PIPs are identified. The excellence team complete analysis of data (data sources include but not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the teams identification of Opportunities for Improvement.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and additional suggested corrective actions required to meet the gaps in performance. The Hey Team Leader program provides a vehicle for feedback and efficient process to implement corrective action.

Supporting Documents

No records were found

III. Physical Environment, Technology, & Equipment

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	0 0	0 0	0 0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No
Eating	Sufficient	Sufficient	Sufficient	No

Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Not Applicable	Not Applicable	Not Applicable	No
Rehabilitative Services (for those receiving therapy)				
Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based in the center needs and customers being served drives the type/quantity of equipment and supply. Our Central Supply coordinator collaborates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Point of care charting for direct care, PCC for EMR. This also includes migration of supporting electronic systems that include but not limited to risk management, PIP process through Insight, Abaqis for the Center Facility Assessment. The electronic screening process at the front door provides format for the requirement of our Infection Control program.

2. Maintenance and activity logs- Maintenance utilizes TELS system for logging center upkeep, repairs, and routine maintenance. Safety committee collaborates for center opportunities. Specific assessments/evaluation like the Legionella water plan and NFP risk assessment are completed annually. Report is generated monthly to reflect completed and outstanding activities.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets m ly. Changes and upgrades to center physical environ , technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Additionally, our Hey Team Leader program is designed so that 100% of all staff across shifts and departments are able to communicate Opportunities for Improvement. OFI are brought to the QAPI committee for review. For example phone system functionally or the aging, whirlpool tubs, and aging in room heating units.

3. Corrective actions- The maintenance department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Additional tasks for maintenance are also entered into the system for completion/tracking. Once an OPI has been identified, corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be through center budget or capital request.

B. Acuity-Diseases, Conditions, & Treatments

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■1 □0	Y-1 N-38
Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	Sufficient	Sufficient	No
Nutritional	Sufficient	Sufficient	Sufficient	No
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	Sufficient	Sufficient	No
Pulmonary	Sufficient	Sufficient	Sufficient	No

Vision	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	Sufficient	No
Radiation	Sufficient	Sufficient	Sufficient	No
Oxygen	Sufficient	Sufficient	Insufficient	No
Suctioning	Sufficient	Sufficient	Sufficient	Yes
Tracheostomy	Sufficient	Sufficient	Sufficient	No
Invasive Mechanical Ventilator (ventilator or respirator)	Not Applicable	Not Applicable	Not Applicable	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Not Applicable	Not Applicable	Not Applicable	No
Dialysis	Not Applicable	Not Applicable	Not Applicable	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	Sufficient	Sufficient	Sufficient	No
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No

Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No
Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Equipment and Supply Inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and costumers being served drives the type/quantity of equipment and supply. Medical director/NP/PCP collaborate with the IDT to determine it.

2. Maintenance and activity logs- in addition to the TELS system for logging center upkeep, repairs, and routine compliance, the center utilizes a weekend manager program to ensure specific tasks are validated daily- like door checks for locking to ensure resident and staff safety. This supports the acuity of wandering and cognitively impaired folks.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly, changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence areas of focus. These are key performing areas including 5 star data. Once an OFI is identified and is brought to the QAPI committee for review. For example the training of a staff member to train CPR to keep to staff to ensure ongoing competence.

3. Corrective actions- Once and OFI has been identified corrective action can be developed including identifying resources needed to

need for capital requisition along with resid room heat registers.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 ■0	■0 ■0	■0 ■0	Y-0 N-11
Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	Sufficient	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Sufficient	Sufficient	Sufficient	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and customers being served drives the type/quantity of equipment and supply. Our Center Supply coordinates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Meditelicare, telehealth visits, third eye all utilize the computer and internet to connect the provider with the residents. The access to internet, and the ability to facetime, zoom meetings etc. has supported the residents in staying connected, and for the cognitive folks to be able to "see" their loved ones, and seeing their provider on the screen provides a stronger experience.

2. Maintenance and activity logs- Maintenance collaborates with the vendors providing the service to our center. This includes installation and ongoing upkeep.

1. Facility QAPI plan- QAPI team meets monthly. Changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These areas of excellence review Key Performing areas including 5 star data. OFI are brought to the QAPI committee for review. For Example Accessing specialty services such as meditelicare for mental health partnering and Third Eye after hours coverage by physician were created as a result of gaps in services. These gaps were identified and a plan developed to remedy the gap.

3. Corrective actions- The maintenance department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Additional tasks for maintenance are also entered into the system for completion/tracking. Once and OPI has been identified corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be though center budget or capital request. Upgrade of our internet router was completed in 2022 as a result of outdated technology being identified.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-11
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No

D. Cultural, Ethnic, & Religious Factors

Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	No
Other	Sufficient	Sufficient	Sufficient	No

D.1. Cultural - Sufficiency Analysis Summary

1. Equipment and Supply inventory- having laptops and Wi-Fi internet available keeps residents connected with loves ones, religious groups and any other organization that has online connection. Center provides a guest internet connection for residents and guests to use while in the center. Center Provides local telephone services and the long term care residents provide their own phones. Center provides in room TV to use during their stay. Streaming movies and programs on smart tv is another option..

2. Maintenance and activity logs- Interruptions in service are addressed by the maintenance department for the coordination of restoring service. Excellence committees discuss ongoing issues that impact the quality of resident experience as it pertains to the environment, technology, and equipment.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI plan meets monthly, changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriated.

2. Performance Improvement projects- Center has Customer Excellence, Safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Satisfaction surveys conducted annually provide additional feedback on the above cited areas. Additionally, resident council meeting, care plan meeting and 72 hour meetings provide a forum for feedback.

3. Corrective actions- PIP/IA that are identified through formal and informal means are addressed through QAPI process. For example- food and nutrition action plan to improve the quality. Specific interventions may include a new electronic meal ticket process, training, auditing tray accuracy and satisfaction validated through resident food council and 1:1 interviews.

Supporting Documents

No records were found

IV. All Hazards Risk Assessment

No records were found

Supporting Documents

Name	Date Uploaded
Genesis Risk Assessment 2022 (4).pdf	Dec 27, 2022

V. Assessment Contributors

Medical Director/Designee

Dr. Leslie Pitts

Director of Nursing Services

Brandice French

Administrator/Executive Director

Patrick Lyons

Name	Title/Role
Daniel Birmingham (daniel.birmingham@genesishcc.com)	Maintenance Dir.
Sarah Rodgers (sarah.rodgers@genesishcc.com) (sarah.rodgers@genesishcc.com)	NPE
Amanda Kingsbury (amanda.stubbs@genesishcc.com) (amanda.stubbs@genesishcc.com) (amanda.stubbs@genesishcc.com)	IP
Melanie Lucious	UM 2nd Floor
Nicole Wilcox	UM 3rd floor

Supporting Documents

No records were found

Additional Supporting Documents

No records were found

Keene Center Neighborhood Relations Plan

Keene Center maintains active and friendly relationships with our neighbors and customers both abutting the property and in the community. Keene Center is an active participant with One Hundred Nights Shelter through volunteering and donations. Keene Center provides a school for Licensed Nurse Assistants to earn their certificates through training on site. Keene Center does require emergency medical vehicles to conduct business on the property, and no sirens and or disruptions have been reported from neighbors.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled _____
Rec'd By _____
Page _____ of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

○ Drug Treatment Center	○ Group Home, Small	○ Homeless Shelter
○ Fraternity/Sorority	○ Group Resource Center	○ Lodging House
○ Group Home, Large	○ Residential Drug/Alcohol Treatment Facility	● Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 136A Arch Street, Keene, NH 03431

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Sunbridge Healthcare LLC	**NAME/COMPANY:** Langdon Place of Keene
MAILING ADDRESS: 101 E. State St, Kennett Square, PA 19348	**MAILING ADDRESS:** 136A Arch Street, Keene, NH 03431
PHONE: 505-468-4572	**PHONE:** 603-357-3902
EMAIL: lawdepartment@genesishcc.com	**EMAIL:** michael.johnson3@genesishcc.com
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** Michael Johnson **TITLE:**

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	**NAME/COMPANY:**
MAILING ADDRESS:	**MAILING ADDRESS:**
PHONE:	**PHONE:**
EMAIL:	**EMAIL:**
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** **TITLE:**

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Please see attached facility assessment that includes this information

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

104661 gross area
99531 finished living area
14.82 acres

Please see attached operating licenses and facility assessment.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

Please see attached facility assessment.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: LANGDON PLACE OF KEENE
Located at: 136A ARCH STREET
KEENE NH 03431

To Operate: Supported Residential Care Facility

This annual license certificate is effective under the conditions and for the period stated below:

License#: 03921
Effective Date: 04/01/2023
Expiration Date: 03/31/2024
Administrator: JENNIFER ROUSSEAU

Comments:
1. CRIM WAIVER 805.18(b)(1)

Total Number of Beds: 156

Chief Legal Officer

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 PLEASANT STREET, CONCORD, NH 03301

ANNUAL LICENSE CERTIFICATE

Under provisions of New Hampshire Revised Statutes Annotated Chapter RSA 151, this annual license certificate is issued to:

Name: LANGDON PLACE OF KEENE
Located at: 136A ARCH STREET
KEENE NH 03431

To Operate: Nursing Home

This annual license certificate is effective under the conditions and for the period stated below:

License#: 02693
Effective Date: 04/01/2023 Expiration Date: 03/31/2024
Administrator: MICHAEL T JOHNSON
Medical Director: MICHAEL KASSCHAU, MD

Total Number of Beds: 25

Chief Legal Officer

NEW HAMPSHIRE
Online Licensing

nh.gov
Licensing
Home

Person Information

Name: MICHAEL JOHNSON, NHA

Address Information

State: NH

License Information

License No:	3736	**Profession:**	Nursing Home Administrators	**License Type:**	Nursing Home Administrator
License Status:	Active			**Expiration Date:**	12/31/2023

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

NEW HAMPSHIRE
Online Licensing

nh.gov Licensing Home

Person Information

Name: MICHAEL F KASSCHAU, MD

License Information

License No: 13287 **Profession:** Medicine **License Type:** Physician
License Status: Active **Issue Date:** 10/4/2006 **Expiration Date:** 6/30/2024

Additional Information

Specialty: Family Practice/Family Medicine

Board Certification Information

Board Certified	Certification	Expiration	ABMS Board Specialties
Yes	Family Medicine	Jan 1 2029 12:00AM	family medicine

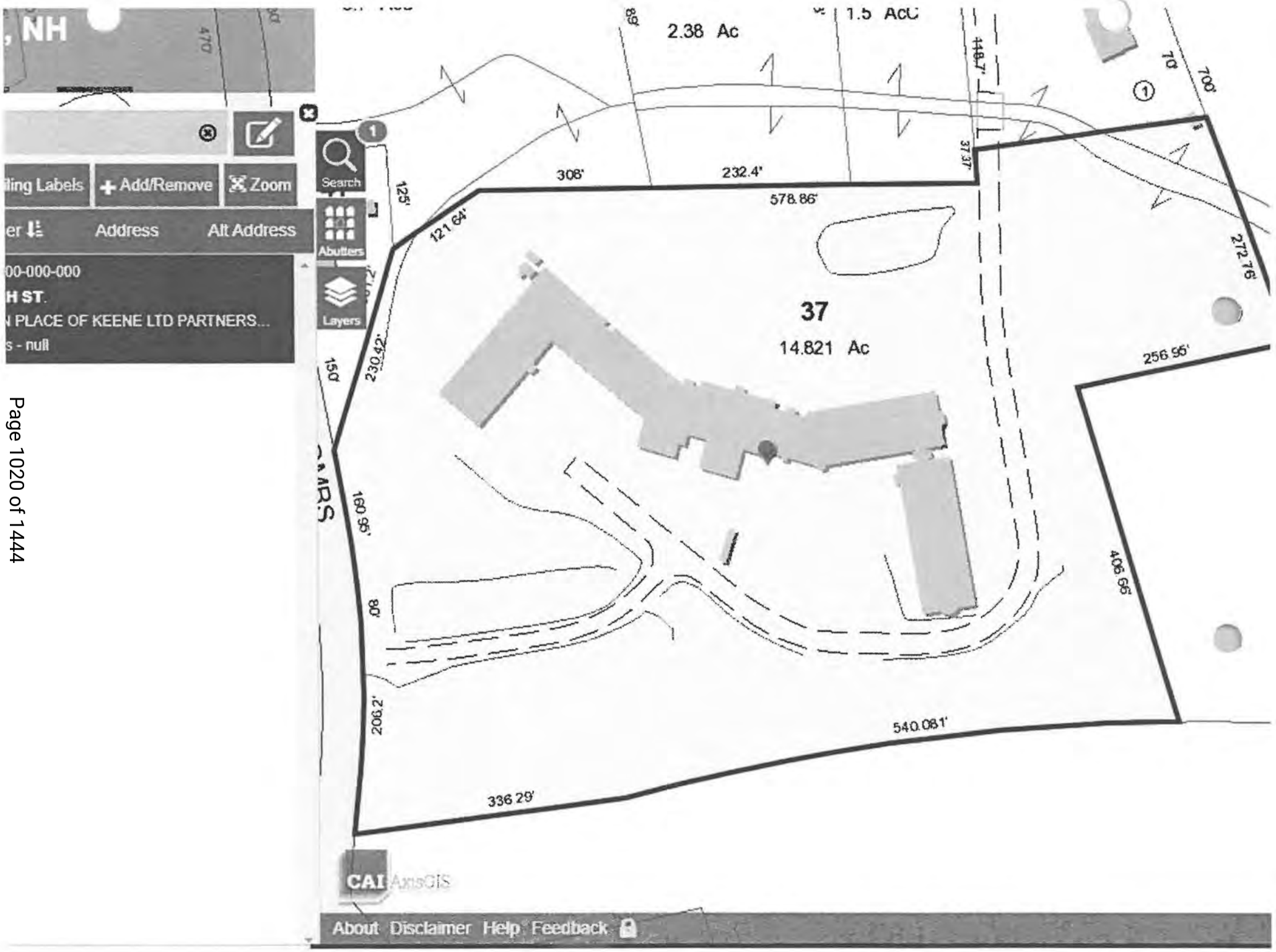
Medical Education Information

Type	Facility Name	Country	Year
Medical School	UNIVERSITY OF TEXAS, DALLAS TX	US	1999
Internship	JOHN PETER SMITH HOSP, FORT WORTH TX		2000
Residency	JOHN PETER SMITH HOSP, FORT WORTH TX		2002

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.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Layers
2.38 Ac
1.5 Acc
37
14.821 Ac
308'
232.4'
578.86'
121.64'
125'
230.42'
150'
160.96'
206.2'
336.29'
540.081'
406.66'
256.95'
272.76'
700'
70'
37.37'
CAI AxisGIS
About Disclaimer Help Feedback

Genesis Langdon Place of Keene Security Plan

Genesis Langdon Place of Keene security measures include lighting in all parking lots, surrounding the building, and at all entrances. The entrances on the ground floor stairwells in Buildings A, B, C and D are locked at all times. Entrance doors are locked by nursing personnel at 8:00pm. All exterior doors to the building are locked by except the front main entrance remain locked, with the maintenance door to the rear of the building being controlled by a key code pad. The code is changed periodically as needed. The main front door to the building is locked daily at 6pm and unlocked at 6am.

All privileged patient information is kept according to HIPAA guidelines. This included both written and electronic medical records.

All staff members will be issues a photo ID badge upon hire. Staff are required to wear badges while on duty. All visitors to the center will screen in using our Advanced Entry System that will screen them for COVID symptoms prior to authorizing their visit. They will also receive a visitor sticker with their photo once the screening process has been completed and approved for a visit. Vendors are also screened per the same process as visitors and are required to COVID test if they are unvaccinated.

All staff sign agreements upon hire acknowledging weapons, drugs, or alcohol are not allowed on the property.

The center utilizes a secure care system to ensure resident safety on the memory care unit and nursing care unit. Resident's elopement wander guards are in place of high risk residents

Submitted with this Security Plan is the Langdon Place of Keene Emergency Preparedness Plan.

SECURITY PLAN

This center has established a security plan to help protect the safety of residents/patients, staff, and visitors.

1. Exterior building security
    a. This center has a schedule for locking/unlocking of exterior doors during nighttime hours, including persons responsible; and
    b. This center follows a schedule to inspect outdoor lighting adequacy.
2. Interior building security
    a. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection.
    b. This center's security plan includes a schedule to inspect indoor lighting adequacy.
    c. The center's plan also contemplates resident-specific security needs, including:
        i. Security measures for special units;
        ii. Risk for resident elopement;
        iii. Use of Electronic alarms systems; and
        iv. Communication call bells.
3. Administrative controls for security
    a. The center follows the communications protocols established in Section V of this plan as needed to address security issues.
    b. The center's security plan describes the check-in procedures for visitors.

Refer to Appendix 20: Security Plan

Lighting Evaluation: When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting and remove brush or debris to eliminate shadowed areas.

Interior Building Security:

Describe what the center has in place for stairwell protection (if applicable). Included in the description may be door security alarms/keypads, persons responsible for updating/changing entry codes, CCTV cameras and how the system is monitored, or other systems used for stairwell protection.

The entrances on the ground floor stairwells in Buildings A, B, C and D are locked at all times. Entrance doors are locked by nursing personnel at 8:00pm. Staff should check stairwells. All exit doors are alarmed and will page nursing staff after 8:00pm. All staff receive orientation and inservice on these procedures. Maintenance is responsible for this education.

Lighting Adequacy- When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting to eliminate shadowed or dark areas.

Describe the check-in procedures for visitors and how identification badges for employees and/or visitors being used.

All staff members will be issues a photo ID badge upon hire. Staff are required to wear badges while on duty. All visitos to the center will screen in using our Advanced Entry System that will screen them for COVID symptoms prior to authorizing their visit. They will also receive a visitor sticker with their photo once the screening process has been completed and approved for a visit. Vendors are also screened per the same process as visitors and are required to COVID test if they are unvaccinated.

Describe how the following are used for Resident-Specific Security:

- Security measures for special units: The center utilizes a secure care system to ensure resident safety on the memory care unit and nursing care unit.
- Resident Elopement Wander Guards: Residents elopement wanderguards are in place of high risk residents
- Electronic alarms systems such as door alarms: All doors are alarmed in the building after 8:00pm. When a door is open a page will alert the staff on SRC as to the door location and staff are to respond.
- Communication call bells: All staff have access to two way radios for communication
- Visitor Log Protocol: All visitos to the center will screen in using our Advanced Entry System that will screen them for COVID symptoms prior to authorizing their visit. They will also receive a visitor sticker with their photo once the screening process has been completed and approved for a visit. Vendors are also screened per the same process as visitors and are required to COVID test if they are unvaccinated.

MENU

Tasks in Use

Print List

Search for :. All task types

Weekly

Category	Title	Assigned To			
Generators	**Exercise generator (with no load), perform routine checks, create entry in logbook.**		Regulatory	Logs	Maintenance
Resident Wandering System	**Check operation of door monitors and patient wandering system.**		Regulatory	Logs	Maintenance
Water Systems	**Inspect eye wash stations.**		Regulatory	Maintenance	
Water Temps	**Test and log the hot water temperatures.**		Regulatory	Logs	Maintenance
Laundry Inspection	**Check dryer**		Maintenance		
Oxygen Concentrators	**In-House Maintenance**		Maintenance		
Resident Lifts	**Weekly Lift Rounds/Clinical Check-In**		Maintenance		

Monthly

Category	Title	Assigned To			
Defibrillators (AED)	**In-House Maintenance**		Regulatory	Maintenance	
Elevators	**Firefighters' Emergency Operation Testing**		Regulatory	Maintenance	
Emergency and Exit Lighting	**Conduct a 30 second functional test.**		Regulatory	Logs	Maintenance
Fire Extinguishers	**Check and initial fire extinguishers**		Regulatory	Maintenance	
Generators	**Test generator under load, perform routine checks, create entry in logbook - Diesel**		Regulatory	Logs	Maintenance
Kitchen Exhaust Hoods	**Owner's Inspection - Quick Check**		Regulatory	Maintenance	
Magnetic Exit Locks	**Test operation of doors and locks.**		Regulatory	Logs	Maintenance
Resident Lifts	**Inspect mobile lifts.**		Regulatory	Maintenance	
Exhaust Fans	**Inspect exhaust fans for proper operation and clean if necessary**		Maintenance		
Facility Inspection	**Inspect kitchen small appliances**		Maintenance		
Resident Scales	**Check calibration of resident scales**		Maintenance		

Every 2 Months

Category	Title	Assigned To	
Grease Traps	**Inspect grease trap** Next due: February 2023		Maintenance

Every 3 Months

Category	Title	Assigned To				
Dryer Vent	**Complete In-House System Cleaning** Next due: January 2023		Regulatory			Maintenance
Emergency and Exit Lighting	**Conduct a 90 minute operational test** Next due: February 2023		Regulatory		Logs	Maintenance
Fire Drills	**Perform a fire drill during 1st shift- (Upload copy of drill with signature sheet to TELS when complete)** Next due: March 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 2nd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: January 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Drills	**Perform a fire drill during 3rd shift - (Upload copy of drill with signature sheet to TELS when complete)** Next due: February 2023		Regulatory	Requires Doc	Logs	Maintenance
Fire Sprinkler System	**Have fire sprinkler system certified/inspected.** Next due: January 2023		Regulatory	Requires Doc		Maintenance
Ice Machines	**Check filters (if present), clean coils, sanitize interior, delime as necessary** Next due: February 2023		Maintenance			
Rooftop Inspections	**Regular maintenance and safety inspection.** Next due: January 2023		Maintenance			

Every 6 Months

Category	Title	Assigned To			
Disaster Drills	**Conduct a Facility-based exercise (Disaster Drill)** Next due: June 2023		Regulatory	Requires Doc	Maintenance
Emergency Preparedness Drills	**Conduct elopement drill (Missing Resident Drill)**		Regulatory	Requires Doc	Logs Maintenance

	Next due: February 2023				
Facility Safety	**Life Safety Documentation Audit** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Fire Alarm Test	**Have fire alarm system inspected by a contractor** Next due: April 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have Fire Suppression System inspected by outside contractor** Next due: March 2023		Regulatory	Requires Doc	Maintenance
Kitchen Exhaust Hoods	**Have hood cleaned by a certified contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Nurse Call System Test	**Conduct a test of the nurse call system.** Next due: March 2023		Regulatory	Logs	Maintenance

Every 12 Months

Category	Title	Assigned To			
Beds - Electric	**Bed Safety Audit 001-040 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 041-080 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Beds - Electric	**Bed Safety Audit 081-120 beds** Next due: November 2023		Regulatory	Logs	Maintenance
Electrical	**Test and Document the Electrical Receptacle Inspections** Next due: September 2023		Regulatory	Requires Doc	Maintenance
Elevators	**Schedule certification and ensure certificate in unit is up-to-date** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Complete Risk Assessment - Click Instructions for the Assessment Tool and Procedure** Next due: February 2023		Regulatory	Requires Doc	Maintenance
Facility Safety	**Inspect all facility window openings*** Next due: April 2023		Regulatory	Logs	Maintenance
Fire Extinguishers	**Have fire extinguishers certified.** Next due: July 2023		Regulatory	Requires Doc	Maintenance
Fire and Smoke Doors	**Inspection - Latch and Gap** Next due: June 2023		Regulatory	Logs	Maintenance
Generators	**Have generator serviced by contractor** Next due: January 2023		Regulatory	Requires Doc	Maintenance
Water Systems	**Complete training on Water Management Plan**		Regulatory	Maintenance	

	Review – Click on instructions Next due: December 2023	
Water Systems	**Water Management Plan Review - Upload your plan to TELS** Next due: November 2023	Regulatory Requires Doc Maintenance
HVAC - Air Handlers	**Inspect air filter, verify operation** Next due: October 2023	Maintenance
HVAC: Condensing Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
HVAC: Package Units	**Clean / change air filter and verify unit operation** Next due: October 2023	Maintenance
HVAC: Package Units	**Inspect condenser coils; clean as necessary** Next due: April 2023	Maintenance
Resident Lifts	**Genesis Safe Handling Center Assessment - Lift Program** Next due: August 2023	Logs Maintenance
Safety Committee	**Conduct April Safety Committee Meeting** Next due: April 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct August Safety Committee Meeting** Next due: August 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct December Safety Committee Meeting** Next due: December 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct February Safety Committee Meeting** Next due: February 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct January Safety Committee Meeting** Next due: January 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct July Safety Committee Meeting** Next due: July 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct June Safety Committee Meeting** Next due: June 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct March Safety Committee Meeting** Next due: March 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct May Safety Committee Meeting** Next due: May 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct November Safety Committee Meeting** Next due: November 2023	Loss Prevention Requires Doc Maintenance
Safety Committee	**Conduct October Safety Committee Meeting** Next due: October 2023	Loss Prevention Requires Doc Maintenance

Safety Committee	**Conduct September Safety Committee Meeting** Next due: September 2023		Loss Prevention	Requires Doc	Maintenance
TELS Masters Training	**TELS Offers Free Trainings - See instructions for further assistance** Next due: November 2023		Maintenance		
Vital Signs Monitors	**Unit Recalibration** Next due: August 2023		Maintenance		

Every 36 Months

Category	Title	Assigned To			
Emergency Generators	**Conduct a 4 hour Load test** Next due: November 2025		Regulatory	Requires Doc	Maintenance

Every 48 Months

Category	Title	Assigned To			
Facility Safety	**Inspection and Testing - Fire Dampers and Smoke Dampers** Next due: November 2025		Regulatory	Requires Doc	Maintenance

Genesis Healthcare Annual Mandatory Training

- Module 1 - Understanding the World of Dementia: The Person and the Disease
- Module 2 - Being with a Person with Dementia: Listening and Speaking
- Module 3 - Being with a Person with Dementia: Actions and Reactions
- Active Shooter in Long Term Care
- Residents' Bill of Rights & Staffs' Responsibilities
- Electrical Safety & Work-Related Practices 1
- Electrical Safety & Work-Related Practices 2
- Hazardous Communication
- Fire Safety
- Bloodborne Pathogens - BBP & PPE
- Elopement
- Access to Exposure & Medical Records
- Tuberculosis
- Infection Prevention and Control Overview
- Musculoskeletal Disorder Prevention
- Abuse Prohibition
- Respiratory Protection Training - Training on the use of Respirators
- Welcoming Program Centers Completion
- 2022/2023 Code of Conduct - All Staff
- GHC Emergency Preparedness Plan

Nurse Aide (CNA/LNA) Orientation Checklist

Employee Name:	Orientation Start Date"
Mentor Name:	Shift:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire.
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____

Date Checklist Completed: _____

CENTER TOUR & GENERAL INFORMATION	
Office Locations: • Scheduler • Director of Nursing • Center Administrator	• Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) • Unit Manager, Nursing Supervisor • Human Resources
Nursing Unit(s)	
Assigned Unit Introduction/Tour	
Bed Location Identification (door/window)	
Location of AED/crash cart *By DAY 1 Orientation*	
Telephones: • Locations • Use & Paging Demonstration • Phone Directory	
Wandering System: • Location(s) • Demonstration & Code • Location of Elopement Book • Center Elopement Protocol	
Emergency Door Alarms (Codes)	
Location of Personal Protective Equipment (PPE)	
POLICY & PROCEDURE HIGHLIGHTS	
Communication	
Nurse to CNA Shift Report STOP AND WATCH (Early Warning Tool) CNA Assignment/Tasks	VItal Signs Weights Kardex
Safe Resident Handling	

Nurse Aide (CNA/LNA) Orientation Checklist

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Demonstration; *Specific to Center Type*
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Resident with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Resident Off the Floor S/P Fall**

Bed Rail Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Nurse evaluates need for bed rail
- If the bed rail is NOT indicated, the rail will be removed or secured in the DOWN position by maintenance
- Kardex indicating the use of the bed rail
- Immediately report any bed rail incidents

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based (Isolation) Precautions
- Respirator Fit Testing
- COVID protocols

Skin Health & Pressure Injury Prevention

- **Pressure Injury (Ulcer/Bed Sore) Prevention is a PRIORITY!**
- **Prompt Identification, Reporting and Interventions are Essential!**
  - Promptly report skin changes, skin concerns, or new/worsening wounds to the nurse supervisor
  - Promptly report interventions that are not working as intended or are missing &/or need replacement (e.g., heel lift boots, specialty surfaces)
  - Seek direction before using/applying any new intervention (e.g., heel lift boot)
- Refer to Kardex for:
  - Heel positioning devices/techniques/schedules
  - Turning/Repositioning devices/techniques/schedule
  - Skin care/incontinence care products & strategies
  - Seating devices (e.g. cushions, chairs)
  - Other individualized pressure injury prevention efforts

Elopement

- Resident Leaves the Premises Without Authorization
- Wandering Device use
- Report elopement behaviors to Nurse

Falls Management

- Center Process for Communicating High Risk Residents
- **Immediately Report Any Fall**
- Licensed Nurse evaluation required prior to moving the resident who had a fall
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a patient Off the Floor after Fall**

Nurse Aide (CNA/LNA) Orientation Checklist

Nutrition/Hydration:	
• Thick Liquid (Dysphagia)/NPO Status Communication • Diet Orders/Consistency	• • Validation of Diet Order Prior to Serving

Current Center Survey Plan of Correction
• Review, if applicable

ADL Documentation *(**Utilize SmartZone Application within PointClickCare as indicated)*
Complete Point of Care (POC) course - ***By Day 1 SmartZone****
• Review Center's process for documentation
• Review tub/shower schedule & documentation

Restorative Nursing
• Identifying Patients with Restorative Nursing Program (Kardex)
• Review Center's process for documentation (paper or electronic)

Patient Care Needs
• Inventory of Effects
• Patient Supplies (e.g. Basin, Urinal, etc.)
• Assistive Devices (eg. Walker, Wheelchair)
• Incontinence Products
• Special Care Needs: Tracheostomy, Dialysis, Ventilator, Infusion Devices, Enteral Feeding Devices, Oxygen/Respiratory Therapy

OTHER
OTHER
OTHER
OTHER
OTHER
OTHER
OTHER

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

Employee Name:	Orientation Start Date:
Employee Job Title:	Mentor Name/Title:

Instructions:

1. The *Orientation Checklist* is to be maintained by the new employee. The assigned mentor and new employee will complete the listed learning objectives by Day 3 of hire..
2. The new employee signs/dates the completed checklist. The original signed *Checklist* is to be returned to the Nurse Manager/Shift Supervisor or designee.

Employee Signature:_____ Date Completed: _____

CENTER TOUR & GENERAL INFORMATION	
Office Locations: • Scheduler • Director of Nursing • Center Administrator • Human Resources	• Assistant Director of Nursing (ADON)/ Nurse Practice Educator (NPE) • Unit Manager, Nursing Supervisor • Central Supply • Other
Nursing Unit(s) (e.g., names of units, locations, secured/unsecured, etc.)	
Assigned Unit Introduction/Tour (e.g., medication room, utility rooms, kitchenette, etc.)	
Bed Location Identification (door/window)	
Location of AED/crash cart *By DAY 1 Orientation*	
Location of Omnicell and/or Emergency Drug Kit	
Telephones: • Phone Directory(s)	• Use & Paging Demonstration
Wandering System: • Location(s) • Demonstration & Entry/Reset Code	• Location of Elopement Book • Center Elopement Protocol
Emergency Door Alarms (Codes)	
Location of Personal Protective Equipment (PPE) / Clinical Supplies	
POLICY & PROCEDURE HIGHLIGHTS	
Cardiac &/or Respiratory Arrest – *Must Be Completed By DAY 1 Orientation*	
• Location of Code Status Orders	• Center Process for Emergencies / Code
Communication	
Nurse to Nurse - Nursing Shift Report Nurse to CNA Shift Report STOP AND WATCH/Early Warning Tool CNA Assignment/Tasks	24 Hour Report Kardex Provider Notifications Patient/Patient Representative Notifications
Incident & Accident Reporting	

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

- PCC Risk Management Portal
- Event Completed for Any Patient Accident/Incident or Grievance/Concern
- Nursing Supervisor Notified of Any Accident/Incident
- Physician/Patient Representative Notification

Safe Resident Handling

- **Lift equipment requires two (2) staff members**
- Safe Resident Handling = Lift & Turning & Positioning
- Lift Transfer Reposition UDA
- Lift Demonstration; Specific to Center Equipment Brand
- Location of Lifts, Slings, Gait Belts, & Repositioning Devices
- *Safe Resident Handling Skills Checklist(s)* Must Be Completed Prior to Transferring a Patient with a Lift
- **Total Lift Full Body Sling & Two (2) Staff Must Be Used to Lift a Patient Off the Floor S/P Fall**

Bed Safety

- Bed Rails will **ONLY** be used as mobility enablers
- Bed Rail Evaluation (UDA): completed upon admission, readmission, quarterly, change in bed/mattress, & change in condition
- If the bed rail is NOT indicated, the rail must be removed or secured in the DOWN position by maintenance
- Requirements for bed rail use:
  - Utilize Bed Action Safety Grid to identify & minimize any zones of entrapment
  - Consent & physician order
  - Care Plan & Kardex indicating use of the bed rail

Infection Prevention & Control / COVID-19

- Hand Hygiene
- Donning & Doffing PPE
- Transmission Based Precautions
- Antibiotic Stewardship
- Immunizations
- Respirator Fit Testing
- COVID Screening
- Cleaning and Disinfection
- Outbreak Management

Skin Health & Pressure Injury Prevention

- **Pressure Injury Prevention is a PRIORITY**
- **Skin Check** UDA admission & weekly
- **Braden** (or Norton Plus): admission, weekly x 4, quarterly, & with change in condition
- At Risk & Actual **CP & Kardex** initiated upon admission (no later than 24 hours after admission)
- Review **Guidelines** (Surfaces, Skin Care, Turning/positioning, Heels, Skin, Wound)
- Weekly Wound Evaluation (SWIFT)
- **Prompt Identification, Reporting & Interventions Essential**
- **Promptly** observe & respond to any reports of skin/wound concerns by CNA or others
- **New Wound:** complete Change in Condition UDA, wound evaluation, notify provider/RP, update care plan, & obtain treatment order
- **PCC Risk Portal:** Completed for all new IHA pressure injuries

Elopement

- Patient Leaves the Premises Without Authorization
- Wandering Device Placement & Function Documentation Required
- PCC Risk Management Portal , Physician, Patient Representative, Administrator/Director of Nursing Notification, Preventive Intervention(s), Care Plan Updates

Falls Management

- Process for Communicating High Risk Patients
- **Immediately Report Any Fall**
- Nurse Evaluation Prior to Moving the Patient
- **Total Lift & (2) Staff Must Use Lift to upright Patient Off the Floor S/P Fall**
- Complete PCC Risk Management Portal for All Falls; Physician & Patient Representative Notification, Preventive Intervention(s), Care Plan updates
- **Neuro checks for ANY Fall Unwitnessed by Staff or Head/Facial Injury**

Neuro Checks Documented on Paper Flow Sheet

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

- Every 15 minutes x 2 hours, then
- Every 30 minutes x 2 hours, then
- Every 60 minutes x 4 hours, then
- Every 8 hours until least 72 hours has elapsed

Nutrition / Hydration

- Dysphagia/NPO Status communication process
- Diet Orders/Consistency
- Enteral Feeding: Administration / Pump
- *Diet Order Communication Form*
- Validation of Diet Order Prior to Serving

Controlled Substance Documentation

- New Orders for Schedule II-V Controlled Substances
- Delivery and Receipt of Controlled Substances
- Inventory of Controlled Substances
- Routine Reconciliation (e.g. Shift Count) of Controlled Substances
- Accessing Emergency Medications from eKit/Automated Medication Dispensing System (e.g. Omnicell)
- Disposal/Destruction of Expired or Discontinued Controlled Substances
- **Loss/Theft of Controlled Substances: Any Discrepancy Must Be Reported Immediately to Nursing Supervisor**

Notification of Patient Change in Condition

- eInteract Change in Condition UDA
- Print SBAR from Change in Condition UDA
- Complete PCC Risk Management Portal, if applicable
- Physician/Patient Representative Notification
- Changes in Orders or Treatment
- Transfer or Discharge
- STOP AND WATCH
- Clinical Dashboard Monitoring

Medication Administration *(**Utilize SmartZone Application within PointClickCare as indicated)*

Complete eMAR Order Supply Management course - ***By Day 1 SmartZone*****
Complete EMAR course - ***By Day 1 SmartZone*****
Complete Pharmacy Orders course - ***By Day 1 SmartZone*****

- Omnicell Access
- Medication Error Requires Physician & Patient Representative Notification
- Electronic Order Entry
- Medication Receiving
- EMAR Documentation
- 24 Hr. Chart Check
- Monthly Order Review
- Medication Not Available, Check Omnicell, Pharmacy & Physician Notification
- Medication Refusal Requires Physician Notification
- Behavior Monitoring Documentation
- Medication Disposal
- Omniview Medication Returning
- Omniview Resident Discharge
- Omniview Resident Leave of Absence

PointClickCare (PCC) *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Assessments Management course - ***By Day 1 SmartZone****
- Assessment and Progress Notes
- Document Manager
- UDA Schedule
- Dashboard
- Care Plan(s)
- Lab and Radiology

Admissions / Discharges *(**Utilize SmartZone Application within PointClickCare as indicated)*

- **Complete** Resident Entry course - ***By Day 1 SmartZone****
- Nursing Documentation UDA Upon Admission
- Bed Rail Evaluation UDA
- Skin Check UDA
- Discharge Documentation UDA and Discharge Transition Plan
- Omniview Patient Discharge
- Baseline Care Plan

Point of Care Testing

Licensed Nurse (RN/LPN/LVN) Orientation Checklist

• Finger Stick Glucose, Fecal Occult Blood, Hemoglobin, INR, Influenza, SARS antigen testing performed according to manufacturer instructions.
Infusion Therapy
• **Nurses Who Lack Infusion Experience Must Complete an Approved Infusion Education Program Prior to Caring for Patient with Infusion Devices** • **RN ONLY UPON HIRE:** May perform assessment and management of Short Peripheral Catheters and Midline/PICCs • IV Pumps
Respiratory Management
• Oxygen Administration. • Location of Oxygen/Respiratory Equipment. • CPAP / BiPAP / Tracheostomy Care • Respiratory Equipment: Supply Cleaning, Disinfection, Labeling/Replacement • Aerosol Generating Procedures
Current Center Survey Plan of Correction
Review, if applicable

OTHER
OTHER
OTHER
OTHER
OTHER

Genesis

2023 Mandatory Annual Training Quarterly Crosswalk

Quarter 1 2023 (Total Approximate Duration: 3 Hours 5 Minutes)

** Done in conjunction with skills/competency validation.

Topic	Regulating Body	Requirements / Regulation	Suggested Resources for Training	
			HealthStream	Policy/Procedure
Respiratory Protection	OSHA Life Safety	1910.134(k)	Duration: Approx. 10 minutes	Safety & Health
Infection Control and Prevention Efforts	Federal	§483.95 F945	Duration: Approx. 35 minutes	Infection Control
Importance of Hand Hygiene**	Federal	§483.95 F945	Duration: Approx. 25 minutes	Infection Control
Transmission-Based Precautions: Contact and Droplet	Federal	§483.95 F945	Duration: Approx. 15 minutes	Infection Control
NEW: Unconscious Bias *(all new hires within 60 days of hire)*	Genesis		Duration: Approx. 60 minutes	
NEW: Trauma Informed Care: Helping Traumatized Individuals Achieve Well-Being	Federal	§483.25 F699	Duration: Approx. 16 minutes	Center Operations

Quarter 2 2023 (Total Approximate Duration: 3 Hours 10 Minutes)

Topic	Regulating Body	Requirements / Regulation	Suggested Resources for Training

Mandatory training requirements published in this crosswalk are completed annually. Mandatory education topics vary by State. Refer to State Operations Manual for specifics. Centers must determine the amount and types of additional training necessary based on a facility assessment.

Rev. 11.2022

Genesis

			HealthStream	Policy/Procedure
Preventing Violence in the Workplace	OSHA		Duration: Approx. 30 minutes	Safety & Health
Understanding the Risks Posed by Bloodborne Pathogens	Federal OSHA	§483.95 F945 1910.1030(g)(2)(ii)(B)	Duration: Approx. 41 minutes	Safety & Health
Protecting Yourself with Personal Protective Equipment**	Federal OSHA	§483.95 F945 1910.1030(g)(2)(ii)(B)	Duration: Approx. 35 minutes	Safety & Health
Protecting the Rights of Residents	Federal	§483.95 F942	Duration: Approx. 30 minutes	Operations
Elopement (*in conjunction with elopement drill*)	Genesis	§483.12(b)(3) F607	Duration: Approx. 15 minutes	Operations
Protecting Residents for Assault and Abuse	Federal	§483.95 F943 §483.95 F947	Duration: Approx. 35 minutes	Operations

Quarter 3 2023 (Total Approximate Duration: 3 Hours 5 Minutes)				
Topic	**Regulating Body**	**Requirements / Regulation**	**Suggested Resources for Training**	
			HealthStream	**Policy / Procedure**
Understanding Alzheimer's Disease and Related Disorders: Managing Challenging Behaviors	Federal	§483.95 F947	Duration: Approx. 51 minutes	Nursing
Safe Resident Handling Program* ~ Mechanical Lift / Repositioning (*Direct Care Staff Only*)	Genesis		Duration: Approx. 45 minutes (clinical staff) / 10 minutes (non-clinical staff)	Nursing
Code of Conduct/Compliance Program (*includes*	Federal	§483.95 F946	Duration: Approx. 90 Minutes	Human Resources

Mandatory training requirements published in this crosswalk are completed annually. Mandatory education topics vary by State. Refer to State Operations Manual for specifics. Centers must determine the amount and types of additional training necessary based on a facility assessment.
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Genesis

Abuse/Neglect Reporting, Elder Justice Act, HIPAA, Patient Civil Rights)				Corporate

Quarter 4 2023 (Total Approximate Duration: ~2 Hours 50 Minutes)				
Topic	**Regulating Body**	**Requirements / Regulation**	**Suggested Resources for Training**	
			HealthStream	**Policy/Procedure**
Preventing Back Injury in Post-Acute Setting	OSHA		Duration: Approx. 20 minutes	Operations
Resident Restraints in the Post-Acute Setting	Federal	§483.12 F604	Duration: Approx. 25 minutes	Nursing
Behavioral Health	Federal	§483.95 F949	Duration: Approx. 20 minutes	Nursing
NEW: Cultural Competence: Providing Culturally Competent Care	Federal	§483.25 F699	Duration: Approx. 20 minutes	Center Operations
Emergency Preparedness for Post-Acute Organizations	Federal	§483.95 F949	Duration: Approx. 25 minutes	Corporate
Protecting Post-Acute Care Residents from Fire	OSHA	1910.157(g)(4)	Duration: Approx. 20 minutes	Safety & Health
Effective Communication Skills	Federal	§483.95 F941	Duration: Approx. 10 minutes	Human Resources
NDNQI Pressure Injury Training v8.0 (*Licensed Nurses Only*)	Genesis		Duration: Approx. 15 minutes	Nursing
Quality Assurance and Performance Improvement (QAPI) for Long Term Care	Federal	§483.95 F944	Duration: Approx. 15 minutes	Operations

Mandatory training requirements published in this crosswalk are completed annually. Mandatory education topics vary by State. Refer to State Operations Manual for specifics. Centers must determine the amount and types of additional training necessary based on a facility assessment.
Rev. 11.2022

Genesis

Other Required Education	Regulating Body	Rules of Participation	Suggested Resources for Training	
			HealthStream	Policy/Procedure
IT Security Training Awareness Program (*all new hires within 12 months of hire*)	Genesis		Duration: Approx.	Corporate

Mandatory training requirements published in this crosswalk are completed annually. Mandatory education topics vary by State. Refer to State Operations Manual for specifics. Centers must determine the amount and types of additional training necessary based on a facility assessment.
Rev. 11.2022

Langdon Place of Keene Health and Safety Plan

Please see attached Infection Control Policies and Procedures

1. Patient Placement in Transmission Based Precautions
2. Discontinuing Transmission Based Precautions
3. Droplet Precautions
4. Special Droplet and Contact Precautions
5. Standard Precautions
6. Respiratory and Hygiene/Cough Etiquette
7. Contact Precautions

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC306 Patient Placement in Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 2

POLICY

Transmission Based Precautions (Airborne Infection Isolation (AII), Contact, Droplet) will be implemented when indicated. The precautions should be the least restrictive possible for the patient. Personal Protective Equipment (PPE) will be readily available near the entrance to the patient's room.

Transmission Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission, more than one Transmission Based Precautions category may be required. Whether used singly or in combination, they must always be used in addition to Standard Precautions. The type of PPE and precautions used depends on the potential for exposure, route of transmission, and infectious organism/pathogen (or clinical syndrome if an organism is not yet identified).

PURPOSE

To prevent the transmission of infectious disease.

PROCESS

1. Notify the attending physician or Medical Director (in the absence of the attending physician) and the Infection Preventionist if there is reason to believe that an individual has an infectious disease.

2. Initiate Precautions (Standard plus Airborne Infection Isolation, Contact, or Droplet) as indicated. May utilize *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions* to guide choice of precautions. Post "STOP. Please see nurse before entering room." sign on door.

    2.1 Empirically initiate Transmission Based Precautions based on signs and symptoms that are consistent with a communicable disease.

        2.1.1 If laboratory tests confirm diagnosis, continue with precautions indicated.

        2.1.2 If test(s) results are negative, adjust or discontinue precautions as indicated.

3. Notify patient, family/health care decision maker, and all departments of precautions.

4. Instruct patient and visitors regarding Precautions and use of personal protective equipment (PPE) as indicated.

4.1 Patients on Transmission Based Precautions should remain in room except for medically necessary care.

5. Document in medical record:

5.1 Notification of physician;

5.2 Initiation of Precautions;

5.3 Notification of patient, family/health care decision maker, and departments;

5.4 Instructions to patient and visitors.

Refer to:

- *Airborne Infection Isolation Precautions policy*
- *Contact Precautions policy*
- *Droplet Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC302 Discontinuing Transmission Based Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 1

POLICY

Transmission Based Precautions will be discontinued when it has been determined that the risk of transmission of disease is over.

PURPOSE

To discontinue precautions when indicated.

PROCESS

1. Refer to *"Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions"* to evaluate the appropriateness of discontinuing Precautions.

2. When appropriate duration criteria has been met, consult with Infection Preventionist or Director of Nursing to consider the discontinuation of Precautions.

3. When discontinuation of Transmission Based Precautions is appropriate:

   3.1 Notify all departments;

   3.2 Instruct patient and visitors that Precautions are no longer needed;

   3.3 Return patient to his/her room if a move to a separate room occurred, if indicated;

   3.4 Inform the Environmental Services Department to perform discharge/turnover cleaning;

   3.5 Remove "STOP" signs once discharge/turnover cleaning is complete.

4. Document:

   4.1 Discontinuation of Precautions;

   4.2 Instruction of patient and visitors;

   4.3 Room change, if indicated.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC303 Droplet Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/20
PAGE:	1 of 3

POLICY

Droplet Precautions will be followed in addition to Standard Precautions when caring for a patient who has known or suspected infection by microorganisms that are transmitted by droplets (large particle droplets, larger than 5 µm in size); for example, influenza. State regulations will be followed when applicable.

PURPOSE

To prevent transmission of infectious agents by droplets.

PROCESS

1. Place patient in private room, if possible.

    1.1 Patient may cohort with an individual who has the same organism.

        1.1.1 Avoid placing immunocompromised patients with patients who are on Droplet Precautions.

    1.2 When neither private room nor cohorting is possible, patient may share a room with a roommate with limited risk factors. Maintain spatial separation of at least three feet between the infected individual and others, including other patients and visitors.

    1.3 Draw curtain between patient beds.

    1.4 Special air handling is not necessary.

    1.5 May keep door to room open.

2. Post a "STOP. Please see nurse before entering room." sign on door.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and use of personal protective equipment (PPE).

4. Staff will put on surgical mask upon entry to room of infected individual. Handle items contaminated with respiratory secretions (e.g., tissues) with gloves.

    4.1 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles/face shield should be worn.

4.2 Change personal protective equipment and perform hand hygiene between contact with patients in the same room.

4.3 If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.

4.4 Before exiting room, remove and bag PPE and wash hands.

4.4.1 Remove bagged PPE from room and discard in soiled utility.

5. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/containment of infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

5.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

5.2 For patients being transported outside of the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

6. Dedicate personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

6.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *COVID-19 policy*

- *Respiratory Hygiene/Cough Etiquette procedure*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC310 Special Droplet and Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	12/07/22
REVIEW DATE:	
REVISION DATE:	
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POLICY

Special Droplet and Contact Precautions will be used to prevent transmission of infectious organisms that can be spread via pathogens that spread through the air or by direct person-to-person respiratory transmission. An example of a disease requiring special droplet and contact precautions is SARS-CoV-2. State regulations will be followed, when applicable.

PURPOSE

To prevent the spread of infectious agents.

PROCESS

1. Display Special Droplet/Contact Precautions sign outside the patient/resident (hereinafter "patient") room on the door.

2. Keep the patient's door to the room closed unless doing so would endanger the patient.

3. Instruct patients and visitors regarding the precautions in use and the required personal protective equipment (PPE).

    3.1 Have the patient wear a surgical mask anytime staff is in the room.

4. Wear proper PPE including respiratory protection (N95 respirator), eye protection, gown, and gloves prior to entering the room of those who require Special Droplet and Contact Precautions.

    4.1 Before exiting the room, remove gown and gloves and bag PPE and perform hand hygiene. Once outside of the room, remove and clean eye protection. Discard N95, perform hand hygiene, and don a new mask.

    4.2 Remove bagged PPE from the room and discard it in the soiled utility.

5. Limit transport of patients to essential medical purposes. If transport out of the room is necessary:

    5.1 Place a surgical mask on the patient and instruct them to observe respiratory hygiene and cough etiquette;

    5.2 Transport personnel need to wear a surgical facemask during transport if the patient is masked.

5.2.1 If the patient is not masked, transport personnel need to wear an N-95 respirator;

5.3 Notify the receiving location of precautions.

6. Dedicate use of personal care equipment (thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment, when available.

7. If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

7.1 Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. The duration of these transmission-based precautions will be determined per Centers for Disease Prevention & Control (CDC) guidance for discontinuing precautions for persons with COVID.

Refer to:

- *COVID-19 policy*
- *Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions*
- *Cleaning and Disinfecting policy*
- *Safety and Health Policies and Procedures:*
  - *Personal Protective Equipment policy*
  - *Respiratory Protection Program policy*

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC307 Standard Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/21
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POLICY

All blood and body fluids are considered potentially infectious and, therefore, Standard Precautions are always used when providing patient/resident (hereinafter "patient") care.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Perform hand hygiene per *Hand Hygiene* policy.
2. Wear gloves whenever exposure to any of the following is planned or anticipated:
   - 2.1 Blood, blood products, and other potentially infectious materials (all body fluids including urine, feces, saliva) except sweat;
   - 2.2 Mucous membranes;
   - 2.3 Wound drainage;
   - 2.4 Drainage tubes;
   - 2.5 Non-intact skin;
   - 2.6 Potentially contaminated intact skin (i.e., patient incontinent of stool or urine).
3. Change gloves:
   - 3.1 Between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms;
   - 3.2 After contact with patient and/or surrounding environment (including medical equipment);
   - 3.3 During patient care if hands move from contaminated body site to clean body site.
4. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.

5. Wear mask, eye protection, and face shield during procedures/care that are likely to generate droplets/splashing/spraying of blood/body fluids/secretions or excretions.

    5.1 During aerosol generating procedures (i.e., suctioning of respiratory tract) if patients not suspected of being infected with an organism for which respiratory protection is otherwise recommended (i.e., TB, influenza).

    5.2 Wear face mask if in contact (i.e., within three feet) with a patient with a new, acute cough or symptoms of a respiratory infection (i.e., influenza-like illness).

6. Wear gowns:

    6.1 During procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

    6.2 Remove gown and perform hand hygiene before leaving the patient's environment..

7. Prevent transmission of microorganisms from used equipment.

    7.1 Wear gloves and PPE as needed when handling used equipment soiled with blood and/or body fluids.

    7.2 Do not use reusable equipment for the care of another individual until it has been cleaned and disinfected appropriately.

        7.2.1 Disposable equipment may be used when available.

    7.3 Discard single use items promptly.

8. Before exiting room, remove and bag PPE and perform hand hygiene.

    8.1 Remove bagged PPE from room and discard.

9. Provide routine cleaning and disinfection of environmental surfaces, beds, bed rails, bedside equipment, and other frequently touched surfaces.

10. Handle, transport, and process used linen soiled with blood and/or body fluid in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other individuals and the environment.

11. Follow Sharps safety (refer to *Safety and Health Policies and Procedures, Needle Handling and Sharps Injury Prevention* policy).

12. Follow respiratory hygiene/cough etiquette.

13. Use protective mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is possible.

14. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions, or wound drainage in a single patient room, when available).

15. **Safe Injection Practices:**

    15.1 Use aseptic technique to avoid contamination of sterile injection equipment.

    15.2 Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single use items. They should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

    15.3 Use fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion or administration set.

    15.4 Use single dose vials for parenteral medications whenever possible.

    15.5 Do not administer medications from single dose vials or ampules to multiple patients or combine leftover contents for later use.

    15.6 If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.

    15.7 Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

    15.8 Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC307 Standard Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/22
REVISION DATE:	11/15/21
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Refer to:

- *Hand Hygiene policy*
- *Linen Handling policy*
- *Cleaning and Disinfecting policy*
- *Respiratory Hygiene/Cough Etiquette procedure*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures:*
  - *Needle Handling and Sharps Injury Prevention policy*
  - *Personal Protective Equipment policy*

Genesis

PROCEDURE:

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Post signs at entrances instructing patients/residents (hereinafter "patients") who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection and to practice Respiratory Hygiene/Cough Etiquette. Refer to CDC for examples of signage.

2. **Respiratory Hygiene/Cough Etiquette**:

   2.1 Individuals who have signs and symptoms of a respiratory infection (cough, congestion, runny nose, or increased production of respiratory secretions) should:

      2.1.1 Cover the nose and mouth with a tissue when coughing or sneezing.

      2.1.2 Use tissues to contain respiratory secretions. Dispose of used tissues in a waste receptacle.

      2.1.3 Perform hand hygiene after contact with mucus and contaminated objects. Hand hygiene consists of:

         2.1.3.1. Hand washing with plain soap and water, OR

         2.1.3.2. Using alcohol based hand rub.

3. **Masking and Separation of Persons who have Respiratory Symptoms:**

   3.1 Offer masks to persons who are coughing, when tolerated and appropriate. Masks with ear loops or with ties may be used to contain respiratory secretions.

   3.2 Encourage persons with a respiratory infection to maintain separation of least three feet away from others.

4. **Droplet Precautions:**

   4.1 Health care personnel should observe Droplet Precautions when examining or caring for a patient who has symptoms of a respiratory infection.

      4.1.1 These Precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

   4.2 Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a surgical mask must be worn while providing patient care.

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC301 Contact Precautions
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/22
REVISION DATE:	10/24/22
PAGE:	1 of 3

POLICY

In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the resident/patient (hereinafter "patient") or the patient's environment (e.g., C. *difficile*, norovirus, scabies). State regulations will be followed when applicable.

Contact Precautions should also be used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. For patients colonized with multi-drug resistant organisms, refer to *Modified Enhanced Barrier Precautions* policy.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Place patient in private room, if possible.
    - 1.1 Patient may cohort with an individual who has the same organism.
    - 1.2 Do **not** place colonized or infected patient with another patient who has:
        - 1.2.1 A different multi-drug resistant organism;
        - 1.2.2 An invasive device such as a port, IV line, track, or indwelling bladder catheter;
        - 1.2.3 A recent post-operative wound;
        - 1.2.4 Open wound(s) (including pressure injury);
        - 1.2.5 Severe immunosuppression (e.g., cancer, HIV, etc.).
2. Place a "STOP. Please see nurse before entering room." sign on door.
    - 2.1 Print Precautions sign in color or order from Smartworks.

3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and the use of personal protective equipment (PPE).

4. Staff must use barrier precautions before or upon entering the room. PPE must be worn before contact with the patient or the patient's environment

   4.1 Wear gown and gloves.

   4.2 Wear eye protection if splashing of infectious material is likely.

   4.3 Change gloves and gowns during care if gloves/gowns come in direct contact with infectious material.

   4.4 Change gown and gloves, and perform hand hygiene before providing care to other patient in the room.

   4.5 Before exiting room, remove and bag gown and gloves and wash hands upon exiting room.

      4.5.1 Remove bagged PPE from room and discard in soiled utility.

      4.5.2 Wash hands.

5. Dedicate personal care equipment (e.g., thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.

   5.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.

6. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/ containment of .infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.

   6.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

   6.2 For patients being transported outside the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).

8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Multi-Drug Resistant Organisms (MDROs) policy*
- *Modified Enhanced Barrier Precautions policy*
- *Appendix A: Type and Duration of Precautions Needed for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*

Center Emergency Preparedness Plan (EPP) 2022/2023

Center Name: Langdon Place of Keene
Address: 136A Arch Street, Keene, NH 03431
Phone Number: 603-357-3902

This document outlines the center's integrated approach to emergency preparedness. When appropriate, the center team contacts local emergency response services officials and other healthcare providers, to participate in collaborative and cooperative planning efforts. This Emergency Preparedness Plan is reviewed and updated annually, and on an as-needed basis.

IMPORTANT NOTE: After this document has been reviewed completed by the center Emergency Preparedness Leadership Team, it must be saved electronically on Central and printed and stored in multiple, unlocked locations that may be accessed by center staff.

SAFETY PHILOSOPHY

This center is committed to operating in a manner that promotes the safety, health, and well-being of our staff while providing the quality care to all of our customers. We strive to continually develop, promote, and enforce safe work practices and provide a healthful working environment consistent with established federal, state, and accreditation requirements. This center encourages team cooperation and collaboration with local, tribal, regional, state and/or federal emergency preparedness officials to participate in an integrated response during disaster and emergency situations.

Information contained in the Emergency Preparedness Plan (the "Plan") is based on available best practices. The Plan has been prepared as guidance for emergency response and crisis management. It cannot be assumed that the Plan takes into consideration all potential events, scenarios, and/or circumstances. As a result, the Plan is designed to be flexible based on the specific and unique circumstances, conditions, and/or events related to any emergency situation. Notably, while the Plan has been developed consistent with legal authority, the experiences and judgments of those responsible for local leadership and implementation of the Plan will determine how best to utilize it in an emergency situation. This center does not make any guarantees or representations related to the absolute sufficiency and comprehensiveness of the Plan, and notes that additional information/steps may be required in the event of an actual emergency.

Throughout this document, the terms "disaster" and "emergency" are used. Emergency is defined as a serious, unexpected, and often dangerous situation requiring immediate action; disaster is a sudden event, such as an accident or a natural catastrophe, that may cause great damage or loss of life. This Plan is written to address both types of events. The term "staff" is also used, to reference center employees, contract personnel, regularly scheduled volunteers and medical professionals that provide service to center residents and patients.

In the event of a public health crisis such as the coronavirus ("COVID-19") outbreak, policies and procedures may be temporarily modified or adjusted to align with Company and facility needs and/or directives issued by federal, state, local health care, and/or regulatory authorities. These modifications may be communicated either through Company notices or other communications

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EPP GENERAL STATEMENT/PURPOSE

THE PURPOSE OF THIS PLAN IS TO PROVIDE GUIDELINES FOR THE CENTER TO:

1. Respond effectively during disasters/emergencies;
2. Reduce human vulnerability to adverse effects of the disaster or emergency;
3. Reduce environmental and structural vulnerability to adverse effects of the disaster/emergency;
4. Provide care and services to the center's residents/patients during an emergency and/or an evacuation;
5. Identify staff responsibilities during an emergency;
6. Provide timely and effective communication;
7. Provide for recovery after the emergency.
8. Comply with relevant legal authority and guidance including but not limited to: Life Safety Codes, OSHA's Employee Emergency Action Plans (29 CFR 1910.38), CMS guidelines, elements of the Nursing Home Incident Command System (NHICS), and any pertinent state/local requirements.

SCOPE OF PLAN

THIS CENTER HAS THE POTENTIAL OF BEING AFFECTED BY, BUT NOT LIMITED TO, THE FOLLOWING EMERGENCIES:

1. Threats to security;
2. Utility failures;
3. Weather conditions;
4. Structural damage from fires or explosions;
5. Chemical spills;
6. Community disasters; and
7. Community, regional, national or global infectious disease outbreaks.

THESE SITUATIONS MAY REQUIRE:

1. Suspension of routine processes (further described below);
2. Center employees performing non-routine tasks should understand the task completely.
    a. If a staff member does not know how to safely perform the task, the employee is guided to ask their department head for instructions on how to safely perform the task.
    b. If the department head is not aware of the task's safety considerations, the department head will contact the Director of Employee Safety for guidance.
3. Triage;
4. Decision-making regarding evacuations and sheltering-in-place;
5. Evacuation of residents/patients, visitors and personnel;
6. Resident elopement; and
7. Acceptance of unscheduled admissions.
    a. The Center only accepts admissions within its scope of care unless directed by a regulatory agency.

THIS PLAN IS DEVELOPED SPECIFICALLY FOR THIS CENTER BASED ON A SITE-SPECIFIC HAZARD VULNERABILITY ASSESSMENT, AND INCLUDES:

1. A developed and tested incident management process, including the center's communication plan;
2. A corresponding analysis of the resources of the center;
3. Center-specific planning and response tools for emergency management; and
4. Elements that promote collaboration, interoperability, and communication with state, local, tribal and community resources.

This center provides a copy of this completed plan to the local Emergency Management Services on an Annual Basis, and as necessary.

Refer to: Appendix 1: Hazard Vulnerability Assessment (HVA)

GENERAL GUIDELINES

WHEN POSSIBLE, THIS CENTER TAKES ADVANTAGE OF AVAILABLE LEAD-TIME BEFORE EMERGENCIES. STAFF SHOULD:

1. Immediately report all potential emergency and/or disaster situations to the Administrator or designee and the Director of Nursing (DON);
    a. Notify additional department heads or designees as instructed by the Administrator.
    b. Administrator/designee: Notify the Marketing President (MP) of any potential emergency situation. Provide a copy of this completed plan to the local EMS;
2. Keep a radio/television tuned to an emergency weather channel or other Emergency Alert System broadcaster on at all times;
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, communication plan and contact information;
4. Locate the emergency and protective action supplies. Replenish if necessary;
5. Clear corridors of obstructions;
6. Reassure residents/patients, visitors, and team members;
7. Assist in the Incident Commander (see below) determinations regarding the number and mix of employees necessary if emergency is activated;
8. Notify the Administrator, DON, or designee of the potential staffing and supply needs;
9. Conserve resources (e.g., water, linen, supplies, etc.);
10. Keep phone lines free of personal calls;
11. Ensure a supply of food and water is available for residents/patients and staff in collaboration with the Dining Services Director;
    a. The center acknowledges during a disaster visitors may be present. The center's first priority for water and food distribution is to staff and residents.
    b. Note: Water can be used indefinitely as long as container intact. Dates do not imply expiration.
12. Be sure resident census is updated and accurate;
13. Estimate the number of ambulatory and non-ambulatory residents, and identify residents on transmission-based precautions that will need cohorting or segregation from other residents;
14. Identify residents with communication impairments, limited English proficiency, and plan for interventions to provide effective communication, such as interpreter services, large print or translated materials.
15. Centers with pets or resident service animals should consider the pets/animals in any emergency situation - i.e. food, water, care needs, and handling/controlling the animal.

NOTIFICATION and INCIDENT COMMANDER

1. During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.
2. When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. Refer to Appendix 22 for the center succession plan.
3. The Incident Commander is responsible for activation, implementation, and termination of the Emergency Preparedness Plan, staff assignments, patient oversight and associated documentation.
4. The Incident Commander is responsible for contact, and collaboration with, as appropriate:

a. Department heads;
b. MP;
c. Residents and responsible parties;
d. State Licensing Board;
e. Local, tribal, regional, state or federal emergency management officials; and
f. State Ombudsman Office.

LEVELS OF EMERGENCY

1. After determining an emergency situation exists, the Incident Commander declares an emergency. The levels of emergency are:
   a. ***Alert.*** Disaster possible; increased awareness. Administrator or designee notified;
   b. ***Stand By.*** Disaster probable, ready for deployment. All department heads notified;
   c. ***Activate.*** Disaster exists, deployment. Department heads or designees report to Center; and
   d. ***Stand Down.*** Disaster contained, resumption of normal activities.

NOTIFICATION OF PLAN

1. Residents are notified of the EPP via a statement in the Admission Kit and a posting in the Center.
2. The Administrator requests time to review the EPP during Resident Council meetings.

Refer to Posting GHC 5408 in SmartWorks and the Emergency Preparedness Compliance Guide.

COMMAND AND CONTROL

1. The Incident Commander coordinates activities in the center;
2. All staff are generally considered to be essential for the duration of a declared emergency; and
3. Emergencies are typically managed from a central location, identified as the Emergency Operations Center.

Refer to:
Appendix 2: Building Construction and Life Safety
Appendix 3: Center Administrative Staff Contact List
Appendix 4: Emergency Operation Center Designation

COMMUNICATION PLAN

1. During emergencies, this center uses primary and alternate means of communication;
    a. Landline telephone, cell phones, and the Regroup Mass communication platform are primary means of emergency communication. Email, and text messaging are alternate means for communication efforts; and
    b. Two-way radio communications are used where required to communicate with the local EMS during a regional emergency.
2. Internal Communication
    a. The Incident Commander is responsible for communicating the initial and ongoing situation status with the center's department heads and MP or designee.
    b. The MP or designee is responsible for communicating the status of any emergency to area/division leadership and appropriate corporate staff.
    c. Center staff attempt to use simple, precise language when communicating during an emergency. Codes are not used.
3. External Communication
    a. The Incident Commander is the key spokesperson for the center and:
        i. Notifies and communicates with regulatory and community agencies and resources regarding the center's occupancy, status, needs and ability to provide assistance;
        ii. Notifies/self-reports incidents involving fire, death, and/or serious bodily injury in accordance with federal and state guidelines.
        iii. Notifies the public relations department (Lori Mayer at 610-283-4995) who will handle radio/TV or other media inquiries, press releases or statements.
            1. NOTE: Center and regional employees do NOT communicate directly with the media; rather, all communications are handled by the public relations department. (Refer to Appendix 6.)

Refer to:
Appendix 5: Area Administrative Contact List
Appendix 6: Company Contacts
Emergency Notification Announcements

CRISIS PUBLIC RELATIONS: STAFF MEMBERS, VOLUNTEERS, CONTRACTORS, PHYSICIANS, FAMILY OF RESIDENTS AND COMMUNITY (INCLUDING OTHER LONG TERM CARE FACILITIES, AS APPOPRIATE)

1. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations.

COMMUNICATION WITH RESIDENTS, FAMILY MEMBERS AND OTHERS

2. This center uses the Genesis HealthCare CareLine as the emergency contact number (866-745-2273) as alternate communication in addition to primary telephone numbers for the residents' responsible parties and family members for contact during an emergency.

3. Based on direction from the Administrator/Incident Commander, residents, responsible parties and family members are notified as soon as possible when there is an emergency declaration at the center by center staff in person, via telephone, and through use of the Genesis CareLine. This communication includes patients who are included in census but outside of the center at the time of the emergency (i.e., at external physician appointments, dialysis, etc.). If the center determines additional alternate communication methods are needed, the Incident Commander works with company resources to obtain support, equipment and services.
4. If the center determines it has additional surge capacity (see below), local EMS and other long term care providers are notified of such capacity.
    a. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts, and to assist patients in receiving the care they need. In addition, while the HIPAA Privacy Rule is not suspended during an emergency, the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the privacy rule.
    b. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices.
    c. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures, and apply administrative, physical and technical safeguards of the HIPAA Security Rule to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy if possible, and disclosures are limited to the minimum necessary to accomplish the purpose.
    d. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

Refer to:
Appendix 7: Emergency Resources and Contacts
Appendix 8: Additional Resources

INTERNAL FUNCTIONS

THE CENTER TAKES ADVANTAGE OF LEAD-TIME BEFORE EMERGENCIES:

1. Staff will notify the Administrator or designee and DON of all potential emergency situations.
2. Keep a radio/television on at all times (if possible) and tuned to an emergency weather channel or other Emergency Alert System broadcaster.
3. Review the Emergency Preparedness Plan for evacuation routes, emergency specific guidelines, emergency supplies, communication plans and appropriate contact information, with staff, visitors, volunteers and onsite contractors. Staff are monitored through use of the staffing schedules (updated as needed), and volunteers, visitors and others are monitored using the visitor log (typically kept in the reception area).
    a. Locate the emergency supplies; replenish if necessary. Refer to **Appendix 12: Emergency Supplies and Location of Critical Equipment**.
        i. The following equipment is typically available at this center: wheelchairs, walkers and canes, portable/folding chairs (for Staging Area), oxygen concentrators, IV poles, feeding pumps, suction machines, bedside commodes.
        ii. The following medical supplies are typically available at this center; first aid supplies, gauze, bandages, alcohol, triple antibiotic ointment, disposable gloves, eye protection, disposable gowns, surgical masks, BioMasks, N95 respirators, saline eyewash solution, incontinence products, barrier cream, sanitizing wipes, hand sanitizer, medications, medication cups/straws, shelf-stable nutritional supplements, food thickener, bladder catheter supplies, sterile pads, first aid tape, syringes, stretch gauze, elastic bandages, glycerin swabs, normal saline, and insulin supplies.
4. Remind staff to remain calm and in control, for organized response and to reassure the residents.
5. Clear corridors of obstructions.

DEPARTMENT HEAD EMERGENCY RESPONSIBILITIES:

1. Train personnel on department responsibilities;
2. Assign on-call responsibility for emergency management;
3. Provide support as directed by the Incident Commander;
4. Assure emergency duties are assigned;
5. Assign duties to staff based on physical capabilities and competencies;
6. Maintain a current list of all employees and their phone numbers;
7. Identify staff interested in volunteering to work in receiving facilities if evacuation is initiated;
8. Determine the minimal number and mix of employees necessary if an emergency is activated.
9. Notify the Administrator, DON, or designee of the potential staffing and supply needs; and
10. Conserve resources (e.g., water, linen, and supplies).

EMERGENCY PROCEDURE: TAKE COVER

1. It is the Incident Commander's responsibility to monitor all threatening situations and determine when the **Take Cover Procedure** is initiated. Situations involving risk to

residents, staff, and visitors due to events occurring inside and outside of the center are considered in the decision to **Take Cover**.

2. Upon making the decision to **Take Cover,** an announcement is broadcast over the center intercom system stating the following message:
    a. **"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."**
    b. Staff, if it is safe to do so, assist residents to Areas of Refuge identified in Appendix 2 of this EPP. If unsafe, staff takes immediate cover.
    c. Residents who use wheelchairs and cannot get into the Take Cover position are positioned with wheelchairs facing a wall with wheels locked, and covered with linens to help protect from flying debris (time permitting).
    d. Staff, residents and visitors (as they are able to), get into the Take Cover position (see below).

3. Emergency Job Tasks – Take Cover
    a. Administrator/Incident Commander
        i. Direct all individuals to Take Cover.
        ii. Be prepared to contact authorities if injuries and damages occur.
        iii. Direct everyone to remain in the refuge area until the danger has passed.
            1. **An "All Clear, Take Cover is over" message is then paged to signal the Take Cover situation has ended.** Afterwards, the Incident Commander accounts for residents, staff, and visitors.
    b. Nursing Staff
        i. Connect oxygen concentrators/tanks to residents requiring oxygen as needed.
        ii. Take first aid supplies/medical supplies to designated Area of Refuge, time permitting.
        iii. Relocate the residents to safe refuge and stay in close proximity of the residents while **taking cover**. Maintain transmission-based precautions as best as possible.
        iv. Close drapes, blinds, doors, and windows (time permitting).
4. Upon broadcast of the Take Cover announcement, all staff immediately discontinues tasks they are working on and begin implementing their **Take Cover** responsibilities.
    a. Immediately relocate residents and visitors to bathrooms or interior hallways (refer to Areas of Refuge, Appendix 2) away from all windows and doors. Staff closes all drapes, blinds, and doors.
    IMPORTANT NOTE: If residents, visitors, and staff are directed to Take Cover in a hallway having a door or window at the end of the corridor, attempt to keep a distance of 30 feet (30') away from the door or window.

b. Staff avoid areas with large ceiling spans. Small rooms or interior hallways away from windows and doors are suitable for **taking cover**.
c. Upon relocating all residents to a safe refuge, the staff stays in proximity of the residents while **taking cover** as well.
d. **Maintenance staff and Managers on Duty** should be prepared to activate Utility Shut-Off Procedures.
e. All *other* staff members immediately secure records, close drawers and cabinets, shut down electronic appliances, and report to the nearest Area of Refuge (refer to Appendix 2).
f. If a situation allows for advanced warning, residents, staff, and visitors will be re-located a designated area providing optimum refuge.
g. Upper floor occupants are moved to the basement or lowest level within the center.
h. Priority is given to evacuating the highest floor first.
i. Census is taken to account for all residents, staff, and visitors.
j. Upon issuance of the All Clear announcement, residents are taken back to their rooms.

Administrator (OR DESIGNEE) ALL EMERGENCIES:

1. Administrators are responsible for execution of Transfer Agreements and/or Memorandums of Understanding (MOU) for patient care and transportation. Updating your center's EPP ensures Divisional and Corporate support can access the Transfer Agreements or MOU's and activate those as you coordinate center emergency response.
    a. Where possible, centers attempt to transfer residents to Genesis-affiliated centers, as this allows for usage of existing databases and continuity of care.
    b. Administrators use Transfer Agreements and/or MOUs with non-affiliated centers, which are often mutual agreements, to arrange for patient care and services and evacuation transportation. (These agreements are activated after a decision has been made to evacuate.)
    c. Administrators activate this Emergency Preparedness Plan when necessary. If applicable, the *National Criteria for Evacuation Decision-Making in Nursing Homes* is reviewed with the management team to evaluate whether to evacuate or Shelter-in-Place. The availability and duration of emergency power is considered when making such determinations.
2. The Administrator/Designee is the Incident Commander and is responsible for activating and coordinating all activities related to the emergency.
    a. Only the Incident Commander, in collaboration with the MP and/or an authority with jurisdiction, can declare an evacuation.
3. The Administrator/Designee contacts the MP and directs internal and external communication as described above.
4. The Administrator/Designee contacts the local EMS and collaborates on integrated response, as appropriate.
5. The Administrator/Designee contacts the Ombudsman and communicates:
    a. How the residents will be sheltered;
    b. When/If the residents will be evacuated; and
    c. Where the residents will be sheltered.
6. The Administrator/Designee contacts the state licensing board.
7. The Administrator/Designee notifies the Medical Director and department heads.

8. The Administrator/Designee instructs staff to keep all doors closed in resident rooms, stairwells and functional rooms (storage, pantry, linen, etc.).
9. The Administrator/Designee instructs staff regarding suspension of non-essential services and procedures during emergencies.
10. The Administrator/Designee tracks the incident's progress and disseminates information to respective staff.
11. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers.
12. The Administrator/Designee establishes frequent communication with staff members, residents, and resident responsible parties.
13. The Administrator/Designee contacts vendors and others who may be needed for post-incident restoration and makes arrangements for services.
14. The Administrator/Designee completes NHICS Form 251, Center System Status Report to assess the center's damage.
15. The Administrator/Designee directs additional emergency documentation completion; refer to Appendices and Exhibits in this EPP.

Refer to Appendix 9: Transfer Agreements
Appendix 10: Short-term Evacuation Plan

Administrator (OR DESIGNEE) SHELTER-IN-PLACE (SIP): During emergencies the Administrator/Designee:

1. Meets with management team to discuss preparations for SIP.
2. Activates the center's SIP Plan as directed by area/divisional, regional, or corporate Leadership; and local authorities.
3. Notifies staff members, residents, and resident responsible parties of the decision to SIP.
4. Instructs individuals in the center to remain until it is safe to leave.
5. When it is safe, allows staff, volunteers, visitors, and vendors to communicate with their family members.
6. Oversees moves of residents to Areas of Refuge as necessary.

Administrator (OR DESIGNEE) EVACUATION: During emergencies the Administrator/Designee:

1. Activates the center's Evacuation Plan as directed by area, divisional, regional, or corporate leadership; or by local authorities. (Management team then notifies supervisors and staff.)
2. Meets with management team to finalize instructions for evacuation.
3. Coordinates evacuation efforts with local Emergency Management Agencies.
4. Notifies the following of the evacuation decision:
    a. The Genesis CareLine (866-745-2273) to determine bed availability;
    b. Residents and responsible parties of decision to evacuate. Communicates emergency phone numbers including alternate care center numbers;
    c. The Medical Director; and
    d. The receiving facility(ies) of the pending arrival.
5. Designates a staff member to monitor and complete the NHICS Master Resident Evacuation Tracking Log Form 255.
6. Notifies alternate care facilities of the pending arrival. Activates Transfer Agreements/MOU as necessary.

7. Secures the center and verifies all electronics and computers have been turned off and unplugged.
8. Approves shut-down procedures for non-essential utilities and designates appropriate personnel to implement shut-down.
9. Verifies emergency supplies for transport.
10. Initiates recovery and re-entry efforts when deemed safe.

SENDING CENTER: ADMINISTRATION TASK LIST

1. Schedule additional staff to coordinate transportation; consider and determine plans for cohorting patients, when applicable.
2. Work with MP to schedule transportation.
3. Update original evacuation report to reflect any changes; i.e., residents in hospital.
4. Review return plan with staff and ensure plan is followed.
5. Schedule additional staff to coordinate transportation.
6. Send supplies to receiving center as needed. Consider need to provide beds, wheelchairs, over bed tables, oxygen, food, water, bathing materials, linens, means for privacy, medical supplies and continence supplies.
7. Communicate daily with receiving center Administrator on return status.

RECEIVING CENTER: ADMINISTRATION TASK LIST

1. Verify all local emergency services are available prior to resident transport.
2. Contact center staff and ensure adequate staff is available to meet the needs of the residents; discuss and determine plans for cohorting patients when applicable.
3. Schedule staff to prepare the building for residents and ensure adequate supplies for each department are available.
4. Verify local vendors and contractors are available i.e. food and nutrition services, housekeeping/laundry, dialysis, physicians, pharmacy, oxygen, gas stations, x-ray and lab services.
5. Coordinate the return schedule with Senior Vice President of Operations and MP.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): ALL EMERGENCIES

1. During all emergencies nursing is responsible for:
    a. Coordinating resident care;
    b. Coordinating communication with medical providers;
    c. Printing and securing the following resident-specific documents:
        i. Admission Record (face sheet).
        ii. MARs;
        iii. TARs;
        iv. Most recent monthly order sheet;
        v. Care Plan;
        vi. Weight and VS Summary;
        vii. Most recent 7 days of nursing notes;
        viii. Most recent physician progress notes;
        ix. Behavior Monitoring Form;
        x. Skin integrity report; and

xi. Patient-specific medications, treatment and feeding supplies, including adaptive equipment, special needs items and preventive devices for falls and skin breakdown.

d. Obtaining additional clinical staff in collaboration with the Administrator and Human Resources;
e. Coordinating resident needs with food and nutrition services and materials management;
f. Notifying pharmacy services of pending evacuation and alert for need to provide back-up medications;
g. Communicating the status of care and resident conditions to the Administrator;
h. Accounting for and keep track of residents and staff;
i. Maintaining effective lines of communication with nursing staff members;
j. Preparing medications (one week supply if possible) for those residents going to alternate facilities, hospitals, or home;
k. Verifying all physician orders are current and have been obtained for residents.
l. Updating and printing resident/patient census reports;
m. Estimating the number of ambulatory and non-ambulatory residents/patients for transportation and assistance purposes. Identify residents on transmission-based precautions that require cohorting or segregation from other resident; and
n. Identifying residents with communication impairments, and associated planned interventions and updating resident care plans as necessary.

DIRECTOR OF NURSING OR DESIGNEE (NURSING): EVACUATION TASK LIST

1. Designates Phase I and Phase II Evacuation Nurse Coordinators.
    a. Nurse Coordinator Phase I works to transfer the highest acuity residents first via ambulance if possible. Considers hospital transfers as appropriate.
    b. Nurse Coordinator Phase II works to transfer lower acuity residents via the most appropriate methods available. Phase II residents may be moved to a staging area prior to evacuation. Staff members are designated to each of the vehicles to assist and care for the residents during the transport. Identifies patients that may be cared for by family/friends and arranges discharge.
2. Groups the residents according to unit, acuity, and those on transmission-based precautions and assigns staff members accordingly.
3. Prepares the lists of residents and receiving location(s) so staff can prepare clothing, supplies, medications, and any other items.
4. Completes the *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient. This tracking includes patients that are counted in the resident census even if they are off-site at the time of the emergency.
5. Designates staff members to accompany each group.
6. Assists in coordinating transfer of all residents to alternate hospitals or other locations. Use *NHICS 255 Master Resident Evacuation Tracking Form.*
7. The Evacuation Nurse Coordinators or designees:
    a. Complete *NHICS 260 Individual Resident Evacuation Tracking Form* for each patient noting patient-specific supplies and equipment.
    b. Collect patient-specific information (see above).
    c. Collect the supplies as noted on NHICS 260 and supervise load of medications, supplies and administration records to accompany transport vehicle:

i. A licensed nurse is assigned to safeguard controlled substances.
ii. If residents needing critical medications are deemed unsafe to carry their own medications, then a licensed nurse carries the medications.
iii. When necessary and appropriate, a separate cooler is provided for temperature-controlled medications.

d. Contact the DON of receiving center to inform him/her of the status of the evacuation.
e. Transfer residents from bed and transport in accordance with care plans.
f. If possible and time-permitting, inspect the residents for:
   i. Proper attire for the weather;
   ii. Identification (ID) wristbands (if applicable);
   iii. Assistive devices including hearing aids, dentures, glasses, and prosthesis.
g. Provide a change-of-shift (hand off) report. Include information regarding patients at risk for falls and elopement.
h. Supervise resident evacuation from the building and the resident flow to transportation.

SENDING CENTER: NURSING TASK LIST

1. Provide the *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
2. Pack resident medical records, supplies, clothing, necessary personal items and medications. Inventory sheets are completed if there is ample lead-time.
3. Prepare/pack any special needs equipment or supplies as necessary. (For example: special size Foley/ostomy supplies, enteral feed formula, oxygen).
4. Load residents with assistance from transport crew.
5. Give report and narcotics/controlled medications to transport nurse/crew.
6. Provide the resident records to transport crew.
7. Provide a method for resident identification either via use of wristbands or use of photo identification.
8. Provide resident identification.
   a. The sending center nursing team reports significant resident information to receiving center in a verbal or written hand-off report, including (wristbands may be used for this purpose):
      i. Code status/Advanced Directives
      ii. Potential for Fall Risk
      iii. Potential for Elopement Risk
      iv. Diagnoses
      v. Food, Medication and Other Allergies
      vi. Thickened liquid consistency
      vii. Diet consistency
      viii. NPO Status
      ix. Seizures
9. Provide medication management
   a. Medications are checked against the MARs to ensure all meds are accounted for per physician order before the residents are transported to the receiving center.
   b. Narcotics/controlled medications are separated and provided to the transport nurse who keeps control of the medications until arrival at the receiving center.

c. The transport nurse and DON or designee include the narcotic count sheet/MAR with each medication.

10. Provide resident special needs equipment.
    a. The DON/Designee uses the *NHICS 260 Individual Resident Evacuation Tracking Form* to identify special equipment or supplies needed during transport.
    b. Pressure relief devices for residents identified with specific wound needs.
    c. When possible, special equipment or supply needs (i.e., positioning devices, oxygen (see below) and means of securing oxygen, nebulizers, gel pads, special size colostomy bags) are loaded on the transport vehicle prior to the residents.
11. Provide oxygen needs to appropriate residents.
    a. Oxygen use is documented on the *NHICS 260 Individual Resident Evacuation Tracking Form*.
    b. Residents requiring oxygen are transported by wheelchair with the oxygen tank secured to the chair. Chair wheels are locked to prevent rolling during transport.
    c. Extra oxygen tanks are secured to prevent movement.
    d. Residents requiring oxygen may be transported separately due to limited number of wheelchair spaces on transporting vehicles.
12. Provide enteral feeding supplies to appropriate residents.
    a. The DON/Designee is responsible for ensuring enteral feeding formula and supplies are packed.
    b. Formula, tubing and syringes are collected, packed for transport, and labeled with the resident name(s).
    c. If support is necessary (i.e. inadequate formula on hand), the DON/Designee contacts the Regional Manager of Food and Nutrition Services for assistance.

TRANSPORTING CREW: NURSING TASK LIST

1. Find/Load first aid kit.
2. Ensure all transported supplies are labeled.
3. Inspect oxygen to ensure it is secured for transport.
4. Ensure transport team and residents have required PPE.
5. Upon arrival at the sending center, notify Administrator and DON and obtain a copy of *NHICS 260 Individual Resident Evacuation Tracking Form* and *NHICS 255 Master Resident Evacuation Tracking Form* for transport.
6. Assist with loading assigned residents.
7. Check actual residents loaded against *NHICS 255 Master Resident Evacuation Tracking Form* to ensure accuracy.
8. Check for critical medications and equipment: snacks/drinks; clothing and belongings; and associated administration records (MARs and TARs).
9. Take report from evacuating center nurse and take possession of narcotics.
10. As time allows, document resident condition on departure.
11. Provide care/services as necessary during transport and document such services.
12. Contact the receiving center periodically to coordinate arrival time.
13. Report to the nursing team at the receiving center upon arrival and transfer resident medications, belongings, documentation, and supplies.

TRANSPORTING CREW NURSING POLICY AND PROCEDURE

1. Oxygen.

a. The center uses *NHICS 260 Individual Resident Evacuation Tracking Form* to identify residents that require continuous or PRN oxygen. Residents with continuous or PRN oxygen needs are transported via wheelchair so the oxygen tank can be secured to the chair. During transport, the chair wheels are locked to prevent rolling. Residents using oxygen may be transported separately due to the limited number of wheelchairs spaces on transport vehicles.
b. Extra oxygen tanks are secured to prevent movement.
c. Guidance for the Safe Transportation of Medical Oxygen for Personal Use
    i. Vehicle operators take precautions to ensure medical oxygen for passengers' personal use is handled and transported safely.
    ii. For Transportation in the Passenger Area Task List/Instructions:
        1. Only transport oxygen in a cylinder maintained in accordance with the manufacturer's instructions. The manufacturer's instructions and precautions are usually printed on a label attached to the cylinder.
        2. Before boarding, inspect each cylinder to assure that it is free of cracks or leaks, including the area around valve and pressure relief device. Listen for leaks; do not load leaking cylinders. Visually inspect the cylinders for dents, gouges or pits. A dented, gouged, or pitted cylinder should not be transported.
        3. Limit the number of cylinders to be transported on board the vehicle to the extent practicable.
        4. If transportation arrangements allow, the vehicle operator considers limiting the number of passengers requiring medical oxygen.
        5. Cylinders used for medical oxygen are susceptible to valve damage if dropped. Handle these cylinders with care during loading and unloading operations. Never drag, roll or carry a cylinder by the valve or regulator.
        6. Do not handle oxygen cylinders or apparatus with hands or gloves contaminated with oil or grease.
        7. Secure each cylinder to prevent movement and leakage. "Secured" means the cylinder is not free to move when the vehicle is in motion. Each extra cylinder should be equipped with a valve protection cap.
        8. Oxygen cylinders or other medical support equipment are not stored or secured in the aisle. Make sure the seating of the passenger requiring oxygen does not restrict access to exits or use of the aisle.
        9. Since the release of oxygen from a cylinder could accelerate a fire, secure each cylinder away from sources of heat or potential sparks.
        10. Smoking or open flames (cigarette lighter or matches) are not permitted in the vehicle when medical oxygen is present.
        11. When the destination is reached, remove all cylinders from the vehicle as soon as possible.
    iii. For Transportation in the Cargo Compartment Task List:
        1. Place each cylinder in a box or crate or load and transport in an upright or horizontal position.
        2. Protect valves from damage, except when in use.
        3. Secure each cylinder against movement.
2. Narcotics/controlled medications.

a. When necessary, narcotics/controlled medications are transported from the sending center to the evacuation center.
b. All narcotics/controlled medications should have the count sheet/MAR attached to the medication.
c. A log listing the narcotics/controlled medications/MAR for each resident is sent to the receiving center. A copy is provided to the transporting nurse.
d. A nurse completes a narcotic count with the receiving center nurse upon arrival.
e. All narcotics/controlled medications should remain in the possession of a nurse during transport.

3. Illness or death enroute.
   a. If a resident/patient has a significant change in condition or expires during transport, the transporting vehicle diverts to the closest acute care center, if possible.
   b. If this is not possible, the transport crew alerts the receiving center and manages the patient situation until arrival.
4. Documentation.
   a. During transport, the transportation nurse/crew document resident conditions and status at the time of transfer and also documents medications administered, treatments given and any other information that is deemed pertinent.

NURSING: RECEIVING CENTER TASK LIST

1. On arrival take report from the transport nurse/crew and count narcotics/controlled medications.
2. Complete triage.
3. Pull original documents from the transport nursing documentation, make copies, and return original documentation to the sending center as soon as possible, and as appropriate.
   a. Give copies of the documentation from the sending center to medical records for retention to support continuity of care during the evacuation process.
4. Review MARs and TARs against documentation received from sending center to ensure all physician order changes were posted to these documents. Review other changes to identify orders for continuation.
5. Depending on appropriateness and availability, arrange for grief counselors to counsel evacuees.

NURSING: TRIAGE EVACUATION RECEIVING CENTER TASK LIST

1. If possible, set up stations for providing care as follows:
   a. Station I: Complete the resident admission assessment including:
      i. Vital signs with pain assessment
      ii. Evaluate presence of infections
      iii. Weight
      iv. Height
      v. Provide resident belongings to receiving nurse along with resident assessment information.
   b. Station II: Provide:
      i. Hydration
      ii. Snacks
   c. Station III:
      i. Transport resident and belongings to assigned room

ii. Provide as-needed personal care

NURSING: SHELTER-IN-PLACE TASK LIST

1. Assist in moving residents to Area of Refuge (if indicated) and frequently monitor their conditions.
2. Connect oxygen concentrators/tanks to residents requiring oxygen.
3. Take first aid supplies/medical supplies to designated safe areas and initiate treatment.
4. Be prepared to assist as needed at the direction of the Incident Commander.

NURSING: EXPANSION/SURGE OF RESIDENTS

1. Coordinate triage of casualties, if necessary.

Refer to Appendix 11: Triage of Casualties

MEDICAL DIRECTOR: ALL EMERGENCIES TASK LIST

1. If possible and appropriate, report to the center;
2. Provide assistance as appropriate, via telephone, electronically or in-person, during an external or internal emergency requiring medical evaluation and /or intervention and coordinate the activities of physicians as necessary;
3. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
4. The center only accepts admissions within its scope of care unless directed by a regulatory agency.
5. Triage casualties;
6. Obtain additional medical resources in collaboration with the SVP/VP of Medical Affairs or Regional Medical Director; and
7. Assist center with transfer decisions and emergency orders if attending physician cannot be reached.

HUMAN RESOURCES AND SCHEDULING: ALL EMERGENCIES TASK LIST

1. Human Resources /Benefits Designee and Scheduler are responsible for scheduling and assembling adequate staff in consultation with the Administrator/Designee:
    a. Maintain current information all center personnel and volunteers with addresses and phone numbers for contact purposes;
    b. Coordinate with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event that staff is needed in alternate locations;
    c. Update the department heads with results of attempts to obtain staff. Confirm expected availability as well as the number of family members joining the staff members;
    d. Coordinate, if necessary, transportation of the center staff to work;
    e. Monitor the length of time each employee works during the declared emergency and provide adequate time off to rest and recover. Time worked should not exceed sixteen (16) hours over a 24 hour period if possible;
    f. Identify areas where employees can rest and recover;
    g. If necessary, work with regional Human Resources staff to contact other Genesis centers to obtain additional staff.

FOOD AND NUTRITION SERVICES: ALL EMERGENCIES TASK LIST

1. The Dining Services Director or designee:
    a. Follows the Food and Nutrition Services Policies and Procedures, Food Service Emergency Plan and associated guidelines including a plan to obtain food and water in the event of an emergency;
    b. Obtains additional staff in collaboration with Human Resources;
    c. If power outage is likely, set refrigerators and freezers to the lowest setting to preserve items for the longest possible time period;
    d. Unplugs non-essential equipment;
    e. Obtains supplies of food and water for residents/patients and staff;
    f. Creates water supply:
        i. Fill tubs, pitchers, and as many containers as possible with water;
        ii. Bags as much ice as possible and stores bags in the freezers; and
        iii. If advanced warning is provided, purchases ice and stores in freezers.
    g. Determines the numbers of residents, visitors, volunteers, and employees for whom food service may need to be provided.
    h. Provides food service as appropriate and able. Refer to Exhibit 1 for Sample Emergency Menus.

FOOD AND NUTRITION SERVICES EMERGENCY EVACUATION GUIDELINES

1. The Dining Services Director/Designee:
    a. Coordinates food service with the center Incident Commander following the EPP.
        i. Provides adequate snacks and fluids for each vehicle transporting residents;
        ii. A sample snack menu, extended for consistency modified and Gluten-Free diets, has been developed for these purposes and may be customized as needed; and
        iii. All therapeutic diets are waived during an emergency with the exception of consistency-modified and Gluten-Free diets as allowed by state regulations.
    b. Packaged snacks and fluids (including thickened water) are provided in disposable containers or bags, if possible, with labeling for consistency-modified and Gluten-free (when appropriate).
    c. Gathers relevant vital resident and department records.
        i. Enteral feedings for residents are managed by nursing staff with support from the Dining Services Director/Designee.

SENDING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director or designee sends Food and Nutrition Services staff ahead to the receiving center(s) to prepare snacks and fluids for residents **on their arrival;**
2. Consult with the Regional Manager of Food and Nutrition directly to review plans for evacuation;
3. Dining Services Director makes plans for meals to be served prior to transport. (Note: Meals may be served inconsistently with the normal center schedule to ensure residents are prepared and fed at designated departure times);
4. Create/Print diet roster for distribution to receiving facilities;
5. Create/Print 2 tray card copies for each resident;
6. Prepare a simplified shelf-stable snacks and liquids master list. Include specific-consistency diets, thickened liquids, and disposable supplies (napkins, plastic cutlery).

7. Prepare and label snacks for consistency-altered diets (Dysphagia Advanced and Puree). A snack list identifying snacks for consistency-altered diets is included for transport.

RECEIVING CENTER: FOOD AND NUTRITION SERVICES TASK LIST

1. If possible, the Dining Services Director and assigned staff arrive at the center in sufficient time to allow for inventory of food items to ensure nutrition needs of the residents.
2. The Dining Services Director/Designee prepares beverages and light snacks to be provided upon evacuated residents' arrival to the center. Include meals appropriate for consistency-altered diets and thickened liquids

REHABILITATION SERVICES: ALL EMERGENCIES TASK LIST

1. The Director of Rehab or designee:
    a. Assists with triage, transfer, or evacuation of residents;
    b. Obtains additional staff in collaboration with Human Resources; and
    c. Directs rehab staff to assist on the units as required.

MAINTENANCE SUPERVISOR: ALL EMERGENCIES TASK LIST

1. Gather emergency supplies. See Appendix 12: Emergency Supplies Checklist;
2. Evaluate the safety of the physical plant;
3. Coordinate emergency repairs;
4. Communicate the status of the center environment to the Administrator.
5. Make rounds of the center and grounds;
6. Secure potential flying debris (above, below, around, and in the center);
7. Check equipment for functionality:
    a. Monitor fuel supply for generator; and
    b. Check that equipment and utilities are functioning properly.
8. Prepare all vehicles for evacuation if needed;
    a. Check fuel, oil, and water levels for each vehicle;
    b. Move vehicles away from trees;
    c. Prepare maps/obtain directions with evacuation routes and alternate routes for each vehicle. A paper map with all routes should accompany each vehicle.;
    d. Load phone or other communication devices in each vehicle;
    e. Load first aid kit in each vehicle; and
    f. Identify storage space for medical and business records, medications, and equipment in each vehicle.
        i. Identify oxygen storage area, as needed, in each vehicle. Follow the guidelines for oxygen transport in vehicles.
9. Transporting Crew/Maintenance
    a. Service van as necessary to include air conditioning, oil, gas, tires, fire extinguisher, safety belts, etc. are all in good condition by completing the Pre-trip Vehicle Safety Inspection Checklist. Check transport supplies and load them into the vehicle;
    b. Identify route with maps for travel from evacuating center to receiving center and back to original center as appropriate;
    c. Identify van driver, licensed staff transporting evacuees, and schedule departure. Staff are made familiar with the use of safety devices in the vehicle;
    d. Bring money or purchase cards in the event supplies are needed during for the trip; and

e. Load communication devices.

Refer to Appendix 12: Emergency Supplies and Location of Critical Equipment

MAINTENANCE SUPERVISOR: EVACUATION TASK LIST

1. Secure the center and verify all electronics and computers have been turned off and unplugged;
2. Designate someone to stay behind, if deemed safe, to safeguard the center;
3. Activate shut-down procedures for non-essential utilities;
4. Work with responding emergency agencies on building security, traffic control, utility control, and elevator operations;
5. Make final rounds of the center and grounds;
6. Secure windows and other building openings; and
7. Pull shades and close all drapes.

MATERIALS MANAGEMENT (CENTRAL SUPPLY): ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain medical supplies and PPE;
2. Provide supplies and linens to the nursing units; and
3. Notify medical and medication suppliers of additional needs.

SOCIAL WORK: ALL EMERGENCIES TASK LIST

1. Provide support and crisis intervention services for residents, residents' families, and staff;
2. Notify responsible parties and residents, as directed by the Administrator/Incident Commander, of decisions to Shelter-in-Place/Evacuate and resident status;
3. Review and update Advanced Directives;
4. Manage resident discharges and placement, if possible, based on resident/responsible parties' requests;
5. Follow-up within 24 hours, if possible, to confirm care and services for discharged residents.

SENDING CENTER: SOCIAL SERVICES TASK LIST

1. Contact evacuated residents' families to let them know the residents' location;
2. Assist DON in supervising certified nursing assistants as they pack and inventory residents' belongings; and
3. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment and care plan accordingly.
    a. For residents experiencing adjustment difficulty, follow up as indicated.

RECEIVING CENTER: SOCIAL SERVICES TASK LIST

1. Provide receiving center with a social services report on each resident in an effort to ease transition, promote adjustment to new environment, and care plan accordingly.
2. Assist DON in supervising certified nursing assistants to ensure resident's personal belongings are made available to each resident and inventoried in accordance with established procedures;
3. Notify Responsible Parties of resident arrival/admission; and
4. Assess psychological/social needs to ensure needs and preferences are communicated to the interdisciplinary team.

a. Follow up with status call to Responsible Party as soon as possible following admission.

ADMISSIONS DEPARTMENT: ALL EMERGENCIES TASK LIST

1. Maintain a current list of residents;
2. Print face sheets if evacuation is possible;
3. Coordinate admissions with the DON/Administrator;
4. Assist social services with contacting responsible parties; and
5. Report available transportation and receiving center capacities to the Incident Commander.

ADMISSIONS DEPARTMENT: EVACUATION TASK LIST

1. Notify agencies with Center Transfer Agreements of the emergency situation and potential to evacuate;
2. Communicate resident information and status to the receiving center; and
3. Maintain a list that includes each resident name and the time/place of each resident's transfer.

BUSINESS OFFICE/PAYROLL: ALL EMERGENCIES TASK LIST

1. Manage payroll; and
2. Provide means to pay for food, supplies, and/or transportation.

BUSINESS OFFICE/PAYROLL: EVACUATION TASK LIST

1. The Cash Handler secures the following items for evacuation:
    a. Center petty cash;
    b. Resident trust fund (RTF);
    c. Petty cash;
    d. Resident trust check stock;
    e. Printed copy of most recent RTF Trial balances;
    f. Imprest checkbook;
    g. Payments to be deposited; and
    h. If applicable, purchase cards.
2. Turn off and unplug all computers; and
3. Take laptop(s) if applicable.

ENVIRONMENTAL SERVICES: ALL EMERGENCIES TASK LIST

1. Develop a plan to obtain linen in the event of an emergency;
2. Secure:
    a. Linens;
    b. Blankets;
    c. Trash can liners;
    d. Mops;
    e. Rags;
    f. Buckets;
    g. Trash cans;
    h. Cleaning and disinfecting supplies; and
    i. Toilet paper.
3. Place emergency orders for supplies;
4. Clear corridors of any obstructions such as carts, wheelchairs, etc.;

5. Check equipment (wet/dry vacuums, etc.);
6. Unplug non-essential equipment; and
7. Maintain sanitation considering best practices for infection control.

LAUNDRY: ALL EMERGENCIES TASK LIST

1. Close all laundry chutes; and
2. Unplug non-essential equipment.

MEDICAL RECORDS: EVACUATION TASK LIST

1. Prepare resident medical records transport to the appropriate receiving facilities;
2. Assist nursing to obtain charting from each nursing station and provide them to the transporting nurse; and
3. In situations of planned evacuation to affiliated centers, centers follow a process to obtain/grant access to electronic medical records. Refer to the Planned Evacuation Process on for details.

RECEIVING CENTER: MEDICAL RECORDS

1. Place the Clinical Record at the appropriate nurse's station;
2. Make copies made of documentation from sending facilities, place the copies in a manila envelope marked "CONFIDENTIAL: Do Not Destroy". Place with the clinical record in the event of discharge of the resident. Send originals back to the sending center as soon as possible, and appropriate;
3. Without a waiver, patient information is permitted to be disclosed in accordance with the Privacy Rule and as noted in the center's Notice of Privacy Practices;
4. During an emergency, the center implements reasonable safeguards to protect patient information against impermissible uses and disclosures by applying administrative, physical and technical HIPAA Security Rule safeguards to electronic protected health information. Protected health information continues to be managed in a manner that is most likely to protect privacy and disclosures are limited to the minimum necessary to accomplish the purpose; and
5. During emergencies, the center monitors communications from U.S. Department of Health and Human Services and state and local regulatory agencies for additional guidance.

SURGE CAPACITY

1. External disaster expansion guidelines:
    a. In the event of an external disaster, this center may be used by local hospitals and other health care facilities to care for additional patients as space/staff permit;
    b. Unplanned admissions from an external disaster are completed in collaboration with:
        i. External agencies;
        ii. Healthcare providers;
        iii. Administrator;
        iv. DON;
        v. Medical Director;
        vi. Admissions Coordinator;
        vii. Human Resources or Staffing Coordinator; and
        viii. The CareLine.
    c. The center only accepts admissions within its scope of care unless directed by the local health authorities or a regulatory agency.
    d. If the center team determines it is experiencing a healthcare surge, the following guidelines are used to assess, prepare, and mobilize to meet the need for increased patient care capacity:
        i. Transfer patients to other institutions in the region, state, or other states;
        ii. Group like-patient types together to maximize efficient delivery of patient care;
        iii. Convert single rooms to double rooms or double rooms to triple rooms, if possible;
        iv. Designate units or areas of the facility for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients;
        v. Use cots, beds, or other sleeping surfaces in flat space areas (e.g., cafeterias, recreation areas, lounges, lobbies) for noncritical patient care;
        vi. Beds should not be placed near windows, if possible and appropriate to the emergency, so as to avoid broken glass and protect patient privacy and security; and
        vii. Determine whether additional staff, including State or Federally designated health care professionals and volunteers, may be used to address surge needs.
    e. The center identifies areas and spaces that could be opened and/or converted for use as patient treatment areas, such as activity rooms, dining rooms, rooms with unlicensed beds, or other unused center space. Areas are selected based on the intensity of the incident and the anticipated number of healthcare surge patients the center may receive. The identified areas are cleared of excess furniture and equipment as needed.
2. Roles and Responsibilities
    a. The Director of Nursing/Resident Care Director and Admissions Director determine bed availability and admission placement in collaboration with CareLine;
    b. The Medical Director is notified and is responsible for emergency physician coverage, if necessary;
    c. The DON/Resident Care Director evaluates nurse staffing needs;

d. The Administrator/Designee and department heads are responsible for assuring adequate supplies and staff;
e. The Administrator/Designee contacts area leadership, the law department and regulatory agencies, as necessary to obtain waivers for additional capacity;

f. The Social Worker is responsible for notifying the residents' responsible parties of admission;
g. Center staff coordinates admission, identification, assessment and care planning for new residents following established operational, clinical, and admissions policies and procedures. Exception would be when suspended or waived by management and/or in consideration of CMS, state agency and other regulatory guidance; and
h. The center assumes responsibility for the care and services of residents admitted as the result of an emergency.

Refer to Appendix 13: Surge Capacity

EMERGENCY PHYSICIAN COVERAGE

The Medical Director is notified of all center-related emergencies having the potential for or currently requiring medical intervention.

DEPENDING ON THE CIRMCUMSTANCES AND TYPE OF EMERGENCY, IT IS THE MEDICAL DIRECTOR'S RESPONSIBILITY TO:

1. Provide on-site and/or offsite assistance during an external or internal emergency;
2. Coordinate unplanned admissions resulting from external emergencies with the Director of Nursing;
3. Triage casualties; and
4. Obtain additional medical resources in collaboration with the Vice President/Senior Vice President of Medical Affairs.

INTERRUPTION OF NORMAL OPERATIONS

The Incident Commander may suspend or relax policies and procedures during an emergency. These decisions and the associated potential consequences are considered carefully. In making these decisions, the Incident Commander prioritizes essential operations that must continue to prevent compromise of resident care. All significant departures from established policy and procedures and this EPP must be approved by the Incident Commander, Regional, Divisional, and Corporate leadership.

CAPACITY FOR DECEASED RESIDENTS

1. This center plans for the potential handling and holding of deceased individuals if support from local emergency responders or other community resources is not immediately available;
2. Human remains
   a. This center considers the following information in handling, processing, and storing human remains onsite on a temporary basis:
      i. The center's normal capacity, if any, to store deceased individuals; including refrigeration capacity available to store human remains safely and separated from emergency food supply;
      ii. Suitable areas on the center's periphery to store human remains without refrigeration;
      iii. Equipment (ice-making, etc.) or materials/supplies needed (storage bags for ice, deodorizers, body bags, heavy duty plastic wrap, personal protective equipment (PPE), tarps, pallets, etc.) to provide temporary storage of human remains; and
      iv. Ways to control and isolate temporary morgue provisions away from healthy center occupants (residents, staff, and visitors).
   b. The Incident Commander makes decisions and provides direction regarding temporary storage of human remains, and contacts support services and the local EMS for assistance.
3. Documentation
   a. The center documents information about deceased individuals on **NHICS Form 259: Master Center Casualty Report.**

RECOVERY AND RESTORATION

1. Post-emergency procedure
   a. Immediately following the emergency, when it is safe to do so, the Incident Commander undertakes the following actions:
      i. Coordinate recovery and restoration operations with area, division, region and corporate representatives, the Emergency Management Services (EMS), and other agencies with jurisdiction to restore normal operations.
      ii. Provide local authorities with a master list of displaced, injured, or dead and notify next of kin/responsible party. ***Refer to NHICS Form 259 Master Facility Casualty Fatality Report.***
      iii. Advise personnel to dispose of any food/supplies suspected to be or actually contaminated or spoiled.
   b. Inspection task list:
      i. When it is safe to do so, the Incident Commander and the Maintenance Director, with support services as necessary, perform an initial damage inspection. **NOTE: If there is concern of structural damage, center staff do not enter the building. The following precautions are taken to avoid injury and damage:**
         1. Open doors carefully.
         2. Avoid the use of open flame in the event of fuel leakage, dampened electrical equipment, or flammable materials;
         3. Watch for falling objects or downed electrical wires. Do not touch downed electrical wires or objects touched by downed wires;
         4. Stay away from windows and/or glassed areas;
         5. Take pictures and document damage; and
         6. Arrange for cleaning services, including removal/clean up of spilled medications, drugs, and other potentially harmful materials following center policies and procedures. (Refer to: Safety and Health P&P SH800.)
   c. When it is safe to do so, the Incident Commander and the Maintenance Director perform a utilities inspection. **The following precautions are taken to avoid injury and damage:**
      i. If a natural gas smell is noticed, open windows and doors, shut off main gas valve, leave premises, and contact the Utility Provider **IMMEDIATELY;**
      ii. If damage to wiring is suspected, do not use any appliances and shut off electrical power. Contact the Utility Provider and the contracted Electrical Contractor; and
      iii. If damage to plumbing is suspected, check water outlets and sewage lines. Shut off the main water valve if damage is observed. Contact the Utility Provider and contracted Plumbing Contractor.
   d. The Incident Commander reports all building, equipment, or utility damage to the MP;
   e. Upon notification from the proper authorities, center support services and/or utility providers the emergency has been terminated or de-escalated, the Administrator oversees the orderly return of residents and staff;

f. Before reoccupation of the building, a safety inspection of the center and surrounding areas, including the utilities delivery systems and HVAC units, is performed by the Incident Commander, the Maintenance Director, and regulatory agency(ies);
g. Recovery and restoration is managed in consideration of best practices for infection control, including:
    i. Frequent hand washing. If local water supply contaminated, use bottled water. If hands not visibly soiled – use alcohol-based hand rub;
    ii. In response to flooding or water damage and when possible, cleaning out damaged areas within 24 to 48 hours to prevent mold growth;
    iii. Cleaning, wearing rubber gloves, with a solution of approximately 1 cup bleach to each gallon of water, with open doors and windows for air circulation. (Bleach solution is not mixed with ammonia or other cleaners);
    iv. Use of dust masks during activities that may stir up mold spores or excessive dust.
    v. If applicable, following local officials' instructions for use of bottled water. If instructed to boil water, boiling for at least a full minute before using it to cook, clean or bathe;
    vi. Discarding all perishable food items that may have become contaminated or in contact with flood water including canned food;
    vii. Treating wounds in accordance with routine infection control practices;

    Note: Adapted from Becker's Infection Control and Clinical Quality, "APIC: 6 tips for infection prevention after a hurricane" written by Brian Zimmerman, 8/29/17.
h. After center reoccupation is considered safe, the Incident Commander and department leaders work to prepare the center to resume normal operations, and coordinate transportation and re-admission of residents;
i. After re-admission, the center re-establishes all essential services; and
j. After re-admission, the Incident Commander coordinates provision of crisis counseling for residents/patients, families, and staff as needed.

LOSS OF UTILITIES

1. Loss of electrical power
    a. Back-up Power/Generators: Emergency lighting/power is provided in conformance with center policies and the state's Department of Health policies to maintain temperatures, provide emergency lighting, as well as for fire detection and extinguishing systems and sewage and waste disposal. The ability to obtain and maintain generator power is a factor in whether to evacuate or Shelter-in-Place;
    b. The center follows multiple policies and procedures regarding infection control, hazardous waste, food handling and life safety that guide the center's sewage and waste control practices. The center will seek additional resources as necessary to meet sewage and waste disposal needs in accordance with current standards;
    c. If this center has a generator, the emergency generator system will be inspected weekly by appropriate service location staff and annually by a qualified outside contractor or more frequently if required by state regulation. If this center maintains an onsite fuel source to power the emergency generator(s), the center has contracted with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency.
    d. Service Delays:
        i. In the event electrical service is disrupted, flashlights are distributed throughout the center, prioritized as needed;
    e. Extended Loss: If power is lost and expected to be disrupted for an extended period of time, assistance is requested from local agencies.
        i. Center staff should consider the content of residents' personal refrigerators and advise residents accordingly;
        ii. In the absence of power for the call bell/light system the center uses bells or other methods to alert staff to their needs.
        iii. Loss of Utilities Alert:
            1. When appropriate and possible, the following announcement is made: **"Center Alert-We are activating Loss of Utilities protocols-(Describe loss of Power and Location). Please continue your duties and listen for further instructions."**
        iv. Provide instructions as necessary for the specific circumstances.
2. Air conditioning failure
    a. Notify HVAC Company and report problem;
    b. Monitor room temperatures. When the temperature of any resident/patient area reaches 81 degrees Fahrenheit for four (4) consecutive hours:
        i. Open doors;
        ii. Operate fans;
        iii. Notify the Administrator or designee and the Medical Director;
        iv. Make arrangements for transfer of residents/patients to other areas of the Center, or other facilities if necessary;
        v. Monitor residents'/patients' temperatures every four (4) hours;
        vi. Encourage fluids, begin intake and output records as necessary;
        vii. Relocate residents/patients who are at risk of hyperpyrexia/over-heated;
        viii. Observe residents/patients for symptoms of hyperpyrexia. Document findings.

c. The center follows protocols for addressing significant changes in condition for residents with symptoms of hyperpyrexia.

3. Heating failure
   a. Notify HVAC Company;
   b. If the outside temperature goes below 30 degrees Fahrenheit, drain plumbing and put antifreeze in the toilets and sinks;
   c. Monitor room temperatures. When the temperature inside the center remains at 65 degrees Fahrenheit, for four (4) consecutive hours:
      i. Obtain and distribute blankets, covering hands, feet, and heads;
      ii. Distribute warm soups, coffee, or tea to residents/patients;
      iii. Notify the Administrator, DON, or designees;
      iv. Notify the Medical Director;
      v. Monitor and chart resident/patient temperatures every four (4) hours;
      vi. Relocate residents/patients at high risk of hypothermia; and
      vii. Observe residents/patients for symptoms of hypothermia. Document findings.
   d. The center follows protocols for addressing significant changes in condition for residents with symptoms of hypothermia.
4. Interruption of telephone service
   a. Notify the telephone company and report disruption of service (use cellular or public telephone);
   b. Evaluate all phones and fax lines in the Center to determine the extent of the disruption; and
   c. During the disruption, the Incident Commander uses a cellular phone for emergent communication. Other available cell phones are used as needed with prioritization to avoid interruption to care and services.
5. Loss of water supply
   a. Notify the water division of the public utility department of the disruption of services;
   b. If the water department advises services will be resumed promptly, all residents/patients and service areas will be informed and instructed to refrain from turning on water taps until supply is re-established. Nursing services are responsible for advising residents/patients of the situation;
   c. If necessary, a minimum of the supply in hot water tanks and the emergency supply of water may be used. Contact may be made with the potable water supplier for additional water;
   d. In the event of a disaster in the immediate area creating prolonged and/or indefinite disruption of water supply to the center, the Incident Commander attempts to obtain water for residents/patients. If adequate water is not available, the Incident Commander proceeds with evacuation; and
   e. Prepare and handle disposal of human waste using supplies for containment and specific storage locations, and with use of PPE.

Refer to Appendix 14: Emergency Water Supply
Refer to Appendix 15: Utility Shut-Off Procedures

UTILITY, ELEVATOR & GENERATOR SYSTEM FAILURE

Failure	Contact	Action
Sewer drains backing up	Maintenance	Do not flush toilets or hoppers. Do not use equipment that sends water to drain. Be sure to turn off water except for drinking. If long-term outage expected, consider: Evacuation; Bath in a Bag; Accessible Portable Showers; and Accessible Portable Toilets
Water-sinks and toilets inoperative.	Maintenance	Use distilled or sterile water for drinking.
Fire sprinklers or alarm system inoperative.	Maintenance	Begin fire watch. Minimize fire hazards. NOTIFY LOCAL FIRE DEPARTMENT by calling 911
Water non–potable (not drinkable)	Maintenance	Water cannot be used for drinking, washing or cooking. Place "Non-Potable Water-Do Not Drink" signs at all drinking fountains and sinks. If a water shut-off valve is in place, turn off the water to the sink/drinking fountain. Use emergency water supply for drinking and cooking.
Elevator(s) out of service	Maintenance	Review fire and evacuation plans: modify plans if necessary. If people are trapped inside elevator, notify them help is on the way and call fire department. Notify elevator maintenance contractor.
Telephones	Maintenance	Use pay phones, cell phones, and runners as needed. Contact the phone company.
Electrical power (emergency generators working)	Maintenance	Ensure life support systems are on emergency power (red outlets). Distribute flashlights/glow sticks. Never plug generator into wall outlet. Keep generator dry. Allow generator to cool completely before refueling. Use only approved fuel containers. Monitor the generator for overheating. Always operate generators outdoors.
Generator and all electric systems failure	Maintenance Nursing	Use battery powered lighting (flashlights, etc.). Watch battery levels on all critical medical equipment. Implement transfer agreements for residents on critical medical equipment. Prepare center for evacuation
Nurse call system or resident alarms.	Maintenance Nursing	Establish visual resident monitoring rounds or surveillance. Call in additional staff if necessary.
Natural Gas outage or natural gas odor.	Maintenance	Open windows/ventilate area. Remove residents and employees from the area. Turn off gas equipment. Contact the gas company and the fire department.

BOMB THREAT

1. Center bomb threat guidelines for staff
   a. Do not panic or act in such a way that causes panic to residents, family members, or other employees;
   b. Do not hang up;
   c. Notify other employees;
   d. Have another employee contact 911 and alert authorities to threat;
   e. The following announcement is made: **"Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions.";**
   f. **Do not evacuate** the center until instructed to do so by the Incident Commander. This decision is generally based on advice from the police and/or fire department;
   g. Restrict access to the center;
   h. Close all doors; and
   i. Escort visitors and residents to resident rooms where they remain with doors closed until an all-clear is given.
2. If the bomb's location is mentioned in the threat:
   a. Immediately remove any residents, visitors and staff from the area;
   b. If you find an object out of the ordinary or appearing to be an explosive device, do not touch it and inform authorities of the object's location;
   c. Do not attempt to disarm, remove or disturb the potential explosive device; and
   d. Report all suspicious activities to investigating authorities.
3. Potential explosives
   a. **The center maintains a list of potential explosives to report to the fire/police departments. The potential explosives list:**
      i. Identifies oxygen storage locations;
      ii. Identifies fuel storage locations; and
      iii. Identifies locations of any other potential explosives in the center.

Refer to Appendix 16: Potential Explosives List

4. After the threat is received:
   a. As soon as possible after receiving the call, the receiver of the call documents all information relating to it, including the:
      1. Possible location and type of bomb;
      2. Time of detonation;
      3. Background noises (e.g., music, voices, etc.); and
      4. Voice quality (male/female), accents, or any speech impediments.
5. If a suspicious/explosive object is found:
   a. Immediately contact the Incident Commander. The Incident Commander then contacts law enforcement to immediately report the object's location. In the absence of immediate notification, center staff calls 911;
   b. Do not touch the object; and
   c. Follow the instructions of the bomb squad or local law enforcement officials who assume authority regarding object removal.

6. Law Enforcement and/or the Incident Commander initiates a partial or total evacuation as needed.
7. If a suspicious object is found without prior notification:
    a. Call 911;
    b. Report the exact location and description of the object;
    c. Follow any instructions given to you at this time by law enforcement officers; and
    d. Call Administrator, DON, or Designees.

BIOTERRORISM

1. Reporting requirements and contact information
    a. Any employee recognizing chemical or biological exposure symptoms immediately notifies the Administrator/Designee/Incident Commander;
    b. The Incident Commander immediately contacts 911 and area leadership;
    c. Restrict building entrance and exit until cleared by authorities;
    d. The Incident Commander contacts the Centers for Disease Control Bioterrorism Emergency Response Office at (770) 488-7100;
    e. Employees promptly evacuate all persons from the affected area as instructed by the Incident Commander; and
    f. As instructed by regulatory authorities, all building occupants remain on the premises until cleared and approved to exit.
2. Mail handling
    a. The center follows general mail handling guidelines, including:
        i. Opening all mail with a letter opener or method least likely to disturb contents;
        ii. Opening letters and packages with a minimum amount of movement; and
        iii. Center staff are advised not to blow into envelopes; or shake or pour out contents, and to keep hands away from nose and mouth while opening mail; and to wash hands after handling mail.
    b. Observing for suspicious envelopes or packages such as:
        i. Envelopes/packages with discoloration, strange odors or oily stains, powder or powder-like residue;
        ii. Protruding wires, aluminum foil, excessive tape or string;
        iii. Unusual weights for size, or lopsided or oddly shaped envelopes; and
        iv. Poorly typed or written addresses, no return address, incorrect titles, misspelling of common words, a postmark not matching the return address, and restrictions such as "personal" or "confidential."
3. In Handling Suspicious Mail, staff should:
    a. Stay calm and do not shake or empty contents of any suspicious package or letter;
    b. Keep hands away from mouth, nose, and eyes;
    c. Isolate package or letter and not carry or show to others, and cover gently with clothing, paper, inverted trash can; and
    d. Not try to clean up any spills or walk through any spilled material;
    e. Alert others in area and leave area, closing all doors;
    f. Wash hands with soap and water;
    g. Notify supervisor/designated responder who in turn calls 911, local FBI Field Office, area, division, region and corporate leadership;
    h. Not allow anyone to enter the room until proper authorities arrive; and
    i. List all people who were in the room or area when the package or letter was recognized. Give the list to the health and law enforcement officials.
4. Potential agents
    a. Diseases with recognized bioterrorist potential and the agents responsible for them are described in Table 1. (Note: The Center for Disease Control does not prioritize these agents in any order of importance or likelihood of use.)

Table 1. Most Common Chemical and Biological Agent Used in Terrorist Attacks

Chemical Agents	Effects	Onset
Nerve Agents Tabun Sarin Soman GF, VX	Contraction of the pupils of eyes Watery discharge from nose Labored or difficult breathing Convulsions	Seconds to minutes
Blister Agents (Vesicants) Mustard Lewisite Phosgene Oxime	Skin redness Blisters Eye Irritation Blindness Labored or difficult breathing Coughing	Minutes to hours
Blood Agents Hydrocyanic Acid Cyanogen Chloride Arsine Methyl Isocyanate	Panting Convulsions Loss of consciousness Breathing stops - usually temporary in nature	Minutes
Choking Agents Phosgene Chlorine Ammonia	Tightness in the chest Coughing Labored or difficult breathing	Minutes to hours

Biological Agents	Effects Of Inhalation	Time From Exposure Until Symptoms Appear	Contagious?/Treatment
Anthrax	Fever Headache Fatigue Labored or difficult breathing Death if untreated	1 to 5 days	Not contagious, but spores can survive outside host for years. Treat with IV antibiotics for 30 days. Can also use vaccination which is effective only if begun before symptoms appear.
Botulism	Blurred vision Eyes sensitive to light Difficulty speaking Progressive paralysis Respiratory failure	1 to 5 days	Not contagious. Treat with supportive therapy. Antitoxin available from CDC.
Hemorrhagic Fever	High fever Low blood pressure Bleeding from mucous membranes Organ failure Death	4 to 21 days	Contagious: spread through body fluids. Treat with supportive therapy. Ribavirin for some viruses.
Plague	Fever Chills Headache Nausea Vomiting Pneumonia Septicemia/blood poisoning Death	2 to 3 days	Highly contagious by aerosol/droplet route. Medications available - Should be given within 8 to 24 hours of time symptoms begin.
Smallpox	Fever Severe fatigue Headache Backache Abdominal pain Blister-like skin lesions Death - 20 to 30% of those infected	7 to 17 days	Highly contagious by aerosol route or contact with pox scabs. Symptomatic treatment. Vaccine available through CDC.

NUCLEAR, RADIATION, OR HAZARDOUS CHEMICAL FALLOUT

1. In the event of a nuclear, radiation, or hazardous chemical fallout:
    a. Notify Administrator or designee;
    b. Contact the local health department or police if there is the belief exposure has occurred;
    c. Tune radio to the local emergency broadcast station;
    d. Alert center residents/patients, staff, and visitors and keep them informed of new developments. The following announcement is made:
        i. **"Center Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."** Provide instructions as needed.
    e. Close all doors, windows, and drapes;
    f. Move residents/patients to the hallways and close the fire doors;
    g. In the event of hazardous chemical fallout, seal all openings to the outside air and block all outside air intakes;
    h. Reassure residents/patients, visitors, and staff;
    i. Evaluate the need to restrict entrance into the center in collaboration with Area leadership, division, region, state and local authorities;
    j. Follow the direction of state and local authorities; and
    k. If directed by local authorities, evacuate residents/patients per location Evacuation Plan.

    Note: Facilities located in a Nuclear Emergency Planning Zone should follow the plan developed for their location.

FIRE EMERGENCY GUIDELINES

1. This center monitors potential fire risk. Any unsafe condition is reported to a supervisor immediately so corrective measures can be taken promptly.
2. In the event of a fire:
    a. Extinguishers: Fire extinguishers are used in accordance with instructions.
    b. Transport: Residents are transported to a safe area;
    c. Staff Assignments: One person is assigned to wait outside the building to direct the fire department personnel to the area of the fire;
    d. Evacuation: Residents are evacuated as necessary and according to the Evacuation Plan;
    e. Staff ensure the Fire Lane is clear for emergency personnel and vehicles;
    f. Staff use the census log, staff census/schedule, and visitor log to account for staff, residents and visitors;
    g. Staff relocate wheeled equipment during fire or other emergency; and
    h. Report fire incidents, death or serious bodily injury by phone to the state agency and others as required by state guidelines.
3. Fire response and announcement:
    a. Upon discovering fire or smoke, center staff:
        i. Remove residents from immediate danger according to evacuation guidelines
        ii. Make the following announcement:
            1. **"Center Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."**
        iii. Implement the R.A.C.E. program:
            1. **Rescue** Remove residents to at least 20 ft. from the threatened area, preferably on the opposite side of the closest fire door.
            2. **Alarm** Activate the closest fire alarm. Even though automatic alarms may be activated, contact the fire department by calling 911.
            3. **Confine** After removing endangered residents, close the door(s) of the threatened room or area. Close smoke/fire doors behind you as you go.
            4. **Extinguish/Evacuate** Assess the fire threat to either attempt to extinguish the fire or evacuate residents from the affected station. If the area is evacuated, check that all smoke/fire doors are properly closed. Block the bottom of the doors with sheets or towels to slow smoke penetration into the unaffected areas.
4. Fighting the fire:
    a. **Call 911 for all fires;** and
    b. If the fire is small, it may be extinguished by smothering (covering) with sheets or clothes, or by using a portable fire extinguisher.
        i. Fire extinguishers are used only if the fire is small and there is no threat of endangering the user or other individuals;
        ii. When using a portable extinguisher, staff are instructed to follow the "PASS" protocol: Pull, Aim, Squeeze, and Sweep:
            1. **Pull** the fire extinguisher pin;
            2. **Aim** the nozzle at the base of the flame;
            3. **Squeeze** the handle; and

4. **Sweep** the fire extinguisher back and forth at the base of the flame.

iii. Staff are advised to make **one** attempt to extinguish a fire with a fire extinguisher. If first attempt is unsuccessful, staff should confine the fire area and evacuate the residents and staff.

SPECIAL CARE UNIT/RESIDENTS FIRE PROCEDURE:

Vent units, dialysis units, dementia units, bariatric patients, and hospice patients are subject to special consideration during a fire emergency due to a locked unit and acuity. Due to this consideration, this center has special procedures for addressing these specific patients' safety needs, as documented in Appendix 17.

Refer to Appendix 17: Special Care Unit Fire Procedure

AUTOMATIC SPRINKLER OR ALARM SHUT-OFF

When it becomes necessary to shut off the automatic sprinkler or fire alarm system in the building for any reason, it is the duty and responsibility of the Administrator/Designee to:

Inform the Fire Department that the sprinkler or alarm system has been shut off, the reasons for system shut off, and the approximate length of time the system will be off.

Designate personnel to serve on fire watch for the period the sprinkler or alarm system is shut off.

Fire watch personnel tour the center at least every hour to check for fire or conditions that could result in fire. (The center follows local fire regulations requiring more frequent rounds to the extent that such regulations exist.)

Refer to:

Appendix 18: Fire Sprinkler Shut-Off Procedures
Appendix 19: Fire Alarm Reset Procedures

SECURITY PLAN

This center has established a security plan to help protect the safety of residents/patients, staff, and visitors.

1. Exterior building security
    a. This center has a schedule for locking/unlocking of exterior doors during nighttime hours, including persons responsible; and
    b. This center follows a schedule to inspect outdoor lighting adequacy.
2. Interior building security
    a. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection.
    b. This center's security plan includes a schedule to inspect indoor lighting adequacy.
    c. The center's plan also contemplates resident-specific security needs, including:
        i. Security measures for special units;
        ii. Risk for resident elopement;
        iii. Use of Electronic alarms systems; and
        iv. Communication call bells.
3. Administrative controls for security
    a. The center follows the communications protocols established in Section V of this plan as needed to address security issues.
    b. The center's security plan describes the check-in procedures for visitors.

Refer to Appendix 20: Security Plan

INTERNAL OR EXTERNAL DISTURBANCES

1. For disturbances within the center, staff are advised to:
    a. Approach the individual causing the disturbance (subject) and attempt to calm them down;
    b. If the individual cannot be quieted, politely ask the subject to leave the center;
    c. Call the police department for assistance if the subject does not cooperate; and
    d. If the subject attempts to leave after the call is made, do not attempt to detain him/her. Call the police back and inform them of the current situation.
2. Under the influence
    a. To protect the center, residents, visitors and personnel from being injured or offended by individuals under the influence of alcohol or narcotics, staff are advised to:
        i. Inform the individual of your intention to call them a cab and have them leave the property;
        ii. If the individual refuses to leave, call the police department; and
        iii. If the individual is an employee, immediately notify their supervisor and Administrator.
3. External disturbances
    a. Anyone detecting a civil disturbance or potential civil disturbance during normal business hours reports the situation to the Administrator and/or, after normal business hours, to the Manager on Duty (Incident Commander) who:
        i. Assesses the situation (location of the disturbance, what the disturbers are doing, how many are there, etc.);
        ii. Reports the situation to the police department immediately by dialing 911 and requesting assistance;
        iii. Instructs staff to lock all building doors and windows and close all blinds and curtains in resident rooms;
        iv. Instructs staff to move residents into their rooms and away from exterior windows and close room doors;
        v. Instructs visitors to stay in the resident room(s);
        vi. Monitors building access at all entrances to identify non-authorized persons attempting to enter the center. Unauthorized access/attempts at access to the center are immediately reported to 911;
        vii. Relinquishes control of the situation, if established, to the police department/EMS upon their arrival; and
        viii. When the disturbance has subsided or has been controlled, the Incident Commander surveys the affected areas and determine the need for additional assistance.

HOSTAGE SITUATION

1. If a hostage situation is identified, staff are advised to:
    a. Immediately call 911 and explain the situation to the police and provide specifics such as the:
        i. Subject's name or identifying information;
        ii. Victim(s);
        iii. Exact Location; and
        iv. Known or suspected weapon(s),
2. Notify Administrator or designee as soon as possible and activate the Emergency Plan;
3. The following announcement is made: **"Security Alert-We are activating Hostage protocols- We have a Hostage situation (Location). Please listen for further instructions."** Provide further instructions as needed;
4. Evacuate the affected area per the location's Evacuation Plan, attempt to isolate the subject, and secure the perimeter;
5. Remain calm; follow the subject's directions;
6. If the subject is talking: listen; do not argue;
7. Avoid heroics: be aware not to make sudden movements; and don't crowd the subject; and
8. Be prepared to respond to law enforcement personnel regarding your observations and any additional information you may have involving the subject or victim.

ELOPEMENT: MISSING RESIDENT/PATIENT

1. If a resident/patient is discovered missing:
    a. Communicate internal notification of missing resident/patient. The following announcement is made: **"Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.**;
    b. Begin a coordinated search throughout the building; search every room in the Center;
    c. Search immediate grounds, supply flashlights and associated supplies; and
    d. If the resident/patient is not found, the charge nurse/supervisor should:
        i. Notify the Administrator and DON or designees;
        ii. Call 911 and report the missing resident/patient;
        iii. Notify responsible family member;
        iv. Notify the resident's/patient's physician;
        v. Notify the appropriate state and local agencies; and
        vi. Supply resident's/patient's picture to police, etc.

Refer to Appendix 21: Elopement Drill Documentation Form

SEVERE WEATHER/NATURAL DISASTER

1. **TORNADOES**
   a. Tornadoes are violent local storms extending to the ground with whirling winds reaching 300 mph. Spawned from powerful thunderstorms, tornadoes can uproot trees, damage buildings, and turn harmless objects into deadly missiles in a matter of seconds. Damage paths can be in excess of one mile wide and 50 miles long. Tornadoes can occur in any state but occur more frequently in the Midwest, Southeast, and Southwest, with little or no warning.
      i. Tornado Watch – Atmospheric conditions are right for tornadoes to potentially develop. Be ready to take shelter. Stay tuned to radio and television stations for additional information. NOTE: Multi-floor centers consider relocating non-ambulatory and dependent residents from the higher floors to the lowest floor.
      ii. Tornado Warning – A tornado has been sighted in the area or is indicated by radar. Take cover immediately.
   b. Based on the results of the hazard vulnerability analysis, if this center is at risk for tornado, the center:
      i. Consults Emergency Management officials regarding the tornado warning system;
      ii. Monitors local media and alerts for tornado watches and warnings;
      iii. Has established procedures to inform personnel when tornado warnings are posted and considers the need for spotters to be responsible for looking out for approaching storms;
      iv. Educates staff on Areas of Refuge identified in Appendix 2;
      v. Considers the amount of space needed during a tornado, including consideration adults each generally require about six square feet of space and nursing home residents may require more space;
      vi. Identifies Areas of Refuge considering the best protection in a tornado is usually an underground area. If an underground area is not available, consider:
         1. Small interior rooms on the lowest floor without windows;
         2. Hallways on the lowest floor away from doors and windows;
         3. Rooms constructed with reinforced concrete, brick, or block with no windows or heavy concrete floor or roof system overhead; and
         4. Protected areas away from doors and windows. **Note: Auditoriums, cafeterias, and gymnasiums covered with flat, wide-span roofs are not considered safe.**
      vii. Makes plans for evacuating personnel away from lightweight modular offices or mobile home buildings. These structures offer no protection from tornadoes;
      viii. Conducts periodic tornado drills; and
      ix. Reviews the **Take Cover** Procedure and instructs affected individuals to **Take Cover** inside the center in a safe area if necessary.
   c. Emergency procedure: Tornado Watch
      i. The following announcement is made in the event of a Tornado Watch: **"Medical Alert. We are activating severe weather protocols. A tornado watch has been issued for this area** effective until _____ (*time watch*

ends). A **tornado watch** means current weather conditions may produce a tornado. Close all draperies and blinds throughout the center and await further instructions. Please continue with your regular activities."

ii. The above message is repeated several times after the first announcement, and then approximately hourly until the **watch** has terminated;
iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover procedures (described above);
v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position.
    1. The Incident Commander monitors weather alerts on radio and television.
vi. Staff closes all window drapes and blinds;
vii. Staff distributes flashlights, towels, and blankets to staff and residents;
viii. First aid and medical supplies are secured and taken to central area for refuge;
ix. Staff secures outside furniture, trash cans, etc.;
x. After the **Tornado Watch** has been cancelled and the Incident Commander has determined the dangerous situation has passed, an announcement is made: **"All Clear, Repeat, All Clear"**; and
xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

d. Emergency procedure: Tornado Warning
    i. The following announcement is made in the event of a Tornado Warning: "**Medical Alert. We are activating severe weather protocols. A tornado warning** has been issued for our area. Immediately implement Take Cover procedures. Repeating—a **tornado warning** has been issued for our area. Immediately implement Take Cover procedures." ;
    ii. The above message is repeated several times after the first announcement and then hourly until the **warning** has terminated;
    iii. In accordance with this EPP, the Administrator and DON are notified if not on the premises. Additional center personnel are notified as needed;
    iv. Center management convene together for instruction to be prepared for Shelter-in-Place/Take Cover/Evacuation procedures (described above);
    v. The center team activates this EPP to manage the event. The most qualified staff member on duty at the time assumes the Incident Commander position;
    vi. The Incident Commander monitors weather alerts on radio and television;
    vii. First aid and medical supplies are secured and taken to central area for refuge;
    viii. Upon hearing this announcement, all personnel follow the Shelter-in-Place/Take Cover procedures to provide for the safety of the residents, visitors, and themselves;
    ix. After the Tornado warning is over and the Incident Commander has determined the dangerous situation has passed, am **"All Clear, Repeat, All Clear"** announcement is made to inform affected parties that the **Take Cover** situation has ended;
    x. Upon issuance of the All Clear announcement, residents are taken back to their rooms; and

xi. The Incident Commander/Designee then accounts for residents, staff, and visitors.

EARTHQUAKE PROCEDURE

Earthquake: An earthquake is a sudden, rapid shaking of the ground caused by the breaking and shifting of rock beneath the Earth's surface. This shaking can cause buildings and bridges to collapse; disrupt gas, electric, and phone service; and sometimes trigger landslides, avalanches, flash floods, fires, and huge, destructive ocean waves (tsunamis). Buildings with foundations resting on unconsolidated landfill, old waterways, or other unstable soil are most at risk. Buildings or trailers and manufactured homes not tied to a reinforced foundation anchored to the ground are also at risk since they can be shaken off their mountings during an earthquake. Earthquakes can occur at any time of the year.

Hazards Associated with Earthquakes: When an earthquake occurs in a populated area, it may cause deaths, injuries and extensive property damage. Ground movement during an earthquake is seldom the direct cause of death or injury. Most earthquake-related injuries result initially from collapsing walls, flying glass, and falling objects, or from people trying to move more than a few feet during the shaking. Some of the damage in earthquakes is predictable and preventable.

Aftershocks: Aftershocks are smaller earthquakes following the main shock and can cause further damage to weakened buildings. Aftershocks can occur in the first hours, days, weeks, or even months after the quake. Some earthquakes are actually foreshocks, and a larger earthquake might occur.

1. The following hazards ARE considered if an earthquake may have caused structural damage to the center:
    a. Water system breaks: may flood basement areas;
    b. Exposure to pathogens from sanitary sewer system breaks;
    c. Exposed and energized electrical wiring;
    d. Exposures to airborne smoke and dust (asbestos, silica, etc.);
    e. Exposure to blood borne pathogens;
    f. Exposure to hazardous materials (ammonia, battery acid, leaking fuel, etc.);
    g. Natural gas leaks creating flammable and toxic environment;
    h. Structural instability;
    i. Insufficient oxygen;
    j. Confined spaces;
    k. Slip, trip or fall hazards from holes, protruding rebar, etc.;
    l. Falling objects;
    m. Fire;
    n. Sharp objects such as glass and debris;
    o. Secondary collapse from aftershock, vibration and explosions;
    p. Unfamiliar surroundings;
    q. Adverse weather conditions; and/or
    r. Noise from equipment (generators/heavy machines)
2. In planning considerations for earthquakes, the center:

a. Completes the HVA and determines the probability of an earthquake;
b. Consults with Emergency Management officials regarding earthquake preparedness and response expectations;
c. Identifies safe areas in the center; for example, under a sturdy tables or desks, against interior walls away from windows, bookcases, or tall furniture, considering that the shorter distance the center's occupants need to move to safety, the less likely occupants will be injured;
d. Secures furniture, appliances and other large items in accordance with applicable requirements to help comply with safety compliance and reduce potential damage and injury;
e. Uses NHICS Form 251, Center Systems Status Report, to assess the center following an earthquake;
f. The findings from NHICS Form 251 assist the Incident Commander in determining if the center needs to be evacuated or if occupants can shelter-in-place following the initial earthquake;
g. Trains staff, residents, and families on immediate response procedures to an earthquake including the steps to evacuate or shelter-in-place;
h. Conducts drills to prepare staff and residents for earthquakes;
i. Tracks costs associated with the earthquake's damage;
j. Identifies primary and secondary communications systems;
k. Prepares to address the psychological impact an earthquake can have on residents and staff; and
l. If an immediate peril is identified like a gas leak, uncontrolled fire, or threat of building collapse, the center may immediately evacuate in accordance with the **Evacuation Procedures described in Internal Responsibilities.**

FLOOD/FLASH FLOOD/DAM FAILURE

Flood Watch: An announced Flood Watch indicates local flooding is possible. To the extent practicable, the center team listens to the local radio and television stations for information and prepares to evacuate.
Flood Warning: An announced Flood Warning indicates flooding is already occurring or will occur soon. The center team takes precautions immediately after being made aware of this warning. Center teams prepare to move to higher ground and evacuate.

1. Planning considerations for floods:
   a. The risk of flood is assessed in the Appendix 1: Hazard Vulnerability Assessment. If flood is a probable risk, the center:
      i. Considers purchasing a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup, and staff listens for flood watches and warnings;
      ii. Reviews the local community's emergency plans and becomes familiar with the planned evacuation routes and areas of higher ground;

iii. Inspects onsite areas potentially subject to flooding and onsite areas to which records and equipment could be moved making plans to move records and equipment as needed;
iv. Reviews the center insurance coverage for flooding;
v. Undertakes flood proofing measures, as necessary. These measures include:
1. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings;
2. Installing watertight doors;
3. Constructing movable floodwalls; and
4. Installing pumps to remove flood waters.

b. Note: The center may undertake other emergency flood proofing measures generally less expensive than those listed above but require substantial advance warning. They include:
i. Building walls with sandbags;
ii. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil; and/or
iii. Constructing a single wall by stacking small beams or planks on top of each other.

c. The center evaluates the need for backup systems, such as:
i. Portable pumps to remove flood water;
ii. Alternate power sources such as generators or gasoline-powered pumps; and
iii. Battery-powered emergency lighting.

2. Emergency procedure: flooding general procedures
a. In the event of an expected flood, the following announcement is made:
i. **"Medical Alert-We are activating severe weather protocols. A flood/flash flood watch or warning has been issued for this area effective until _____ (*time watch ends*).** A **flood watch** means that current weather conditions may produce flooding. A **flood warning** indicates flooding is occurring in the area. Please await further instructions." The center provides additional instructions as known and necessary.
ii. Administrator and DON are notified if not on the premises;
b. Center staff accounts for all residents and staff members;
c. Center management staff convene together for a briefing and instruction;
d. The Incident Commander activates this plan to manage the incident. (The most qualified staff member on duty at the time assumes the Incident Commander position);
e. The Incident Commander decides whether to flood proof (see above) or evacuate based on geographical location and history of flooding of the center as well as the results of the evacuation analysis discussed above. If evacuation is necessary, the evacuation processes described above are followed; and
f. The situation is only deemed "under control" after the local authorities have concluded emergency operations and the Incident Commander has declared the situation "safe."

3. **EMERGENCY JOB TASKS: FLOODING**
4. Administrator/Incident Commander:
i. Determine to flood proof the center or evacuate;

ii. If decision is to evacuate, use the evacuation procedures described above; and
iii. Account for residents, staff, and visitors.

b. All Staff/Management:
   i. Assist with flood proofing the center if necessary.

HURRICANES, TROPICAL STORMS AND FLOODING

This center consults with Emergency Management Office to determine flood zone and hurricane evacuation zones, and monitors flood watches and warnings. (Note: Wind damage from a hurricane can necessitate evacuation even if there is no threat of flooding from the storm surge.)
If hurricane or tropical storm warnings are issued for the area, the center team makes plans to protect outside equipment and structures, and follows guidance from the EMS regarding evacuation and other precautions. The center also makes and implements plans to protect windows, such as by use of permanent storm shutters or installation of window covers.
The center also considers and implements backup systems as needed, such as portable pumps to remove flood water and alternate power sources, such as generators or gasoline-powered pumps.

1. Hurricane and tropical storm threat and watch center procedures
   a. Local authorities issue a ***"Watch"*** when a hurricane or tropical storm is expected to hit within 36 hours. The center then makes the following announcement is:
      i. **"Medical Alert: We are activating severe weather protocols. A hurricane/tropical storm watch has been issued for this area effective until _____ (*time watch ends*)."**
   b. After the announcement, each department leaders contacts their staff and creates a schedule of employees to work during the emergency. Staff is scheduled to work:
      i. Before the storm strikes;
      ii. During the storm; and
      iii. After the storm.
   c. The Incident Commander alerts alternate care facilities and transportation providers of the potential evacuation; and
   d. The Incident Commander and center team considers resident acuity/status, infection control precautions in determining transportation needs. (Refer to the procedures above regarding Shelter-in-Place or Evacuation.)

PANDEMIC INFLUENZA

EPIDEMIC GENERAL STATEMENT

The leadership team (Administrator, DON/Resident Care Director, and Center Medical Director) complete the **Epidemic Preparedness Checklist.** If there is an outbreak in the center, the leadership team directs activities.

EPIDEMIC GUIDELINES

1. When an epidemic is declared, follow instructions from clinical leadership to implement the following:
    a. If a severe staffing shortage is apparent, deploy alternative staffing and implement altered standards of care;
    b. Implement use of the **Daily Symptom Screening Form** for all new admissions, re-admissions, staff, visitors, and vendors; and
    c. Make provisions to accommodate overcrowding.
2. **Refer to:**
    a. Epidemic Preparedness Checklist
    b. Influenza Preparedness Plan PowerPoint (on Central)
    c. Altered Standards of Care
    d. Daily Symptom Screening Form
    e. Outbreak Intervention Tiers for Influenza and Gastroenteritis (on Central)

3. General guidelines
    a. Residents with symptoms of or confirmed with targeted epidemic illness should remain in their rooms. Limit transport to medically necessary purposes;
    b. Place a sign stating "Stop-See Nurse Before Entering/For Instructions" on the door;
    c. If there is a widespread outbreak of residents with targeted epidemic illness, or symptoms of influenza, use existing partitions (smoke doors, separate floors) to establish restricted entrance areas in the building furthest away from common areas used by residents and staff;
    d. Label the area as "Stop-See Nurse Before Entering/For Instructions" on the entrances to the area;
    e. Allow serial use of N95 disposable respirators within this area to conserve respirators/masks if the respirator/mask supply is in question;
    f. Place a surgical mask on residents with influenza or other respiratory illness symptoms who are required to be moved out of the restricted area or their rooms;
    g. Instruct visitors:
        i. To limit movements within the building;
        ii. On limiting hand contact with surfaces in the center; perform hand hygiene after surface contact;
        iii. On respiratory hygiene/cough etiquette; and
        iv. On hand hygiene before entering and when leaving the resident room and with any resident contact.
    h. Perform hand hygiene immediately after removing mask or respirator or any PPE;
    i. Treat all excretions, secretions and body fluids as potentially infectious; and

j. Wash hands with soap and water if hands visibly soiled or caring for resident with C. diff or any gastrointestinal infection or use an alcohol-based hand gel.

EMERGING INFECTIOUS DISEASES

1. Definition: Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:
    a. New infections resulting from changes or evolution of existing organisms;
    b. Known infections spreading to new geographic areas or populations;
    c. Previously unrecognized infections appearing in areas undergoing ecologic transformation; and
    d. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

2. General Preparedness for Emergent Infectious Diseases (EID)
    a. Center leadership will be vigilant and stay informed about Emerging Infectious Diseases (EID) with the assistance of Corporate and Divisional Clinical leaders. They will keep Divisional administrative and clinical leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
3. Local Threat
    a. Once notified by the public health authorities at either the federal, state and/or local level the EID is likely to or already has spread to the center's community, the center activates specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities;
    b. The center's Infection Preventionist (IP), with assistance from the National Infection Prevention and Control Team as needed, researches the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies;
    c. Based on the specific disease threat, the center reviews and revises internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated;
    d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing;
    e. If EID is spreading through an airborne route, then the center activates its respiratory protection plan (refer to GHC Policy and Procedure SH408 Respiratory Protection Program) to ensure employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure;
    f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information;
    g. Brief contractors and other relevant stakeholders on the center's policies and procedures related to minimizing exposure risks to residents;
    h. Post signs regarding hand hygiene and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the center along with the instruction that anyone who is sick must not enter the building; and

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the center, screening for exposure risk and signs and symptoms may be done, if possible, prior to admission of a new resident and/or allowing new staff persons to report to work.

4. Self-screening:
    a. Staff will be educated on the center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
        i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health;
        ii. Precautionary removal of employees who report an actual or suspected exposure to the EID;
        iii. Self-screening for symptoms prior to reporting to work; and
        iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
5. Self-isolation:
    a. In the event there are confirmed cases of the EID in the local community, the center may consider closing the center to new admissions, and limiting visitors based on the advice of local public health authorities.
6. Environmental cleaning: The center follows current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
    a. Engineering controls: The center uses appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.
7. Instructions to manage suspected case(s) in the care center:
    a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation/precaution room and notify local public health authorities;
    b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible. Resident to wear mask during the transfer;
    c. If the suspected infectious person requires care while awaiting transfer, follow center policies for isolation/precaution procedures, including all recommended PPE for staff at risk of exposure;
    d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE;
    e. If feasible, ask the isolated resident to wear a mask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated resident unless it advised otherwise by public health authorities;
    f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation/precaution room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC;

g. Implement isolation/transmission-based precautions (TBP) procedures in the center (isolation/TBP rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities; and
h. Activate quarantine (separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

ARMED INTRUDER GENERAL GUIDELINES

In situations in which there is lead-in time to a potential armed intruder violence threat against the center, the center management team discusses actions to be taken by the center and questions to ask the intruder.

1. During an armed intruder event, the center follows steps, when possible, staff will determine which of the "Four Outs" will be the best for their survival:
    a. "Get Out": Identifying current residents, visitors and staff for potential exit from the center. Individuals will proceed to exit the building until they find a safe place. (This is the best choice if staff can safely do so.);
    b. "Lock Out": Identifying if residents, visitors and staff could be protected by potentially locking them in the center, preventing entry by the intruder. Individuals will get behind a locked or barricaded door. This action is the next best choice and if it is safe to do so, the best way to protect residents from becoming a victim;
    c. "Hide Out": Identifying current residents, visitors, staff and locations for potential concealment within the center. Staff will hide in inconspicuous places in the center. Staff can help residents by hiding them in plain sight (e.g. Put extra linens on a resident's bed when the resident is bed-ridden; or
    d. "Take Out": Establishing a plan to stop the armed intruder's activities. Staff will use diversions and weapons of opportunity to take out the Armed Intruder. When considering a takeout plan, if there are several people, use diversions and make a plan to gang up on the Armed Intruder.
2. In addition, a staff member calls 911 when safe to do so. Gives the 911 operator specific details to aid in law enforcement's response to the event. Uses a center phone even if just to leave an open line to the 911 operator;
3. The fire alarm is not pulled/activated; and
4. Refer to the Armed Intruder Training and associated Armed Intruder Table Top Exercise for more information on the center's plan and practices used to manage these emergencies.

WINTER STORMS

Background

Winter storms are often an underestimated threat. For the frail elderly, the single greatest threat posed by winter is the loss of body heat. Normal aging is accompanied by a decline in the ability to thermo-regulate. Chronic ailments and acute injuries exasperate the ability to self-regulate body temperature. In fact, fifty percent of cold-related injuries happen to individuals over the age of 60.

1. Preparing for the Storm
    a. Before the snow begins:
        i. All departments must inventory existing supplies and order low supplies prior to snowfall;
        ii. Generator fuel must be checked and generator test run. If your generator uses diesel or propane, the tank should never fall below ½ tank fill level at any time; and
        iii. Snow blower fuel must be checked and test run.
    b. After snow has started to fall:
        i. Parking lot entrance, fire lane and all facility exits must be kept clear;
        ii. Fire hydrants are to be kept accessible at all times; and
        iii. Areas for ambulances and supply vehicles take priority over parking areas.
2. Winter Hazard Communication
    a. The National Weather Service issues outlooks, watches, warnings, and advisories regarding potentially hazardous winter weather:
        i. Outlook: this is essentially a forecast, informing the public winter storm conditions are possible in a 2 to5 day timeframe. Actions at this time are to monitor local media for weather condition updates;
        ii. Advisory: winter weather conditions are expected and could cause significant inconvenience and could potentially create hazardous conditions. However, if one is prepared and cautious, advisory conditions should not be life threatening;
        iii. Watch: winter storm conditions are possible within a 36 to 48-hour window. Begin preparations; and
        iv. Warning: potentially hazardous winter weather is occurring or will occur in 24 hours.
3. Wind Chill
    a. Wind chill can be a significant problem. Exposure to cold can lead to frostbite or hypothermia. The elderly are highly susceptible. Regardless of whether the temperature is 32F or -32F, cold has the same effect. Wind chill is not the actual air temperature, but is the impact of the combination of wind and cold upon exposed skin. Moving air conducts heat away from the body faster.

Wind Chill Chart

Adapted from the National Weather Service, Originally Published 11/01/01.

Temperature across top, wind speed down left side.

Calm	40	35	30	25	20	15	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	36	31	25	19	13	7	1	-5	-11	-16	-22	-28	-34	-40	-46	-52	-57	-63
10	34	27	21	15	9	3	-4	-10	-16	-22	-28	-35	-41	-47	-53	-59	-66	-72
15	32	25	19	13	6	0	-7	-13	-19	-26	-32	-39	-45	-51	-58	-64		
20	30	24	17	11	4	-2	-9	-15	-22	-29	-35	-42	-48	-55	-61			
25	29	23	16	9	3	-4	-11	-17	-24	-31	-37	-44	-51	-58				
30	28	22	15	8	1	-5	-12	-19	-26	-33	-39	-46	-53					
35	28	21	14	7	0	-7	-14	-21	-27	-34	-41	-48						
40	27	20	13	6	-1	-8	-15	-22	-29	-36	-43	-50						
45	26	19	12	5	-2	-9	-16	-23	-30	-37	-44							
50	26	19	12	4	-3	-10	-17	-24	-31	-38	-45							
55	25	18	11	4	-3	-11	-18	-25	-32	-39	-46							
60	25	17	10	3	-4	-11	-19	-26	-33	-40								

Frostbite Times

30 Minutes

10 Minutes

5 Minutes

1. Response to wind chill
    a. To ensure residents do not suffer from exposure to cold, consider the following:
        i. Providing extra attention to residents who wander or are at risk for elopement;
        ii. Clothing in loose-fitting layers and an insulated head covering, even indoors;
        iii. Attempt to ensure that residents remain dry;
        iv. Should a person succumb to cold, warming the person slowly, starting with the body core. Do not start warming with the arms and legs, as this will drive cold blood toward the heart which can trigger heart failure. Change the resident into warm, dry clothing and then cover them with a blanket. Avoiding providing alcohol, coffee, or any other hot beverage or food. Discuss administration of medications with the attending provider;
        v. Providing high calorie foods and snacks for staff and residents;
        vi. Providing extra blankets. (If possible, hypo-allergenic blankets should be used. Residents who wish to use their own wool blankets or quilts with other natural fibers should be allowed to do so, but they should not be allowed to share these items as other residents may be allergic to the natural fibers); and
        vii. Monitoring residents and increasing hydration activities; increased clothing and use of blankets may increase sweating. Dry air associated with extremely cold weather may also lead to residents dehydrating faster.

2. If the heating system suffers a significant mechanical failure during cold weather, consider evacuation;
3. Residents on medical oxygen should be given alternate safe means of staying warm and should be kept away from any potential source of ignition; and
4. Evacuation under icing conditions is not a good idea. Be prepared to shelter in place in winter.

Refer to <u>Loss of Utilities</u> Heating Failure if center heat is compromised.

1135 WAIVERS

1. In the event a major disaster or public health emergency is declared by the Secretary, the facility reserves the right to request a waiver in accordance with section 1135 of the Social Security Act, and by which certain statutory requirements and or services may be modified or waived during the duration of the emergency;
2. Under the waiver the role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials is such that sufficient services and healthcare items will be provided to the maximum extent feasible and in part, modifies requirements that physicians and other healthcare professional hold licenses in the State in which they provide services if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area).

VOLUNTEERS

The Center may use volunteers in an emergency or other emergency staffing strategies as necessary to provide for the care and treatment of patients. The Center collaborates with the local Emergency Management Services and state or federally designated health care professionals to address surge needs during an emergency. Involvement of volunteers in management of emergencies is addressed in this EPP.

1. The Administrator/Designee determines involvement, appropriate tasks and roles of volunteers;
2. In advance of a crisis or disaster situation, the center works to ensure staff members, contractors, volunteers, physicians, residents, family members, and the community-at-large understand the center has developed a relationship with local emergency responders as well as the local Emergency Management Services to plan for, prepare for, respond to, and recover from such situations;
3. Staff are monitored through use of the staffing schedules (updated as needed).
4. Volunteers, visitors, and others are monitored using the visitor log (typically kept in the reception area);
5. The center maintains current information all center personnel and volunteers with addresses and phone numbers for contact purposes; and
6. The Incident Commander/designee coordinates with center department heads to determine staff/volunteer resources needed both for onsite needs and in the event staff is needed in alternate locations. Trained volunteers are permitted to transport, move and assist residents if necessary.

Refer to Exhibit 8. NHICS Form 523, Volunteer Staff Registration.

ANNUAL REVIEW AND SIGN-OFF

1. The Safety Excellence Team and the Administrator reviews and approves this manual and associated appendices and supporting documentation:
    a. Prior to implementation;
    b. After regulatory updates;
    c. If new hazards are identified or existing hazards change;
    d. After tests, drills, or exercises, if issues requiring corrective action have been identified;
    e. After actual disasters/emergency responses;
    f. After infrastructure changes;
    g. At each update or revision; and
    h. At least annually.
2. Staff Training
    a. All staff are trained and demonstrate competency during orientation and annually with materials based on this Emergency Preparedness Plan and corresponding policies and procedures. The center maintains electronic and/or written documentation of training. Administrators must ensure training is completed as required.
3. Staff Testing: Exercises, Drills and Simulations
    a. This center conducts internal and external training exercises, drills, and simulations **at least annually and in accordance with applicable local, state, and federal guidelines**. This training is discussed further in the center's Emergency Preparedness Compliance Guide.
        i. This center participates in full-scale, community-based exercise or, when a community-based exercise is not accessible, an individual, facility-based exercise.
        ii. This center conducts an additional exercise that may include, but is not limited to the following:
            1. a second full-scale community-based exercise or individual,
            2. a facility-based full scale exercise, or
            3. a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.
        iii. If this center has experienced an actual natural or man-made emergency requiring activation of the emergency plan, the center will not need to participate in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the event; and
        iv. The center documents completion of these activities. This documentation includes an analysis of the center's response to the exercise and emergency events, and revises this Emergency Preparedness Plan as needed.
    b. Exercises, drills, and simulations are used to practice emergency procedures and to identify concerns prior to a crisis or disaster situation;
    c. Drill evaluation are be conducted on different levels of management within the center;
    d. Drill evaluations are not confined to routine fire or evacuation drills;

e. Drill evaluations are used to verify planning, response, and recovery programs are in place for the center;
f. Outside resources, including local emergency responders/support services, are invited to periodically participate in, observe, and evaluate internal exercises, drills, and simulations; and
g. Exercises, drills, and simulations are documented to include:
    i. Who participated;
    ii. Concerns identified;
    iii. Corrective actions taken to correct deficient areas; and
    iv. Reports of such activities are retained within the center per state and federal regulations.

Refer to:
Appendix 24: Annual Review and Sign-off

STATE AND LOCAL REQUIREMENTS

The center may be required to follow more stringent state and local regulations than guided within this manual. As such, additional regulations are analyzed and complied with as necessary.

Refer to:
Appendix 25: State and Local Requirements

POLICIES AND PROCEDURES LINKS

Corporate Policies and Procedures
Emergency Preparedness
Emergency Preparedness: Evacuation and Waivers
Emergency Preparedness: Medical Records
Emergency Preparedness: Shelter in Place
Emergency Preparedness: Supplies
Significant Events Reporting

Food and Nutrition Services Procedures
Food Service Emergency Plan (P&P 6.3)
Food Service Emergency Procedures (P&P 6.4)

Omnicare LTC Pharmacy Services
LTC Facilities Receiving Pharmacy Products and Services from Pharmacy
Relocation of Residents or Pharmacy Services During an Emergency or Disaster

Center Operations
OPS100 Accidents/Incidents
OPS142 Transfer Agreements
OPS161 Facility Assessment
OPS164 Utilization of Outside Resources during an Emergency

Preventative Maintenance Policies and Procedures
Emergency Generators

Safety and Health Policies and Procedures
SH100 Safety Management Program
SH601 Personal Protective Equipment
SH602 Personal Protective Equipment: Assessment of
SH604 Procurement and Distribution of Respirators: Airborne Illness

FEDERAL DEFICIENCIES (ETAG) CROSSWALK

Provided as reference. **Users are strongly encouraged to refer to Genesis Central for up to date policies and procedures and to search for key words within this document and on Central for additional information.**

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0001	Establishment of the Emergency Program	Corporate P & P 1.22, Emergency Preparedness	Completed EPP (Full Plan) Completed EP Compliance Guide Appendices
E-0004	Development Maintain EP Program	Same as above	Same as above
E-0006	Maintain and Annual EP Updates	Same as above	Same as above
E-0007	EP Program Population	Center Operations P & P OPS 161 Facility Assessment	EPP Appendix 23. Description of Center Patient/Resident Population
E-0009	Process for EP Collaboration	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	References to collaboration throughout EPP
E-0013	Development of EP Policies and Procedures	Refer to Links Above	Refer to Links Above
E-0015	Subsistence Needs for Staff and Patients	Refer to Links Above	References throughout EPP
E-0018	Procedures for Tracking of Staff and Patients	Corporate P & P 1.22, Emergency Preparedness	Refer to Exhibit 3 and Exhibit 7 NHICS Forms 255 and 252 and references to these forms in the EPP
E-0020	Policies and Procedures including evacuation	Refer to Links Above	References to Evacuation throughout EPP
E-0022	Policies and Procedures for Sheltering	Corporate P & P 1.31, Emergency Preparedness: Sheltering in Place	References to Sheltering in Place in EPP
E-0023	Policies and Procedures for Medical Documents	Corporate P & P 1.30, Emergency Preparedness: Medical Records	Refer to Section LL, Receiving Center: Medical Records

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0024	Policies and Procedures for Volunteers	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Refer to Section XXIX. Volunteers and Exhibit 8, N HICS Form 523, Volunteer Staff Registration
E-0025	Arrangement with Other Facilities	Center Operations P & P OPS142 Transfer Agreements and OPS 164 Utilization of Outside Resources During an Emergency	Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0026	Roles under a Waiver Declared by the Secretary	Center Operations P & P OPS163 Utilization of Outside Resources during an Emergency	Refer to Section XXVIII. 1135 WAIVERS
E-0029	Development of Communication Plan	Corporate P & P 1.22, Emergency Preparedness	Refer to section V. COMMUNICATION PLAN and associated exhibits
E-0030	Names and Contact Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Appendix 3: Center Administrative/Staff Contact List
E-0031	Emergency Contact Information	Corporate P & P 1.22, Emergency Preparedness; Center Operations P & P OPS164, Utilization of Outside Resources during an Emergency	Appendix 7: Emergency Resources and Contacts
E-0032	Primary/Alternate Means of Communication	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN
E-0033	Methods of Sharing Information	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. COMMUNICATION PLAN and Appendix 7: Emergency Resources and Contacts as well as references to evacuation and medical records throughout the EPP

FEDERAL TAG #	DESCRIPTION	POLICY REFERENCE	EPP REFERENCE
E-0034	Sharing Information on Occupancy/Needs	Corporate P & P 1.22, Emergency Preparedness, Center Operations P & P OPS 142 Transfer Agreements	Refer to Section VII, SURGE CAPACITY and Appendix 13, Surge Capacity, and Refer to Section VI.D. D. Administrator (OR DESIGNEE) ALL EMERGENCIES and Appendix 9, Transfer Agreements
E-0035	LTC and ICF/IID Family Notifications	Corporate P & P 1.22, Emergency Preparedness	Refer to Section V. Communication Plan and Section III. General Guidelines, D. Notification of Plan
E-0036	Emergency Prep Training and Testing	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0037	Emergency Prep Training Program	Corporate P & P 1.22, Emergency Preparedness	Vital Learn Reports and Completed Attestations; refer to Emergency Preparedness Compliance Guide
E-0039	Emergency Prep Testing Requirements	Corporate P & P 1.22, Emergency Preparedness	Refer to Section XXX. Annual review and Sign Off and the Emergency Preparedness Compliance Guide
E-0041	LTC Emergency Power	Preventative Maintenance P & P 2.0, Emergency Generators	Refer to Section XII, Loss of Utilities, Appendix 2, Building Construction and Safety, and Appendix 15, Utility Shut Off Procedures
E-0042	Integrated Health Systems	Not Applicable	Not Applicable

PLAIN LANGUAGE EMERGENCY NOTIFICATION SCRIPT

TAKE COVER

"Attention all staff, there is an immediate situation requiring all occupants to Take Cover. Please initiate the Take Cover Procedure."

"All Clear, Take Cover is over" is then paged to signal the Take Cover situation has ended.

LOSS OF UTILITIES

"Facility Alert-We are activating Loss of Utilities protocols- (Describe loss of Power and Location). Please continue your duties and listen for further instructions."

BOMB THREAT

"Security Alert-We are activating Bomb Threat protocols- (Describe how the threat was received and Location). Please continue your duties and listen for further instructions."

NUCLEAR, CHEMICAL, OR RADIATION FALLOUT

"Facility Alert-We are activating Nuclear, Radiation or Hazardous Chemical Fallout protocols- (Describe Situation and Location). Please continue your duties and listen for further instructions."

FIRE

"Facility Alert-We are activating Fire Emergency Protocols (Describe Situation and Location)."

INTERNAL OR EXTERNAL DISTURBANCE

"Security Alert- We have a disturbance (Location). Please listen for further instructions."

HOSTAGE/ARMED INTRUDER SITUATION

"Security Alert-We are activating Hostage/Armed Intruder protocols- We have a Hostage/Armed Intruder situation (Location). Please listen for further instructions."

ELOPEMENT

"Medical Alert-We are activating Missing Resident protocols- The Resident was last seen (location)."

TORNADO WATCH

"Medical Alert-We are activating severe weather protocols- A tornado watch has been issued for this area effective until _____ (time watch ends)." (Repeated after five (5) minutes and then hourly until the watch has terminated.)

TORNADO WARNING

"Medical Alert-We are activating severe weather protocols- A tornado warning has been issued for our area. Immediately implement Take Cover procedures. Repeating—a tornado warning has been issued for our area. Immediately implement Take Cover procedures." (Repeated after five (5) minutes and then hourly until the warning has terminated)

FLOOD WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- A flood/flash flood watch or warning has been issued for this area effective until _____ (time watch ends)."

HURRICANE WATCH OR WARNING

"Medical Alert-We are activating severe weather protocols- a hurricane/tropical storm watch has been issued for this area effective until _____ (time watch ends)."

GENERAL ALL CLEAR ANNOUNCEMENT

"All Clear, Repeat, All Clear"

Emergency Preparedness Plan (EPP) List of Appendices

- Appendix 1: Hazard Vulnerability Analysis (HVA)
- Appendix 2: Building Construction and Life Safety
- Appendix 3: Center Administrative/Staff Contact List
- Appendix 4: Emergency Operation Center Designation
- Appendix 5: Area Administrative Staff Contact List
- Appendix 6: Company Contacts
- Appendix 7: Emergency Resources and Contacts
- Appendix 8: Additional Resources
- Appendix 9: Transfer Agreements
- Appendix 10: Short-term Evacuation Plan
- Appendix 11: Triage of Casualties
- Appendix 12: Emergency Supplies and Location of Critical Equipment
- Appendix 13: Surge Capacity
- Appendix 14: Emergency Water Supply
- Appendix 15: Utility Shut-off Procedures
- Appendix 16: Potential Explosives List
- Appendix 17: Special Care Unit Fire Procedure
- Appendix 18: Fire Sprinkler Shut-Down Procedures
- Appendix 19: Fire Alarm Reset Procedures
- Appendix 20: Security Plan
- Appendix 21: Elopement Drill Documentation Form
- Appendix 22: Succession Plan
- Appendix 23: Description of Center Patient/Resident Population
- Appendix 24: Annual Review and Sign-Off
- Appendix 25: State and Local Requirements
- Appendix 26: Insertions from Compliance Guide Completed Tasks

Appendix 1: Hazard Vulnerability Analysis (HVA)

Instructions
Evaluate each event type using the hazard specific scale, using an all-hazards approach that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address a wide spectrum of emergencies/disasters.

Event Type
This column includes the event, risk or disaster you are assessing. Additional events may be added and evaluated in the Assessment; use the blank lines for these items.

Probability
Rate the probability of the risk occurring on a scale of zero (event will not occur) to 3 (event is very likely to occur). To rate the probability of an event occurring, at a minimum consider the known risk of the event occurring based on historical data and manufacturer/vendor statistics.

- Scale: How often has the event occurred within the last year to 10 years?
  - There is no likelihood of this event occurring in this setting/area (i.e., volcano). = score of 0 (no additional entries are required for this event type)
  - Event has not occurred in the past 10 years = score of 1
  - Event occurs every 3 to 10 years = score of 2
  - Event occurs approximately every 1 to 3 years = score of 3

Note: The Probability of human events (i.e., workplace violence, mass casualties) can never be assessed with a probability score of 0. These types of events have the score of 0 identified as N/A in the HVA.

Risk
Rate the associated risk of each event to patients and staff, property, finances (such as the cost to replace, cost of repair, time to recover and the potential interruption or inability to provide services). Input the highest associated score.

- Scale: If the event occurs will it result in:
  - A threat to human health, safety or life? Could the event result in significant injury or death? Score = 5
  - Property Damage? Score = 4
  - Economic Loss or Legal Ramifications? Will employees be able to report to work? Will patients be able to get to the center? Would the center be at risk for fines, penalties, or other legal interventions? Score = 3
  - Systems Failure? Score = 2
  - Loss of Community Trust or Goodwill? Score = 1

Preparedness
Rate the center's level of preparedness for the event.

- Scale: If the event occurs the center is:
  - Well prepared: the center has a current plan, the staff is aware of the plan and has participated in drills, back-up systems are available = score of 1
  - Partially prepared: the center has a plan, with current documents and contracts. Staff may require additional training or drills, center may need back-up systems = score of 2

- Not Prepared: the center does not have a plan at all, or only has a plan, and has not trained the staff or collected associated documents and contracts, and does not have back-up systems = Score of 3

Using the HVA

For each row, Multiply the Probability score by the sum of the Risk and Preparedness scores from all columns, enter score Review and highlight the events types with highest Hazard Vulnerability (HV) scores. These events pose the greatest risks to the center, and are carefully considered and prepared for as the center completes the rest of the appendices in the EPP, and associated training and drills.

Hazard Vulnerability Assessment

Center Name Keene Center Business Unit #: _____ Date: 11/1/22

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			HV SCORE
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	←*Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
HURRICANE		X			X							X	
TORNADO		X			X							X	
SEVERE THUNDERSTORM	X				X							X	
SNOWFALL	X				X							X	
BLIZZARD	X				X							X	
ICE STORM		X			X							X	
EARTHQUAKE		X			X							X	
TIDAL WAVE				X					X		X		
EXTREME TEMPERATURES		X				X						X	
DROUGHT				X		X						X	
FLOOD, EXTERNAL			X		X							X	
WILD FIRE			X								X		
LANDSLIDE			X								X		
VOLCANO				X									
PANDEMIC				N/A	X						X		
ELECTRICAL FAILURE		X			X							X	
GENERATOR FAILURE		X			X							X	
TRANSPORTATION FAILURE		X			X						X		
FUEL SHORTAGE		X			X						X		
NATURAL GAS FAILURE		X			X							X	
SEWER FAILURE		X			X							X	
STEAM FAILURE		X			X								
FIRE ALARM FAILURE		X			X							X	
COMMUNICATION FAILURE		X			X						X		

EVENT TYPE	PROBABILITY				RISK					PREPAREDNESS			TOTAL
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	← *Multiply probability score by sum of risk and preparedness scores from all columns, enter score*
MEDICAL VACUUM FAILURE				N/A			X				X		
HVAC FAILURE		X									X		
INFORMATION SYSTEM		X					X				X		
FIRE, INTERNAL			X			X					X		
FLOOD, INTERNAL			X			X					X		
HAZMAT, INTERNAL			X			X					X		
MASS CASUALTY – TRAUMA			X	N/A	X						X		
MASS CASUALTY – MEDICAL			X	N/A		X					X		
MASS CASUALTY – HAZMAT			X	N/A	X						X		
HAZMAT EXPOSURE			X	N/A	X						X		
TERRORISM – BIOLOGICAL			X	N/A	X						X		
TERRORISM – CHEMICAL			X	N/A	X						X		
HOSTAGE SITUATION			X	N/A	X						X		
CIVIL DISTURBANCE (RIOT)			X	N/A		X					X		
LABOR ACTION			X	N/A		X					X		
BOMB THREAT			X	N/A	X						X		
WORKPLACE VIOLENCE			X	N/A	X						X		
DOMESTIC VIOLENCE			X	N/A	X						X		
BUILDING BREAK-IN			X	N/A		X					X		
AUTO BREAK-IN			X	N/A			X				X		
MEDICATION THEFT			X	N/A			X				X		
ASSAULTS (OUTSIDE)			X	N/A					X		X		
ELOPEMENT		X		N/A	X							X	
KIDNAPPING			X	N/A	X						X		

Appendix 2: Building Construction and Life Safety

Instructions: Enter information as prompted.

A. Building Construction Type/Year Built (refer to Life Safety Survey for details): Masonry / Brick 1978

B. Have additions been constructed? Yes X No

1. If additions have been constructed, in what year(s)?

C. Number of Stories: 2

D. Number of Buildings: 1

E. Number of Beds: 128

F. Approximate Number of Staff per Shift: 1st = 45, 2nd=20, 3rd=12

G. Fire Alarm System –
Name of Monitoring Service: Direct link to Keene Fire

H. Generator Vendor Name: Power Up

Generator Vendor Phone Number: 603-657-9080/ 866-420-4906

1. Type, phase and voltage of generator: Kohler 3 phase 102-208
2. Areas of the building supplied by emergency power: Complete building coverage
3. Fuel Type: Diesel
4. Fuel Capacity: 1278 gallons
5. Fuel Duration: 102-142 hours 4-6 days
6. Fuel Tank above or below ground level?: Above Ground
7. How/When is generator tested?: Weekly under partial load
8. Is generator above projected flood level?: Yes, except if local dam is breached.

I. Is the building constructed to withstand hurricanes or high winds? X Yes No
If Yes:
   1. What is the highest category of hurricane or wind speed that the building can withstand? 150 miles per hour
   2. What is the highest category of hurricane or wind speed that the center roof can withstand 100 miles per hour
   3. Is the center in a flood plain? **X** Yes No
   4. If the center is in a hurricane zone, is a storm surge expected? Yes **X** No

J. General description of resident/patient population:
Rehab and long term care residents and patients. Medical conditions vary. Ambulatory and non ambulatory residents with a changing resident population.

For the safety of building occupants, the Emergency Preparedness Leadership Team identifies the best available refuge areas in the center. Many buildings contain rooms or areas designed to offer some degree of protection from all but the most extreme tornadoes and winds. In buildings without specific rooms designed and constructed to serve as safe rooms, the goal should be to select the **best available refuge areas** - the areas that will provide the greatest degree of protection.

In general, the **best available refuge areas** meet the following criteria:

- **Interior rooms.** Rooms without an exterior wall or window are less likely to be penetrated by windborne debris. Examples include resident bathrooms, small office areas without windows, janitor closets, clean and soiled utility rooms, pantry storage rooms, medication rooms, basement rooms and corridors, central supply rooms, center restrooms, staff locker rooms, and closets.
- **Location below ground or at ground level.** Upper floors are more vulnerable to wind damage.
- **No glass in the room.** Typically, windows and glass doors are extremely vulnerable to high wind pressures and the impact of windborne debris.
- **Reinforced concrete or reinforced masonry walls.** Reinforced walls are much more resistant to wind pressures and debris impact, but can fail if the roof deck is blown away.
- **Strong connections between walls and roof and walls and foundation.** Walls and roofs are better able to resist wind forces when they are securely anchored to the building foundation.
- **Short roof spans.** Roofs with spans of less than 25 feet are less likely to be lifted up and torn off by high winds.
- **Long central corridors** often qualify as the best available refuge areas. In addition to having desirable structural characteristics (e.g., short roof spans, minimal glass area, and interior locations), corridors usually are long enough to provide the required amount of refuge area space and can be quickly reached by building occupants. **If a corridor is chosen, marking the high wind area of refuge boundaries at least 30 feet from a glass door or window is advisable**, as well as educating staff to keep occupants within the boundaries and to close all doors leading to the corridor during a high wind event.

*Note: The best available refuge areas do **not** ensure the safety or survival of their occupants. They are simply the areas of a building in which survival is most likely.*

If the center is unsure whether a particular location is appropriate to use as a high wind area of refuge, the Team refers to Federal Emergency Management Agency FEMA's Best Available Refuge Area Checklist to evaluate appropriate areas of refuge

Part B: Refuge Areas

List all areas of refuge according to the guidelines above and mark these areas on the center floor plan:

1. 1st floor conference room.
2. Hallways- 1st floor
3. Library- Concern Glass
4. Main Dining Room 1st floor- Concern Glass
5. Rehab Therapy Room- Concern Glass
6. Beauty Salon- No Glass
7. Recreation Therapy Room- Concern Glass
8. Staff Lunch Room- Inside location no glass.
9. 2nd & 3rd Floor Day Lounge- Concern Glass
10. Inside Hallway Main Floor
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

an emergency (e.g. incident commander, public information officer, patient liaison, etc.). For example, a Facility Incident Commander may be the Administrator. Also, a unit manager may be the facility's identified person as the Safety Officer.

NOTE: INSERT LIST OF ALL STAFF CONTACT LIST HERE: INCLUDE ALL STAFF, PHYSICIANS, LOCAL LTC FACILITIES AND VOLUNTEERS. REVIEW AND UPDATE AS NEEDED.

Appendix 4: Emergency Operation Center Designation

In the event of an emergency/disaster, the center must have 2 areas identified from which the emergency would be managed. The location should have internet and phone access, as well as access to emergency supplies and this EPP, if possible.

The Emergency Operation Center (EOC) will be located in:

1st floor Formal Dining Room

The secondary Emergency Operation Center (EOC) will be located in:

Administrator's Office

Appendix 5: Area Administrative Staff Contact List

INSTRUCTIONS: Fill in the necessary contact information below. Contact as needed based on this EPP.

Area:	Name	Contact Number
Sr. VP Operations	Shayne Hutchinson	(304) 419-5057
Sr. VP Medical Affairs	Carolyn Blackman	(401) 479-4144
SVP Clinical Operations	Julie Britton	(215) 803-5644
MP/RED, Operations	Teale Howe	(603) 571-0279
VP/Director of Clinical Ops	Tina Osborn	(978) 602-0092
Clinical Quality Specialist	Audrey Kerin	(802) 323-6714
	Kristen Marois	(603) 325-8345
VP Property Management	Perry Valentine	(610) 806-2602
Director of Employee Safety	Cynthia Fleming	(603) 387-9380
Region Property Manager	Mike Lenoch	(603) 315-0565
Region/Area HR Manager	Jessica Foley	(603) 686-4396
OmniCare Pharmacy		

CareLine: 1 (866) 745-2273

Appendix 6: Company Contacts

Corporate Office	Genesis HealthCare, 101 E State St., Kennett Square, PA 19348	
Executive Chairman	David Harrington	david.harrington1@genesishcc.com
EVP & CFO	Orrin Feingold	orrin.feingold@genesishcc.com
EVP & COO	Melissa Powell	melissa.powell4@genesishcc.com
SVP Human Resources	Brandon Poole	brandon.poole@genesishcc.com
SVP Medical Affairs	John Loome	410-494-7671
SVP & CIO	Joe Montgomery	610-716-7439
EVP	Michael Sherman	610-864-9751
SVP Spend Management and Support Services	David Bertha	610-247-8822
VP Compliance	Maria Suarez	505-468-2384
IT Help Desk	Help Desk Rep.	800-580-3655
Director, Risk & Insurance Services	Janice Burnap	505-259-1913
GHC Claims & Litigation	Bette Pfeiffer	610-925-2415 610-925-2419 (FAX)

*Communication with media is guided by division Business development leaders. Refer to Crisis Communication Contacts on Central for details.

Appendix 7: Emergency Resources and Contacts

Instructions: Enter information into the table as prompted below. Emergencies involving fire, death or serious injury are reported in accordance with state and federal guidelines. Other reporting and engagement is completed as needed during an emergency.

COUNTY/LOCAL Emergency Management Agencies

County:	Cheshire
Contact/Title:	Herb Stephens, Area Director of Winchester
Address:	1 Richmond Rd
City, State Zip	Winchester, NH 03470
Phone Number:	603-355-0858

State Emergency Management Agency

State:	**New Hampshire**
Contact/Title:	Department of Safety
Address:	33 Hazen Drive
City, State Zip	Concord, NH 03305
Phone Number:	603-271-2231

Federal Emergency Management Agency (FEMA)

Region:	United States
Contact/Title:	Department of Homeland Security
Address:	99 High St.
City, State Zip	Boston, MA 02110
Phone Number:	877-336-2734

COMMUNITY RESOURCES CONTACTS:

Agency:	**Name:**	**Phone:**
County Health Department	Eileen Fernandez	603-354-5454 x2130
LTC Ombudsman	Fleurette Grenier	603-271-4375
State Licensing and Certification Agency	NH Board of Nursing	603-271-2823
County DHHR Office	DHHR- Keene	603-357-3510
Poison Control Center	Northern New England	800-222-1222
Tribal Contact		
Other		

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

Appendix 8: Additional Resources

Use this form to maintain contact information for emergency support services.

NHICS FORM 258 | CENTER RESOURCE DIRECTORY

	CONTACT (COMPANY/AGENCY/NAME)	**PHONE NUMBER** - PRIMARY	**PHONE NUMBER** - SECONDARY	**E-MAIL**	**FAX / WEBSITE**
Agency for Toxic Substances and Disease Registry (ATSDR)	Poison Control	800-232-4636	770-488-7100		www.aapcc.org
Ambulance/EMS	911	911			
American Red Cross	Keene Chapter	603-352-3210			www.redcross.org
Biohazard Waste Company	Stericycle	866-783-7422			www.stericycle.com
Buses	Delano Company	603-399-4371			
Cab, City	Adventure Taxi	603-355-1484			www.advlimo.com
Emergency Management Agency	FEMA	877-336-2734			www.fema.gov
CDC		800-232-4636			www.cdc.org
Clinics	Dartmouth Hitchcock	603-354-5420			www.dartmouth-hitchcock.org
Coroner/Medical Examiner	Cheshire County Coroner	603-271-1235			
Dispatcher - 911	911	911			
Emergency Operations Center (EOC), Local	Keene Dispatch Center	603-357-9861			
Emergency Operations Center (EOC), State	NH Dept of Safety	603-271-2231			
Engineers:					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
HVAC	HVAC	Granite State Plumb	603-529-3322		
Mechanical	Mechanical	Pappas Contracting	603-313-7107	603-380-5252	
Structural	Structural				
Environmental Protection Agency (EPA)	Environmental Protection Agency	NH Dept of Environmental services	603-271-3500		
Epidemiologist	Epidemiologist	NH Dept of Health	603-624-6466		
Family	Family	*SEE FAMILY CONTACT LIST*			
Fire Department	Fire Department	Keene Fire Department	603-209-1742		
Food Service	Food Service	Sysco	508-285-1000		
Fuel	Fuel	Cheshire Oil	603-352-0001		
Funeral Homes/Mortuary Services	Funeral Homes/Mortuary Services	Foley Funeral	(603) 352-0341		
Generators	Generators	Power up Generator	866-420-4906	603-657-9080	
HazMat Team	HazMat Team	Keene Fire Dept.	911		
Health Department, Local	Health Department, Local	Keene Health Dept.	603-357-9836		
Heavy Equipment (e.g., Backhoes, etc.)	Heavy Equipment (e.g., Backhoes, etc.)	Holmes Construction	603-231-3242		
Home Repair/Construction Supplies:	Home Repair/Construction Supplies:	Home Depot	603-355-2113		

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Hospitals:	Cheshire Medical Center	603-354-5400			www.**cheshire-med**.com
Hotel	Best Western				bestwestern.com/Official
Housing, Temporary					
Ice, Commercial	Sysco	508-285-1000			
Laboratory Response Network					
Laundry/Linen Service	People's Linen	(603) 352-2038			peopleslinen.com
Law Enforcement:	Keene Police Dept.	603-352-2222			www.keenepd.org
City Police	Keene Police Dept.	603-352-2222			www.keenepd.org
County Sherriff					
Highway Patrol	NH state police	603-271-1162			
Licensing & Certification District Office	Michael Fleming	(603) 271-9499			https://www.dhhs.nh.gov/contactus/index.htm
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:	Keene Center	603-357-3800			
Media:	WMUR Channel 9				
Print	Keene Sentinel	603-352-1234			
Radio					
Radio					

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
TV					
TV					
TV					
Medical Gases					
Medical Supply	Medline	800-633-5463	603-320-2926		
Medication, Distributor:	OMNICARE	603-625-6406			www.omnicare.com
Moving Company:					
Pharmacy, Commercial:	OMNICARE	603-625-6406			www.omnicare.com
Poison Control Center	Northern NE Poison Center				https://www.nnepc.org/
Portable Toilets					
Radios:	Keene Center/Langdon Place	357-3800			
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds	Joerns	800-826-0270			joerns.com

Additional Resources

	CONTACT (COMPANY/AGENCY/NAME)	PHONE NUMBER - PRIMARY	PHONE NUMBER - SECONDARY	E-MAIL	FAX / WEBSITE
Biomedical Devices	Medline	1-800-633-54 63			www.medline.com
Medical Devices	Medline	1-800-633-54 63			www.medline.com
Oxygen Devices					
Radios					
Restoration Services (e.g., Service Master)					
Road Conditions	*CALTRANS*	*1-800-427-7623*			
Salvation Army					
Shelter Sites					
Staff	*SEE STAFF CONTACT LIST*				
Surge Facilities	Listed with Administrator				
Trucks:					
Refrigeration	Sysco	508-285-1000			
Towing					
Utilities:					
Gas	Liberty Utilities	603-209-2586			
Power	Eversource	800-662-7764			www.eversource.com
Sewage	Keene Water dept.	(603) 352-6550			https://keenetx.com/departments/utilities
Telephone					
Water					
Ventilators					
Water Vendor – Potable, Portable Shower/Portable Toilet	Sysco	See above			
Other:					

Appendix 9: Transfer Agreement

Use this form to document every transfer agreement for transportation and reception of residents (e.g. other Long-Term Care Centers, Hospitals, and Ambulance Companies). **Reminder: Execute at least one agreement with a Long Term Care Center more than 50 miles away.**

Type of Service:	Hospital
Name:	Cheshire Medical
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Ambulance/Transport
Name:	Diluzio
Address:	49 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-0341

Type of Service:	Long Term Care Facility
Name:	Keene Center
Address:	677 Court Street
City, State, Zip	Keene, NH 03431
Phone Number:	603-357-3800

Type of Service:	Long Term Care Facilty
Name:	Alpine
Address:	298 Main Street
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 352-7311

Type of Service:	Long Term Care Facility
Name:	Pleasant View Center
Address:	239 Pleasant Street
City, State, Zip	Concord, NH 03301
Phone Number:	(603) 226-6561

Type of Service:	Long Term Care Facility & Evacuation Center
Name:	Applewood Rehabilitation Center
Address:	8 Snow Road
City, State, Zip	Winchester, NH 03470
Phone Number:	(603) 239-6355

Type of Service:	Long Term Care Facility
Name:	Cedar Crest
Address:	91 Maple Avenue
City, State, Zip	Keene, NH 03431
Phone Number:	(603) 358-3384

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Type of Service:	
Name:	
Address:	
City, State, Zip	
Phone Number:	

Appendix 10: Short-Term Evacuation Plan

Enter the information requested below. Describe the center's plan for short-term evacuation procedures. Consider custody issues for patients in specialty care units, accountability process for visitors and vendors, maintaining clear approach areas for emergency equipment and personnel, and a communication plan when developing these procedures.

Short-term evacuation will be used if immediate evacuation of the center is needed for safety considerations (e.g. the structural integrity of the building is compromised or there is an active fire in the center). Employees, staff, and residents will gather at established meeting spaces outside the center. Choose gathering points away from where emergency personnel will be responding to the center. Plan to use cell phones to communicate the short-term evacuation activation to the MP, transportation services, short-term evacuation site, and the long-term evacuation sites to indicate a long-term evacuation is possible. Plan for no re-entry to the building until it is determined it is safe to do so.

(Note: While areas such as school gymnasiums and churches are not good evacuation sites for a long-term evacuation, they may be used if the structural integrity of the center is compromised. If it is determined a long-term evacuation is necessary, follow the center's plan for evacuation using the short-term evacuation area as the sending center.)

PLAN: Designate area of short-term evacuation site for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients.

Meeting Place 1: Cedarcrest

Meeting Place 2: _____

Transportation Services: Diluzio, Adventure Limousine

Potential Locations: Local stop over location agreement with Cedarcrest on Maple St.

Additional Information:

_____

_____

_____

Appendix : Triage of Casualties (update 1/15/2017)

Instructions:

In the event of an internal or external disaster resulting in injuries, all casualties will be triaged using the priority Mass Casualty criteria and tags identified below. The Director of Nursing and Medical Director or designees will coordinate the process in collaboration with emergency personnel. Where appropriate, victims from external disasters will be triaged at the ambulance entrance.

Priority 1 Immediate (Red): Serious, but salvageable life threatening injury/illness

Victims with life-threatening injuries or illness (such as head injuries, severe burns, severe bleeding, heart-attack, breathing-impaired, internal injuries) are assigned a priority 1 or "Red" Triage tag code (meaning first priority for treatment and transportation).

Priority 2 Secondary (Yellow): Moderate to serious injury/illness (not immediately life-threatening)

Victims with potentially serious (but not immediately life-threatening) injuries (such as fractures) are assigned a priority 2 or "Yellow" (meaning second priority for treatment and transportation) Triage tag code.

Priority 3 Delayed (Green): 2 types

- Victims who are not seriously injured, are quickly triaged and tagged as "walking wounded", and a priority 3 or "green" classification (meaning delayed treatment/transportation). Generally, the walking wounded are escorted to a staging area out of the "hot zone" to await delayed evaluation and transportation.
- Delayed also includes those victims with critical and potentially fatal injuries or illness, indicating no immediate treatment or transportation.

Priority 4 Deceased (Black):

Victims who are found to be clearly deceased at the scene with no vital signs and/or obviously fatal injuries are classified as deceased or priority 4 (Black) in the triage coding system.

Planned Triage Locations

After triage, casualties will be moved to the following locations for treatment, evaluation, and transportation, as appropriate:

Priority 1: Library holding area

Priority 2: Library holding area and rehab department

Priority 3: Dining room-due to its size and location

Priority 4: Unit lounge or holding area on first floor

Appendix 12: Em gency Supplies and Location of itical Equipment

Instructions: *Enter the location of emergency supplies; add additional items as necessary.*

ITEM	LOCATION
Radio (transistor) weather / radio alert	reception
Flashlight / Glow Sticks (extra batteries and bulbs)	nursing units
Self-stick tags for identification purposes	nursing units
Basic tool kit (hammer, pliers, screwdriver(s), knife, etc.)	***maintenance department***
Shovel(s)	maintenance dept and shed
Drinking water supply per contract	dietary
Disposable eating equipment	dietary
Food, emergency supply	dietary
Waterless hand cleaner	medical storage
Respirators, gowns, gloves and masks	medical storage
Linens, blankets, adequate in case of power failure	laundry dept
Emergency first-aid kit	nursing
Trash Bags	laundry
Log or tablet to list residents/patients/employees leaving the Center	reception & nursing
Incontinent supplies (briefs), disposable wash cloths	medical storage
Room thermometers	maintenance
Blood pressure cuffs	nursing
Stethoscopes	nursing
Mass Casualty Tags (red, yellow, green, blue, black)	
Policy and procedure manuals	online
Personal protective equipment	nursing
MSDS	maintenance
Master keys	

FIRE EXTINGUISHERS	LOCATION
1st floor	dining room, kitchen, utility hall, reception, rehab, activities
2nd floor	near oxygen room, north and south ends

Appendix 13: Surge Capacity

Instructions: Enter information into the table as prompted below.

This analysis assists the center in determining the maximum number of patients that may be accommodated if the center is asked to expand services through the local EMS or to meet the terms of a Memorandum of Understanding (MOU) with another provider.

Location	Number of Possible Additional Beds (Based on 70 Sq. Ft./Bed)	Priority Level of the Area (from least desirable to most (Scale: 1 – 10)	Comments (Ex: Possible Isolation Area or Specialty Area)
Private Rooms Which Can Accept Additional Beds	N/A-0		
Semi-Private Rooms Which Can Accept Additional Beds	N/A-0		
Additional Bed Space Dining Rooms	1st floor DR =10	10	
Additional Bed Space Activities Room	remove table=5	5	
Additional Bed Space Rehab Gym	move tables =4	5	
Additional Bed Space Corridor Ends			
Additional Bed Space Lounge Area			
Additional Bed Space Specialty Areas (Ex: Dementia Unit)	Library=4	10	
Additional Bed Space Other Areas			
Other	Conference room=3	8	
Total Additional Beds (Surge Capacity)	26		

Appendix 14: Emergency Water Supply

Instructions: Enter information into the table as prompted below.

1. Potable Water Contract Information

Company: Garelick Farms

Address: Farm Road

City: Boston

State: MA

Zip: 02010

Contact Person: _____

2. Emergency Water Supply

The center may prioritize use of water for activities as follows:

i. Drinking
ii. Medicating
iii. Dietary use
iv. Personal hygiene
v. Waste water (mopping)

The Red Cross, FEMA and USGS recommend an emergency supply of one gallon of water per person, per day. The center has calculated this need as follows:

- Total bed capacity = 128 + 80 Total approximate expected staff per day = 208 Total people
- Total people X 3 days = 624 gallons of water

The center's water source amounts and locations are as follows (enter applicable amounts and sites:

a. Primary

i. 700 gallons bottled water
Location(s): Basement

ii. _____ gallons water in barrels. Location(s): _____

iii. _____ gallons in ice machine(s) Location(s): _____

iv. TOTAL: _____ gallons*
(*Note: should meet or exceed gallons calculated in # 2, Above)

b. Secondary

i. _____gallons in water heaters. Location: _____

ii. _____gallons in toilet tanks.

iii. _____gallons in other _____ Location: _____

iv. _____ ons in other _____. Location: _____ _____

Appendix 15: Utility Shut-Off Procedures

In the event of utility disruption, call the Administrator and Maintenance Director immediately. The Administrator or designee will be responsible for notifying the appropriate state agencies, as required. Enter the information required below.

Utility Shut-Off Locations

1. Water: Boiler Room
2. Electricity: Electrical Room
3. Gas: Electrical Room
4. Heat: Boiler Room
5. Fire Sprinkler System: Boiler Room
6. Oxygen Room: 2nd floor, 3rd floor
7. Oxygen Manifold Shutoff: Not applicable

Generator/Battery System

The generator may be used in emergency situations.

Generator Location: Basements

Extra Fuel Storage Location: N/A

Location of generator Start Up Procedures: Basements

In an emergency situation, the following individuals have the authority to "shut off" the utilities:

Administrator, Maintenance Director, Incident Commander, Maintenance Assistant

---

Use diagrams and instructions on the shut off values, utility controls to explain and use each utility shut-off.

For centers that maintains an onsite fuel source to power the emergency generator(s), insert the contract with a vendor to supply fuel in an emergency to keep the emergency generator operational for the duration of the emergency. (INSERT CONTRACT FOLLOWING THIS PAGE.)

Appendix 16: Potential Explosives List

Instructions: Enter all potential explosives and current location.

ITEM	LOCATION
Oxygen Storage	2nd and 3rd floor
Generator Fuel	outside building to the east
Gasoline/additional fuel	storage shed outside maintenance (metal shed)
Chemical Closet	Maintenance Department

Appendix 17: Special Care Unit Fire Procedure

The purpose of this section is to plan for the safety of Specialty Care Unit (SCU) residents in case of a fire or fire drill. Insert the required information below. *Due to the profile of the SCU residents, procedures may vary from routine center policy.*

In case of a fire or fire drill in any other zone in the building (outside of the SCU):

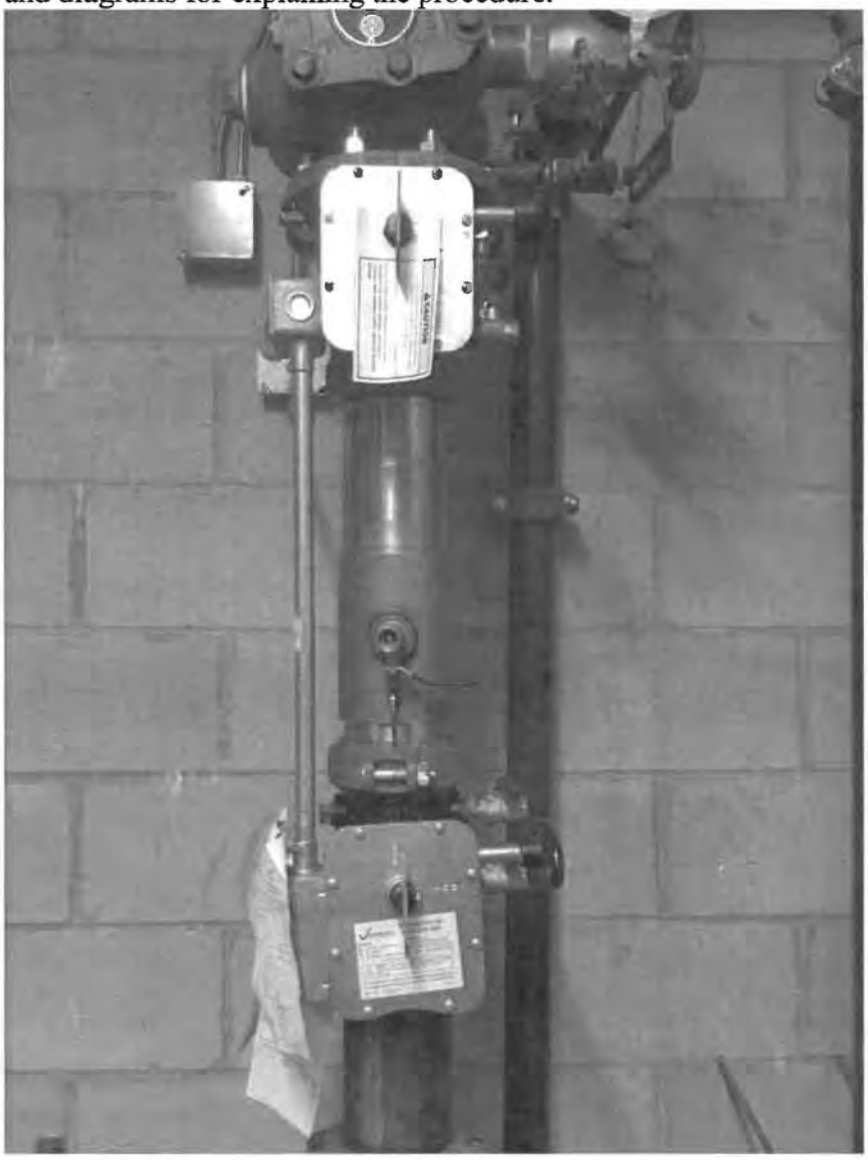
- All SCU residents who are not in bed will be kept together in a specific area.
- SCU staff close all doors in the unit and stay with SCU residents.
- Any residents who are in bed will remain in bed with the room door closed until all clear.

If fire or fire drill is in the SCU:

- SCU staff close all doors to rooms.
- SCU staff move residents past fire doors to safe area.
- SCU staff remain with the SCU residents until all clear.
- If residents are in bed, staff move residents potentially in immediate danger to safe area.

Appendix 18: Fire Sprinkler System Shut-Off Procedures

Instructions: Insert the center's fire sprinkler system's shut-off procedures using pictures and diagrams for explaining the procedure.



Appendix 19: Fire Alarm Reset Procedures

Insert the center's fire alarm shut-off procedures. Use pictures and/or diagrams to help provide a detailed explanation.

Main Fire Alarm Panel inside the electrical room.
Fire Dept and Maintenance Staff use only to silence, reset and maintain/acknowledge the fire alarm and emergency condition.

If fire alarm is activated, due to malfunction or fire, the fire department will reset and shut off.

Reset procedure:
Silence Alarm, Hit Reset in manual controls.

Appendix 20: Security Plan

This form is used to describe the center's plan for access and perimeter security. Instructions: Enter the location of entrances and exits and the security plan for each in the table below.

Entrance/ Exit Location	Used by/ Purpose	Restricted access (Keypad/ lock)		Frequency of entry code change	Type of alarm system	Current signs on door?	Locked/ Open Days/Times		Lighting Evaluation *	Comments and/or Corrective Actior
		YES	NO							
Example: Kitchen Backdoor (by ramp)	*Employees to take out trash; supply vendors.*	*Y*		*Monthly, Qtrly*	*Wander-guard, Watch Mate, IBI, or Catchall.*	*Marked as exit, no sign on outside of door*	*Daily*	*5:00 a.m. – 8:00 p.m.*	*Adequate*	
Main Entrance	employees, visitors	Y		As needed	wanderguard	Exit	daily	8am-6 pm	adequate	
utility hall-1st floor, house keeping, central supply, kitchen	exit only		N	N/A	None	None	interior open daily		adequate	
2nd and 3rd floor stairs-north & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
2nd and 3rd floor stairs-central	employees	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor-North & south	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	
1st floor dining room	exit only	Y		as needed	wanderguard	Exit	always locked		adequate	

Appendix 20: Security Plan

Lighting Evaluation: When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting and remove brush or debris to eliminate shadowed areas.

Interior Building Security:

Describe what the center has in place for stairwell protection (if applicable). Included in the description may be door security alarms/keypads, persons responsible for updating/changing entry codes, CCTV cameras and how the system is monitored, or other systems used for stairwell protection.

Front door live video monitoring that is on 24/7 that may be viewed at the 2nd Floor nursing station when staff are present

Front Doors are electronically locked at 9:30 PM and reopen electronically at 5:30 AM. Other exterior doors are locked and secured after hours. Most exterior doors and stairwell doors are secured via magnetic locks tied into our Secure Care wandering system. All Magnetic doors release with an audible local alarm sounding if appropriate pressure is applied for 15 seconds.

Lighting Adequacy- When evaluating lighting adequacy, look for shadowed areas and for burned-out light bulbs. Replace burned-out light bulbs immediately. Add additional lighting to eliminate shadowed or dark areas.

Describe the check-in procedures for visitors and how identification badges for employees and/or visitors being used.

All employees have identification badges that they are required to wear while on duty. Visitors are strongly encouraged to sign in at the front entrance sign-in Log.

Appendix 20: Security Plan

Describe how the following are used for Resident-Specific Security:

Security measures for special units.

No special units.

- Resident Elopement Wander Guards.
- Electronic alarms systems such as door alarms.
- Communication call bells.

Wanderguard system, locked doors with keypad entry after 6pm.

Wander system near elevators, center stairs, at front door and all 1st floor exits. Tap bells and hand bells.

Communication call bells.

Visitor Log Protocol.

All visitors are screened and checked in at the reception desk upon arrival.

Appendix 21: ELOPEMENT DRILL DOCUMENTATION FORM

Drill Date and Time:_____ Unit:_____

Check all that apply:

____ Nurse alerts all staff of missing resident with plain, simple language. For example, "Medical Alert: We are activating Missing Patient protocols. The resident was last seen at (location)." This alerts all staff that a formal search is underway. Repeat this message 3 times.

____ Each unit sends a person to the unit that announced the code to learn the name and description of the missing resident.

____ A person is designated as the House Person in Charge (HPIC) of the search. The HPIC coordinates the search so that the in-house and outside searches occur at the same time.

____ Each unit charge nurse directs in-house staff to search room to room and all potential areas of the Center: resident rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen, bathrooms, dayrooms/lounges, courtyards, and employee lounges.

____ HPIC assures all areas/floors of the building are searched.

____ During open kitchen hours, dietary staff search the kitchen and related areas, including walk-in refrigerators/freezers.

____ During closed kitchen hours, the HPIC assigns a staff member to search the kitchen and related areas.

____ HPIC sends two staff members outside to search the grounds.

____ Outside searchers go out the front door (or door designated by HPIC), one to the left and one to the right, search the building perimeter and grounds, and meet at the back door.

____ If one does not arrive at the back door, the other staff member proceeds to that staff member in case help was needed.

____ Both staff members return into the building together.

____ All unit, kitchen, and grounds search findings are reported to the HPIC immediately.

____ Staff are able to verbalize what to do if resident is not located by the end of the search.

____ Staff are able to verbalize documentation and follow-up requirements.

Comments:

Plan of Correction (if indicated):

Signature of Person Conducting Drill:_____

Appendix 22: Succession Plan

During an emergency, the center's highest-ranking individual serves as the acting Incident Commander until the Administrator/Designee arrives. This person immediately contacts the Administrator/Designee.

When on-site, the Administrator/Designee is the Incident Commander and is updated on the situation by the acting Incident Commander. In the absence of the Administrator, The Director of Nursing (DON) acts as the Incident Commander. In the absence of the Administrator and DON, the following team members act as the Incident Commanders, in priority order.

Administrator Name: Michael Johnson

DON Name: Lisa Kopcha

Incident Commanders in absence of Administrator and DON:

Name and Title: Andy Mackey, Maintenance Supervisor

Name and Title: Melanie Gorecki, Infection Control

Name and Title: Elizabeth Duquette, Skin Team Lead

Appendix 23. Description of Center Patient/Resident Population
(Insert from or Refer to Center Facility Assessment.
See OPS 161, Facility Assessment for details.)

A)endix 24: Annual Review and gn-Off

This EPP has been reviewed, with changes noted, and approved by the Safety Committee and Administrator:

Safety Committee Chairman Name: Andy Mackey

Safety Committee Chairman Signature and Date: _____

Administrator Name: Michael Johnson

Administrator Signature and Date: _____

Appendix 25: State and Local Requirements

If your state/county/city/municipality has more stringent requirements, enter those requirements below, or insert reference materials. Contact your local EMS for information.

Appendix 26. Insertions from Compliance Guide Completed Tasks

Instructions: After this page, insert the following completed documents from the Emergency Preparedness Compliance Guide:

1. **Resident Council Minutes indicating dates/times of presentations of the EPP.**
2. **Contact with Local Emergency Management Services (EMS) Form.**
3. **Community-Based Drill After Action Report**
4. **Training Acknowledgement Forms (Staff)**
5. **Tabletop Exercise**

Exhibit 1: Food and N[illegible]rition Services – Sample Emergency [illegible]enu, Level 1: No Power

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	3/4 cup	Cold Cereal	Cold Cereal, Moistened	Cream of Wheat or Rice 1/2 cup	Cream of Rice 1/2 cup
	1/4 cup	Cottage Cheese	Cottage Cheese	Puree Cottage Cheese 1/2 #10 scoop	Cottage Cheese
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1-1/2 cup	Beef Stew, Cnd	Beef Stew, Cnd, Ground	Puree Beef Stew, Cnd	GF Peanut Butter & Jelly Sandwich 1 each
	1/2 cup	Seasoned Green Beans	Seasoned Green Beans	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Tuna Salad Sandwich	Plain Tuna Salad on Wheat	Puree Tuna Salad,Puree Bread 1 serving	GF Tuna Salad Sandwich
	1/2 cup	Seasoned Beets	Seasoned Beets	Puree Seasoned Beets 1 #8 scoop	Seasoned Beets
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1/4 cup	Scrambled Egg	Scrambled Egg	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	1 each	Roasted Chicken	Roasted Chicken,Grd, Moistened 1 #12 scoop	Puree Roasted Chicken 1 #12 scoop	Roasted Chicken
	1/2 cup	Mashed Potatoes	Mashed Potatoes	Mashed Potatoes	Fresh Mashed Potatoes
	1/2 cup	Scalloped Tomatoes	Scalloped Tomatoes	Puree Seasoned Green Beans 1 #10 scoop	Seasoned Green Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Ice Cream/Pudding	Smooth Ice Cream/Pudding	Smooth Ice Cream/Pudding	GF Pudding
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	3/4 cup	Soup, Cnd	Puree Soup, Cnd	Puree Soup, Cnd	
	2 packet	Saltines			
	1 each	Grilled Cheese Sandwich	Grilled Cheese Sandwich,No Crust	Puree Grilled Cheese Sandwich 1 serving	GF Grilled Cheese Sandwich
	1/2 cup	Three Bean Salad	Plain Three Bean Salad	Puree Three Bean Salad 1 #8 scoop	Fresh Three Bean Salad
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered.

Meal	Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
BRK	3/4 cup	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk	Juice,Assorted-Bulk
	1/2 cup	Hot Cereal	Hot Cereal	Cream of Wheat	Cream of Rice
	1 each	Hard Cooked Egg	Scrambled Egg 1/2 cup	Puree Scrambled Egg 1 #12 scoop	Scrambled Egg 1/2 cup
	1 slice	Wheat Toast	Wheat Toast, No Crust	Puree Warm Bread 1 #12 scoop	GF Toast
	1 each	Margarine	Margarine	Margarine	Margarine
	1 each	Jelly	Jelly	Jelly	Jelly
	1 cup	Milk	Milk	Milk	Milk
LUN	2 ounce	Baked Ham	Baked Ham,Grd,Moistened	Puree Baked Ham 1 #12 scoop	Baked Ham
	1/2 cup	Sweet Potatoes	Sweet Potatoes	*Puree Sweet Potatoes 1 #10 scoop	Sweet Potatoes
	1/2 cup	Wax Beans	Chopped Wax Beans	Puree Wax Beans 1 #10 scoop	Wax Beans
	1 slice	Wheat Bread	Wheat Bread	Puree Warm Bread 1 #12 scoop	GF Bread
	1 each	Margarine	Margarine	Margarine	Margarine
	1/2 cup	Fruit, Cnd	Fruit, Cnd, Chop	Puree Fruit, Cnd 1 #10 scoop	Fruit, Cnd
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
DIN	1 each	Sliced Meat Sandwich	Sliced Meat Sandwich, Ground, Moistened	Puree Sliced Meat Sandwich	GF Sliced Meat Sandwich
	1 packet	Mustard	Mustard	Mustard	Mustard
	1/2 cup	Baked Beans	Mashed Baked Beans	Puree Baked Beans 1 #10 scoop	Seasoned Green Beans
	2 each	Assorted Cookies	Puree Sugar Cookies 1 #16 scoop	Puree Sugar Cookies 1 #16 scoop	GF Cookies
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
	1/2 cup	Milk	Milk	Milk	Milk
S3	1 packet	Graham Crackers (S)	Pudding,(S) 1/2 cup	Pudding,(S) 1/2 cup	GF Pudding 1/2 cup
	1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch

Note: All therapeutic diets are waived during an emergency, with the exception of consistency modified and Gluten Free diets. Continue to serve thickened beverages, as ordered

Exhibit 2. Sample Emergency Snack M

Portion	Regular/Liberalized	Dysphagia Advanced	Dysphagia Puree	Gluten Free
2 each	*Assorted Cookies	*Puree Sugar Cookies 1 #16 scoop	*Puree Sugar Cookies 1 #16 scoop	GF Cookies
1 each	Chocolate Cream Cookie (S)	Choc. Cream Cookies (S)	Puree Choc. Cream Cookies 1 #16 scoop	GF Cookies
1 each	Oatmeal Crème Cookie (S)	Oatmeal Crème Cookie (S)	Puree Oatmeal Crème Cookie 1 #16 scoop	GF Cookies
1 packet	*Graham Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
4 each	Vanilla Wafers	Puree Vanilla Wafers 1 #24 scoop	Puree Vanilla Wafers 1 #24 scoop	GF Cookies
1 ounce	Cheese Crackers (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	GF Cookies
1 ounce	Cheese Puffs	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1 ounce	Pretzels (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
4 packet	Saltines (S)	Puree Graham Crackers 1 #24 scoop	Puree Graham Crackers 1 #24 scoop	x
1/2 cup	Applesauce	Applesauce	Applesauce	Applesauce
1/2 cup	Mandarin Oranges	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Mandarin Oranges
1/2 cup	Peaches	Peaches	Puree Peaches 1 #10 scoop	Peaches
1/2 cup	Pears	Pears	Puree Pears 1 #10 scoop	Pears
1/2 cup	Pineapple Tidbits	Crushed Pineapple	Puree Pineapple 1 #10 scoop	Pineapple Tidbits
1 each	Fresh Apple	Applesauce 1/2 cup	Applesauce 1/2 cup	Fresh Apple
1 each	Banana	Chopped Banana 1/2 cup	Mashed Banana 1/2 cup	Banana
1/2 cup	Cantaloupe	Soft Chopped Cantaloupe 1/2 cup	Puree Cantaloupe 1 #10 scoop	Cantaloupe
1/2 cup	Grapes	Applesauce	Applesauce	Grapes
1 each	Fresh Orange	Mandarin Oranges 1/2 cup	Puree Mandarin Oranges 1 #10 scoop	Fresh Orange
1/2 cup	Watermelon	Chopped Watermelon 1/2 cup	Puree Watermelon 1 #10 scoop	Watermelon
1/2 cup	Apple Juice	Apple Juice	Apple Juice	Apple Juice
1/2 cup	Orange Juice	Orange Juice	Orange Juice	Orange Juice
1/2 cup	Cranberry Juice	Cranberry Juice	Cranberry Juice	Cranberry Juice
1/2 cup	Lemonade	Lemonade	Lemonade	Lemonade
1/2 cup	Fruit Punch	Fruit Punch	Fruit Punch	Fruit Punch
1/2 cup	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt	Smooth Yogurt
1/2 cup	Smooth Pudding	Smooth Pudding	Smooth Pudding	GF Pudding

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 255 | MASTER RESIDENT EVACUATION TRACKING FORM

1. INCIDENT NAME:		**2. FACILITY NAME:**	
3. DATE PREPARED:		**4. RESIDENT TRACKING MANAGER:**	
5. RESIDENT EVACUATION INFORMATION			

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED (TIME/TRANSPORT CO.)**	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

6. CERTIFYING OFFICER:		**7. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: OPERATIONS BRANCH
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER LEADER

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NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 260 | INDIVIDUAL RESIDENT EVACUATION TRACKING FORM

1. FACILITY NAME:		2. DATE:	
3. UNIT:			
4. RESIDENT NAME:		5. AGE:	
6. MEDICAL RECORD #:		7. SIGNIFICANT MEDICAL HISTORY:	
8. ATTENDING PHYSICIAN:			
9. FACILITY NOTIFIED:	☐ YES ☐ NO	CONTACT INFORMATION:	____

10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY):			
☐ HOSPITAL BED ☐ GURNEY ☐ WHEEL CHAIR ☐ AMBULATORY ☐ SPECIAL MATTRESS	☐ IV PUMPS ☐ OXYGEN ☐ VENTILATOR ☐ BLOOD GLUCOSE MONITOR ☐ RESPIRATORY EQUIPMENT	☐ SERVICE ANIMAL ☐ G TUBE PUMP ☐ MONITOR ☐ OTHER ☐ OTHER	☐ FOLEY CATHETER ☐ OTHER ☐ OTHER ☐ OTHER ☐ OTHER
ISOLATION:	☐ YES ☐ NO	TYPE:	____

11. DEPARTMENT LOCATION			
ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD SENT:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG SENT:	☐ YES ☐ NO		
BELONGINGS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
VALUABLES:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
MEDICATIONS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		

12. ARRIVING LOCATION			
ROOM#:		TIME:	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD RECEIVED:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG RECEIVED:	☐ YES ☐ NO		
BELONGINGS RECEIVED:	☐ YES ☐ NO		
VALUABLES RECEIVED:	☐ YES ☐ NO		
MEDICATIONS RECEIVED:	☐ YES ☐ NO		

13. SPECIAL CONSIDERATIONS			
TIME TO STAGING AREA:		TIME DEPARTING TO RECEIVING FACILITY:	
DESTINATION:		ARRIVAL TIME:	
TRANSPORTATION:	☐ AMBULANCE UNIT ☐ HELICOPTER ☐ BUS ☐ OTHER: ____		
ID BAND CONFIRMED:	☐ YES ☐ NO	ID BAND CONFIRMED BY:	

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: OPERATIONS SECTION – ADMIT/TRANSFER & DISCHARGE UNIT
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING

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Exhibit 5: **NHICS FORM 251: CENTER STATUS REPORT**

1. INCIDENT NAME:		2. CENTER NAME:	Keene Center		
3. DATE PREPARED:		4. TIME PREPARED :		5. OPERATIONAL PERIOD:	

SYSTEM STATUS CHECKLIST		
COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
FAX	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/PATIENT RECORDS/TIME CARD SYSTEM/INTRANET, ETC.)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NURSE CALL SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PAGING – PUBLIC ADDRESS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
RADIO EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SATELLITE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM – CELL	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
VIDEO-TELEVISION-INTERNET-CABLE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

SYSTEM STATUS CHECKLIST (CONTINUED)		
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
CAMPUS ROADWAYS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
FIRE DETECTION/SUPPRESSION SYSTEM	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
FOOD PREPARATION EQUIPMENT	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
ICE MACHINES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
LAUNDRY/LINEN SERVICE EQUIPMENT	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
RESIDENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
PHARMACY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
DIETARY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

SYSTEM STATUS CHECKLIST (CONTINUED)		
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
DOOR LOCKDOWN SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SURVEILLANCE CAMERAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELECTRICAL POWER-PRIMARY SERVICE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SANITATION SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NATURAL GAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
AIR COMPRESSOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ELECTRICAL POWER, BACKUP GENERATOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (IF NOT FULLY OPERATIONAL/FUNCTIONAL, GIVE LOCATION, REASON, AND ESTIMATED TIME/RESOURCES FOR NECESSARY REPAIR. IDENTIFY WHO REPORTED OR INSPECTED)
ELEVATORS/ESCALATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HAZARDOUS WASTE CONTAINMENT SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OXYGEN	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PNEUMATIC TUBE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STEAM BOILER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SUMP PUMP	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WELL WATER SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER HEATER AND CIRCULATORS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

Exhibit 6: NHICS FORM 259 | MASTER CENTER CASUALTY/FATALITY REPORT

1. INCIDENT NAME:		**2. CENTER NAME:**	
3. DATE/TIME PREPARED:		**4. OPERATIONAL PERIOD DATE/TIME:**	

5. REPORTED CASUALTY/FATALITY

RESIDENT NAME:		**MEDICAL RECORD #:**	
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:		**MEDICAL RECORD #:**	
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:		**MEDICAL RECORD #:**	
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:		**MEDICAL RECORD #:**	
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**
RESIDENT NAME:		**MEDICAL RECORD #:**	
INJURY	**TRANSFER DATE / TIME**	**RECEIVING HOSPITAL**	**EXPIRED DATE / TIME**

Exhibit 7: NHICS FORM 252 | SECTION PERSONNEL TIME SHEET (STAFF TRACKING SHEET)

6. FACILITY NAME:	Keene Center		
7. FROM DATE/TIME:		**8. TO DATE/TIME:**	
9. SECTION:		**10. TEAM LEADER:**	

11. TIME RECORD

#	EMPLOYEE (E)/VOLUNTEER (V) NAME (PLEASE PRINT)	E/V	EMPLOYEE NUMBER	NHICS ASSIGNMENT/ RESPONSE FUNCTION	DATE/TIME IN	DATE/TIME OUT	SIGNATURE	TOTAL HOURS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

1. CERTIFYING OFFICER:		**2. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY, INCLUDING VOLUNTEERS NHICS 252

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

Exhibit 8: NHICS FORM 253 | VOLUNTEER STAFF REGISTRATION

12. FACILITY NAME:	Keene Center					
13. FROM DATE/TIME:			**14. TO DATE/TIME:**			
15. REGISTRATION						
NAME (LAST NAME, FIRST NAME)	**ADDRESS** (INCLUDE CITY, STATE, ZIP)	**SOCIAL SECURITY NUMBER**	**TELEPHONE**	**CERTIFICATION/ LICENSURE & NUMBER**	**REFERENCE CHECK**	**SECTION ASSIGNMENT**
16. CERTIFYING OFFICER:			**17. DATE/TIME SUBMITTED:**			

Exhibit 9. PIDEMIC PREPAREDNESS C ECKLIST

	Person Responsible	Date Completed
Planning and Decision Making		
Administrator/Executive Director is responsible for preparedness planning		
Create a multidisciplinary planning committee to include administration, medical director, nursing, reception, environmental, and others as needed; meet a minimum of monthly to evaluate your plan		
Incorporate epidemic preparedness into your Emergency Preparedness plan		
Develop plan to ensure that patient identification is on all patients/residents		
Complete the Emergency Numbers and Contacts List (refer to *Emergency Preparedness Plan: Attachment C*) ➢ **Include local, regional, or state emergency preparedness groups**		
Prepare updated employee contact list		
Ensure Test Kit is available, as indicated (i.e., Influenza)		
Communications		
Designate a person who will be responsible for **daily monitoring of updates (i.e., GHC Flu page)** and internal communications to staff, patients, and responsible parties		
Establish a system for communication with patients and families		
Maintain a list or database for patients' regular clinic, physician, or dialysis appointments in order to cancel non-essential appointments		
Education		
The Nurse Practice Educator/Practice Development Specialist or designee is responsible for coordinating education		
In-service all staff on Emergency Preparedness *(*may also refer to *Influenza Preparedness PowerPoint, if applicable)*		
In-service staff on infection control procedures and precautions, respiratory hygiene/cough etiquette		
Infection Control		
Post signage (Respiratory Hygiene/Cough Etiquette, Hand Hygiene, visitor sign in reception area)		
Implement respiratory hygiene/cough etiquette throughout the facility, as necessary		
Develop a plan for cohorting patients ➢ Discuss with VPMA and CQS if facility will confine all affected patients to one area, close off wings that are affected, or just confine sick patients and their roommates to their rooms		
Implement surveillance of targeted epidemic illness cases in the facility per Infection Control policies		
Collect information on: ➢ Incoming patients – confirmed or suspected targeted epidemic cases ➢ Number of new cases of targeted epidemic illness within the facility		
Report confirmed or suspected cases of targeted epidemic illness to the VPMA		
General Staff Management		
Develop plan for 100% vaccination of staff, if applicable; Administrator/ED and/or DON/RCD will have a personal conversation with staff who decline vaccination		
In collaboration with Area leadership, develop plan for 30% absenteeism; submit plan to MP		

	Person Responsible	Date Completed
➢ Number and categories of personnel needed to keep facility open or take patient overload ➢ Conduct a daily assessment of staffing status (refer to *Daily Review Form*) ➢ Develop plan for work/rest schedule as needed (i.e., place to sleep when extended work hours are necessary)		
Avoid floating staff if possible		
Educate staff to self-assess and report symptoms that they may be having before reporting to work		
Educate staff to develop a child care plan for school closings		
Review guidelines for Altered Standards of Care		
Discuss with staff the possibility of helping with essential patient care at times of severe staffing shortages		
Sick Staff		
Follow protocols for sick staff: ➢ Employees who develop symptoms during work hours should be sent home ➢ Employees who have been ill but are recovered may provide care to patients		
Alternative Staff		
If needed discuss use of alternative staff with SVP, VPMA and VPCO. Develop plan for use of employees not usually involved in patient care to perform basic patient care with supervision (Refer to *Alternative Staff Guidelines*)		
Influx of Infectious Patients		
Develop plan for patients requiring hospitalization ➢ Patient transport ➢ Lists of hospitals with contact information		
Develop plan to accommodate overcrowding and to ensure that an inflow of infectious patients does not overstretch the facility's resources ➢ Capacity of facility ➢ Number of empty beds/cots ➢ Patient care equipment ➢ Availability of treatment options ➢ Availability of vaccine and antiviral drugs ➢ Staffing resources		
Develop strategies to aid hospitals by admitting non-influenza patients not affected		
Environment		
Address whether adequate storage is available for additional supplies, e.g., water, food, medical supplies		
Make arrangements for additional storage, if needed		
Store adequate supplies/equipment (located in appropriate areas of building)		
For droplet precautions, position beds are at least three feet apart if setting up alternate bed areas		
Food Service		
Provide emergency food and disposable supplies are maintained		
Maintain hard copy of resident roster from Tray Trakker		
Develop staffing plans for full-day shifts (12 to 16 hours)		

Exhibit 10. DAILY SYMPTOM SCREENING FORM

INSTRUCTIONS: Use this form during an outbreak to screen **all** new admissions, re-admissions, staff, visitors, and vendors for symptoms of the illness before reporting to duty. Fill in specific symptoms monitored in the associated columns below. If staff report with symptoms meeting the clinical criteria, recommend follow-up treatment and send them home. (Note: this form may be modified based on specific outbreak.)

Name of Screener	**Title**

Date	**Name**	**Time**	**Symptoms**				**Status**		
			Temperature	________	________	________	**OK to work/visit**	**Exclude from duty/visit**	**Screener initials**
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Temperature <100°F, OK to work/visit.

Temperature >100°F with any of above symptoms, exclude from duty/visit.

Exhibit 11. ALTERED STANDARDS OF CARE (ASC) FOR EPIDEMIC/PANDEMIC

In most cases, the order to use ASC will be initiated by state authorities. Following a declaration by the Governor that there is an emergency which is detrimental to the public health, the DPH/HHSD may order adherence to ASC priorities and protocols.

Principles for Allocation of Limited Resources and ASC Protocols

Priority for limited medical resources and ASC protocols will be based upon the allocation of scarce resources to maximize the number of lives saved. This allocation will be:

1. Determined on the basis of the best available medical information, clinical knowledge, and clinical judgment;
2. Implemented in a manner that provides equitable treatment of any individual or group of individuals based on the best available medical information, clinical knowledge, and clinical judgment;
3. Implemented without discrimination or regard to sex, sexual orientation, race, religion, ethnicity, disability, age, income, or insurance status.

ASC protocols will recognize:

- Any changes in practices necessary to provide care under conditions of scarce resources or overwhelming demand for care
- An expanded scope of practice for health care providers
- The use of alternate care sites, at facilities other than health care facilities
- Reasonable, practical standards for documentation of delivery of care

Individual Rights

Civil liberties and patients' rights will be protected to the greatest extent possible; however, it is recognized that the protection of the public health may require limitations on these liberties and rights during an epidemic.

Provider Liability

Health care providers who provide care in accordance with the priorities and ASC protocols, including care provided outside of their scope of practice or scope of license, will be considered to have provided care at the level at which the average, prudent provider in a given community would practice.

Priority Activities for ASC

The term "altered standards" has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation. It could also mean changing who provides various kinds of care or changing privacy and confidentially protections temporarily.

Because there are no nationally defined altered standards of care, Genesis HealthCare has established the priorities listed below. However, state/federal authorities are in the process of developing altered standards of care which may supersede Genesis priorities.

Nursing:

- Basic personal hygiene
- Use of hospital gowns for residents as opposed to personal clothing to reduce laundry
- Turning
- Toileting
- Feeding
- Medication Pass
- Critical documentation only – fever, change in condition, incidents

Housekeeping:

- Focus on high-touch surfaces such as tabletops, side rails, door knobs, telephones, time clocks, faucets, etc.

Dietary:

- Minimum nutritional requirements for three meals a day
- Therapeutic diets will be evaluated on an individual basis
- Essential documentation only

Social Services:

- Limit activities to current pandemic issues
- Essential documentation only

Laundry:

- Additional shifts may be needed to handled increased demands

Maintenance:

- Suspend preventive maintenance activities to reallocate resources

Recreation Services:

- Suspend activities to reallocate resources

Admissions:

- Limited to only those associated with the epidemic
- Consider marketing personnel reallocation to local centers

Business Office, Human Resources, Central Supply, Medical Records, Clerical Functions:

- Limit to essential functions only to reallocate resources

EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

Not Started	In Progress	Completed	Tasks
			• **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			• **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).

			• **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *
			- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
			- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
			- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
			- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:
			  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel
			  - An adequate supply of potable water (recommended amounts vary by population and location)
			  - A description of the amounts and types of food in supply
			  - Maintaining extra pharmacy stocks of common medications
			  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
			- Identifying and assigning staff who are responsible for each task
			- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days
			- Contract established with multiple vendors for supplies and transportation
			- Develop a plan for addressing emergency financial needs and providing security

			• **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: * - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees. - Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established - Adequate food supply and logistical support for transporting food is described.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

Not Started	In Progress	Completed	Tasks
			- The amounts of water to be transported and logistical support is described. - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation - Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff. - Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - It is described whether staff family can shelter at the facility and evacuate.
			• **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *
			• **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			• **Facility Reentry Plan**: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			• **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
			Tasks
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			• **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			• **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: - Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. - Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.
			• **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.
			• **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			• **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - Encourage family participation
			• **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes
			• **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			• **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: - Exercises or drills must be conducted at least semi-annually - Corrective actions should be taken on any deficiency identified
			• **Loss of Resident's Personal Effects:** Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes

Facility Assessment

Langdon Place of Keene

305085: Langdon Place of Keene - 57036, Keene, NH

Langdon Place of Keene
NAME

Insufficiencies by Category & Type

- Staffing, Training, Services, and Personnel
- Physical Environment, Technology, and Equipment

Function Acuity Cognitive

3 INSUFFICIENT CATEGORIES

3 ACTION/PLAN IN PLACE

Nov 27, 2022 - Dec 18, 2022

Last Activity: Dec 2, 2022 ADC: 23 Licensed Beds: 25

I. Resident Population Profile - Nov 28, 2021 - Nov 27, 2022

Admissions/Stays Summary

	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Number of Admissions/Stays in Past Year	197	100	N/A
Number of Admissions/Stays ending in Community Discharge	110	55.8	High
Number of Admissions/Stays ending in Death	14	7.1	High
Number of Admissions/Stays ending in Hospitalization	32	16.2	Low
Number of Admissions/Stays ending in Other Discharge	11	5.6	High
Number of Ongoing Stays	30	15.2	N/A
Number of Short Stays (Less than 100 days)	157	79.7	High
Number of Short Stays 1-14 Days	45	28.7	N/A
Number of Short Stays 1-30 Days	106	67.5	N/A
Number of Short Stays 1-60 Days	144	91.7	N/A
Number of Short Stays 1-90 Days	155	98.7	N/A
Number of Long Stays (100 days or more)	18	9.1	Very Low

Number of Post-acute Admissions/Stays	184	93.4	High

A. Function, Mobility, & Physical Disabilities

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Global Function (Bartnel) Index			
ADL Function Low	95	48.2	Low
ADL Function Moderate	30	15.2	Low
ADL Function High	50	25.4	High
Activities of Daily Living (ADL) - Assistance Required: 1 Person			
Daily Care (excluding Bathing)	165	83.8	High
Bed Mobility	77	39.1	High
Transfer	80	40.6	High
Walk in Room	82	41.6	High
Toilet Use	97	49.2	High
Eating	16	8.1	Very Low
Bathing	117	59.4	Very Low
Dressing	146	74.1	High
Hygiene/Grooming	144	73.1	High
Activities of Daily Living (ADL) - Assistance Required: 2+ Persons			
Daily Care (excluding Bathing)	104	52.8	High
Bed Mobility	91	46.2	High
Transfer	85	43.1	High
Walk in Room	2	1	Low

Toilet Use	73	37.1	High
Eating	0	0	None
Bathing	53	26.9	High
Dressing	22	11.2	Low
Hygiene/Grooming	19	9.6	High
Mobility			
Independently Ambulatory (No Assistive Device)	0	0	N/A
Independently Ambulatory (With Assistive Device)	0	0	N/A
Ambulation with Assistance (No Assistive Device)	21	10.7	N/A
Ambulation with Assistance (With Assistive Device)	85	43.1	N/A
In Chair All or Most of Time	163	82.7	N/A
With Contractures	106	53.8	Very High
Physically Restrained	0	0	None

Rehabilitative Services (for those receiving therapy)	Avg. Number of Days	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Speech-Language Pathology and Audiology Services	1.6	26	13.2	Low
Occupational Therapy	3.5	151	76.6	High
Physical Therapy	2.6	140	71.1	Low
Respiratory Therapy	1.7	6	3	High
Psychological Therapy	0	0	0	N/A
Recreational Therapy	0	0	0	None

A.1. Function - Care Requirements

Considerations.

1. Types of care required: Admissions team (including IDT and hospital screener) review potential admissions and the services/equipment/staffing required to care for the resident. Center has a high population of residents that require ADL assistance. This includes bathing, dressing, grooming and toileting. High incidence of mobility assistance with device and mechanical lift. Types of care provided but not limited to: Skilled nursing care, long term care, advanced care planning, palliative care and memory support. Supporting residents, families and caregivers throughout the continuum of their time with Langdon Place of Keene. Center creates an atmosphere similar to home building relationships for residents, family members and staff. Community partnering has been modified since the presence of COVID 19 and the need to modify the types and ways our center collaborates and connects with the community. Strive to deliver care that is culturally, religiously and ethnically competent/sensitive.

2. Services required: Center collaborates with rehabilitative services located on site- PT/OT/ST (via tele visit and proctor). Through collaboration residents are evaluated for developing plans for the resident to restore function and or maintain highest level of self performance. Health drive provides dental, podiatry, opthamology and audiology services. Residents have the option of community based services as well. US Labs/Trident provide the lab services, x-ray and ekg services. Medi Telecare provides the mental health services. Omnicare provides the services pertaining to pharmacy and therapeutic oversight of medication regimes. Lincare is the provider for oxygen needs and respiratory therapy. Compassus is the primary provider of Hospice service in center, however HCS of Keene and Bayada are available options for residents as well. Center provides Infusion therapy round the clock, supplies from Omnicare. Wound care/pressure relieving/reducing mattresses from Joerns and G-tube nutritional services through consultation with dietician/pcp. Due to the ongoing requirements surrounding COVID 19 and the changing guidance surrounding testing, vaccines and isolation the senior leadership respond to the arising needs and adapt our training/education.

3. Staff/Personnel required: Center employs a full senior leadership team overseeing each department. Nurses, LNA, medical records, Director of nurses, NPE, ICP, Unit Manager, CRC, Skin Lead make up the clinical team. SSD director and Admissions director back each other up in their respective areas. Recreation department has a full time activity director, 2 full time assistants and a bus driver for center 1 day a week. Dietary services are contracted with Health care service group and they include a FSS, dietician (8 hours weekly), cooks, diet aide. Housekeeping and laundry includes a director, laundress and housekeepers. Maint department has a full time director and two full time assistance. Rehabilitation team is contracted through Genesis Rehabilitation Group and offers PT/OT/ST. Genesis Physician Service offers a Medical director and part time Nurse Practitiioner.

4. Staff Competency: New clinical staff complete competencies on hire, and annually. When a new treatment modality is introduced training is provided. Gaps in performance are identified and further education is provided to elevate performance.

5. Physical plant environment required: Center has a 13 resident rooms (12 semi private and 2 private) all beds are duel certified except for one side of the SNF hallway is only Medicare certified to accommodate for placement of SNF customers. The center has a full kitchen, main dining room. Center has a vented and approved Oxygen storage room. External generator that runs dedicated outlets (identified with red face plates) Laundry room is equipped with 2 washers, and 3 gas dryers. Therapy room is equipped with various pieces of equipment for treatment modalities. Center has 2 storage pods for storage of equipment.

6. The center has a shared facility bus one day per week. The city of Keene has 2 ambulances, Diluzio and adventure limousine provide transport to residents. Current transportation needs in the state of NH is in a state of wide spread shortage. This has impacted the ability to schedule appointments, and the lack of follow through with transportation showing up as well as delayed transports from hospital to center. Overall a delay is experienced for the entire healthcare system as it links to transportation.

7. Health information technology resources required – Center uses PCC for the EMR. PCC is also the technology used for MAR/TAR. Sister centers also use PCC which would support center professionals with access to view the EMR remotely. Nursing using E-Mar for medication administration and has a back up system for when the computer system is off line. POC is LNA documentation, SWIFT skin documentation, and Rehab optima for rehab documentation.

B. Acuity-Diseases, Conditions, & Treatments

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Acuity Index			
Acuity Index Low	88	44.7	Low
Acuity Index Moderate	76	38.6	High

Acuity Index High	33	16.8	High
Cancer			
Cancer	36	18.3	Very High
Heart/Circulation			
Heart Failure (CHF)	46	23.4	High
Peripheral Vascular Disease (PVD)	27	13.7	High
Gastrointestinal			
Cirrhosis	1	0.5	Low
Gastroesophageal Reflux Disease (GERD) or Ulcer	62	31.5	Very High
Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease	3	1.5	High
Genitourinary			
Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)	45	22.8	Very High
Neurogenic Bladder	7	3.6	High
Obstructive Uropathy	25	12.7	Very High
Infections			
Multidrug-resistant Organism	3	1.5	High
Pneumonia	15	7.6	High
Septicemia	20	10.2	Very High
Tuberculosis	0	0	None
Urinary Tract Infection (UTI)	12	6.1	Low
Viral Hepatitis	0	0	None
Wound Infection	6	3	Very High
Metabolic			

Diabetes	63	32	Low
Musculoskeletal			
Arthritis	63	32	Very High
Osteoporosis	21	10.7	Very High
Hip Fracture	23	11.7	Very High
Other Fracture	33	16.8	Very High
Neurological			
Alzheimer's	4	2	Low
Aphasia	9	4.6	High
Cerebral Palsy	1	0.5	High
Cerebrovascular Accident (CVA, TIA) Stroke	27	13.7	High
Non-Alzheimer's Dementia	33	16.8	Low
Hemiplegia or Hemiparesis	12	6.1	High
Paraplegia	0	0	None
Quadraplegia	0	0	None
Multiple Sclerosis	4	2	High
Huntington's Disease	0	0	None
Parkinson's	5	2.5	Low
Tourette's	0	0	None
Seizure Disorder or Epilepsy	7	3.6	Low
Traumatic Brain Injury	3	1.5	Very High
Nutritional			

Malnutrition	58	29.4	Very High
Psychiatric/Mood			
Anxiety Disorder	52	26.4	High
Depression	73	37.1	High
Manic Depression	1	0.5	Very Low
Psychotic Disorder	4	2	Low
Schizophrenia	0	0	None
Post Traumatic Stress Disorder (PTSD)	9	4.6	Very High
Pulmonary			
Asthma, COPD, or Chronic Lung Disease	63	32	Very High
Respiratory Failure	21	10.7	Very High
Vision			
Cataracts, Glaucoma, or Macular Degeneration	25	12.7	Very High
Conditions			
Dehydrated	1	0.5	High
Swallowing Difficulty	44	22.3	Very High
Pain Frequency (Frequent or Almost Constant)	15	7.6	Low
Fever	5	2.5	High
Vomiting	10	5.1	Very High
Internal Bleeding	3	1.5	High
Falls with Injuries	9	4.6	Low
Falls Since Admission or Prior Assessment	22	11.2	Low

One or More Unhealed Pressure Ulcers/Injuries	25	12.7	High
Shortness of Breath When Sitting	16	8.1	High
Unplanned Significant Weight Loss	18	9.1	High
Unplanned Significant Weight Gain	7	3.6	High
Current Tobacco Use	0	0	None
Treatments			
Chemotherapy	1	0.5	High
Radiation	0	0	None
Oxygen	31	15.7	Low
Suctioning	0	0	None
Tracheostomy	0	0	None
Invasive Mechanical Ventilator (ventilator or respirator)	0	0	None
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	12	6.1	Very High
IV Medications	10	5.1	High
Transfusions	0	0	None
Dialysis	2	1	Low
Isolation	2	1	High
Parenteral/IV Feeding	2	1	High
Feeding Tube	5	2.5	Low
Mechanically Altered Diet	24	12.2	Very Low
Indwelling Catheter	24	12.2	High

External Catheter	1	0.5	High
Ostomy (urostomy, ileostomy, colostomy)	1	0.5	Very Low
Intermittent Catheterization	2	1	High
Urinary Toileting Program	0	0	None
Bowel Toileting Program	0	0	None
Injections	146	74.1	Very Low
Influenza Immunization	34	17.3	Low
Pneumococcal Immunization	25	12.7	Very Low
Medications			
Insulin	29	14.7	N/A
Psychoactive Medications	99	50.3	N/A
Antipsychotic Medications	16	8.1	N/A
Antianxiety Medications (anxiolytics)	21	10.7	N/A
Antidepressant Medications	93	47.2	N/A
Hypnotic Medications	2	1	N/A
Anticoagulant	44	22.3	N/A
Antibiotics	35	17.8	N/A
Diuretic	83	42.1	N/A

B.1. Acuity - Frequency of Potentially High-Risk Treatments

IV antibiotics	More than 6
IV fluids	More than 6
IV other medications	1-5

PICC line	1-5
Surgical drains	1-5
Anticoagulation - INR monitoring	More than 6
Nebulizer Treatments	More than 6
Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	1-5
Bariatrics	More than 6

B.2. Acuity - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable): Center provides a vast variety of care with higher prevalence of the following: Renal diseases, GI conditions, cardiac /circulatory conditions including vascular, musculoskeletal- arthritis, metabolic prevalence- diabetes. Neurological conditions include-TIA,CVA and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Nutritional conditions- malnutrition, Psychosocial conditions- center has a high prevalence of depression, anxiety and PTSD. Pulmonary conditions with high prevalence include Asthma, COPD, and chronic lung disease. Sensory conditions including visual ailments have a high prevalence at center. Other conditions with a high incidence include pain frequency, falls pre admission/post admission. Treatments- oxygen therapy, CPAP/BiPAP, IV Medications, mechanically altered diet, indwelling catheter, ostomy, injections- including insulin & immunizations. High prevalence of Psychoacitvie medication- predominantly antidepressants.

2. Services required (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other service as outlined in center functions- rehab, ancillary services, hospices, vision, dental, podiatry, mental health services, lab services, O2 etc. Center utilizes Third Eye for after hours/on call physicians. As well as with new equipment, PRN education.

3. Staff/Personnel required- center has agreements/partnership with supporting services. Omnicare, Lincare, Joerns, GRS/powerback, GPS-Medical director/NP services. Staffing is linked to occupancy. Acuity is factored into the overall staffing patterns, and modified as census goes up or down.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided.

5. Physical plant environment required – external generator to run red face plate outlets. Each hallway and main dining room/ pavilion have AC units for cooling. Individual units are placed in the resident room, offices and common areas in spring and removed in the fall.

6. Medical and non-medical equipment required- Each unit is equipped with mechanical lifts and variety of sized slings. The shower rooms on each unit are equipped with a shower and a whirlpool tub. Bladder scanner for use. Center has partnerships with various venders that provide equipment for the care of residents- Omnicare IV pumps, enteral feeding pumps, Lincare CPAP/Bipap, 4 medication carts that are serviced by Omnicare, the omnicell in the medication room for emergency/back up medications, nebulizer machines/O2 concentrators, Joerns wound vacs and specialty sleeping surfaces. The kitchen uses a Robo coupe machine to prepare mechanically altered textures. Center has a facility bus for outings that is shared with 3 other homes.

7. Health information technology resources required – such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC is the EMR for center. Additional supporting technology such as programs like SWIFT for wound care and Omniview for pharmacy. POC and Rehab Optima.

C. Cognitive, Mental, & Behavioral Status

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Interviewable	166	84.3	Low
Memory Impaired on BIMS	22	11.2	Low
Orientation Impaired on BIMS	51	25.9	Low

Recall Impaired on BIMS	36	18.3	Low
Understanding Impaired	0	0	None
Decision Making Impaired	14	7.1	Low
With Intellectual Disability or Developmental Disability	3	1.5	Very High
Dementia: Non-Alzheimer's or Alzheimer's Disease	33	16.8	Low
Wandering	4	2	Very High
Psychotic Symptoms	4	2	High
With Behavioral Health Care Needs	8	4.1	Low
Resident Behavior Impacted Resident Care	1	0.5	Low
Resident Behavior Impacted Others	1	0.5	Low
Potential For Self Harm	0	0	None
Hearing Impaired	7	3.6	Low
Speech Impaired	10	5.1	Low
Vision Impaired	0	0	None
Comatose	1	0.5	High

C.1. Cognitive - Care Requirements

1 Types of care required (including trauma and substance use disorders as applicable) Center provides a vast variety of care with higher prevalence of the following: Cognitive diagnosis/conditions impacting cognition include-TIA,CVA and non Alzheimer's dementia, Huntington's disease and Parkinson's disease. Psychosocial conditions- center has a high prevalence of depression, anxiety and PTSD. Sensory conditions including visual ailments have a high prevalence at center. Other conditions with a high incidence include pain frequency, falls preadmission/post admission. High prevalence of Psychoacitvie medication- predominantly antidepressants.

2. Services required (including behavioral health services as applicable) in house PCP/NP for treatment of acute/chronic conditions. Other service as outlined in center functions- rehab, ancillary services, hospices, vision, dental, podiatry, mental health services, lab services, O2 etc. Center utilizes Third Eye for after hours/on call physicians. Person centered care drives individual care planning, what matters to the resident supports the cognitive and mental health needs of the resident. The recreation team develop programs in collaboration with the residents.

3. Staff/Personnel required- center has agreements/partnership with supporting services listed above in the service required. Omnicare, Lincare, Joerns, GRS/powerback, GPS- Medical director/NP services. Meditelicare provides specialized mental health services, including medication reviews, talk therapy, in-service education on special topics.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided. Special ongoing training includes specialized dementia training, trauma informed care and topics that target techniques to care for those with cognitive/mental or behavioral health conditions.

5. Physical plant environment required – Secure care system at the main entry. Center does not use bed/chair alarms. Center does haveremovable stop signs used for various rooms including resident rooms as a deterrent for wandering residents entering another persons room.

6. Medical and non-medical equipment required- Center has devices for music, animatronic pets and weighted babies available that provide comfort for various levels of cognitive conditions. Center has a facility bus for outings that is shared with 3 other homes. Pocket Talker hearing device.

7. Health information technology resources required – IPAD or similar device for virtual visits. PCC is EMR.

D. Cultural, Ethnic, & Religious Factors

MDS Resident Profile	Admissions/Stays	% of Admissions/Stays	Frequency Relative to Benchmark
Age			
Age less than 65	5	2.5	Very Low
Age 65 to 94	172	87.3	High
Age 95 or greater	20	10.2	Very High
Race/Ethnicity			
American Indian or Alaska Native	0	0	None
Asian	0	0	None
Black or African American	0	0	None
Hispanic or Latino	0	0	None
Native Hawaiian or Other Pacific Islander	0	0	None
White	197	100	Very High
PASRR			
PASRR level II indicates serious mental illness and/or intellectual disability or related condition	0	0	None
Other			
Male	67	34	Low
Married	56	28.4	Low

Need/Want Interpreter	0	0	None
Life Expectancy less than 6 Months	3	1.5	Low
Receiving Hospice Care	2	1	Low

D.1. Cultural - Activities, Services, & Places

Spiritual/Religious Services

Catholic

Holiday Services

Christian holidays

Jewish Holidays

Accommodations for Worship

Time of day (e.g. sunrise, early AM, late afternoon, evening)

Noise (e.g. silence, quiet room)

Furniture (e.g. comfort for sitting, kneeling)

Media (e.g. books, videos, music)

Equipment (e.g. TV, CD player, etc.

Places of Worship

Non-Christian spiritual setting

Transportation to community services

Spiritual Counseling

Non-denominational

Priest

Minister

End of life counseling/visitation

Spiritual Reading/Study

Other sacred texts

D.2. Cultural - Food & Nutrition

Diet

Vegetarian

Vegan

Caffeine-free

Dairy substitutes (e.g. soy)

Gluten-free

Protein preferences (e.g. beef, pork, fowl, fish, vegetarian)

Meal Time

Early (e.g. breakfast, coffee)

Mid-afternoon

Evening

Religious/Holiday Meals

Lent

Easter

D.3. Cultural - Daily Routine

Daily Routine Accommodations

Clothing and cosmetics (e.g. religious garments, jewelry, makeup, oils)

Gender preferences (e.g. same gender personal care providers)

Outside visitors (family, friends, partners, significant relations)

Place and times for privacy

Access to outdoors

Waking time

Bed time

Other daily routine accommodations

D.4. Cultural - Care Requirements

1. Types of care required (including trauma and substance use disorders as applicable) Center serves individuals from a vast group of religious affiliations. provides a vast variety of care with higher prevalence in the age groups 65 to 94. The center does have customers in the younger and older age group as well. Our center community is predominantly white, but have provided service a diverse population. This includes the individual preferences of the resident- rise and bed time, when and what to eat, what to wear, how to spend their time, how they want to be addressed as well as other personal preferences. Our culinary team and recreation team collaborate to provide enriching experiences including multidenominational services and activities. The dietician supports the team regarding religious and cultural needs being met through nutritional services.

2. Services required- through assessment process center is able to determine specific services required by those in our care. Spiritual services include catholic, Christian and nondenominational. The center works with the resident/customer to ascertain the spiritual connection they require and seek partnership with community partners. Resident council help drive the nature of service desired.

3. Staff/Personnel required- The recreation, dietary and social service team collaborate with the residents to identify what matters to them, they frequency and types of spiritual/religious services, food and cultural preferences. Local clergy and religious leaders, volunteers and community groups.

4. Staff Competencies required- competencies are conducted on hire, and annually to ensure ongoing proficiency with services required and provided. Including the importance of what matters to the resident.

5. Physical plant environment required – Space for worship, and spiritual services to accommodate large and small groups.

6. Medical and non-medical equipment required- center has a shared bus. PA system is available for use to project sound quality for all listeners. A podium is also available for those presenting.

7. Health information technology resources required – such as systems for electronically managing patient records and electronically sharing information with other organizations- PCC is the EMR for center where care team complete assessments and collect information specific to the resident and their spiritual/religious and cultural needs.

Supporting Documents

No records were found

II. Staffing, Training, Services & Personnel

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No
Eating	Sufficient	Sufficient	Sufficient	No
Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Not Applicable	Not Applicable	Not Applicable	No
Rehabilitative Services (for those receiving therapy)				

Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Daily discussions regarding staffing. The managers provide updates on resident needs. The scheduler will make staffing adjustments based on census and acuity. Scheduler and clinical team meet weekly for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted service are also evaluated by the IDT to develop plan to ensure services are provided during the identified gaps. During outbreak status and closing of congregate activities/meals staffing is evaluated to determine adjustments that are required. Center has primary assignments with floaters that cover primary staff days off. In the event we have an outbreak of COVID 19 center will consult with regional support team to develop staffing plan based on current guidance for staff to return to work. Caregivers collaborate via hey team leader, huddles, staff meetings and 1:1 to determine changes to work loads, and assignments. All senior leaders with lic support direct care staff and partner to ensure adequate numbers for safety and quality.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff. Training is conducted through a variety of modalities. These include vital learn programs through online programming, education boards, and live education. Nursing staff competencies are conducted on hire and annually.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments.- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams complete analysis of data (data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the teams identification of Opportunities for Improvement and development of PIPS/IA.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance. In 2023 the process of PIP and IA process will be transitioned into PCC Insights. The Hey Team Leader program provides a vehicle for feedback and efficient process to implement corrective action.

B. Acuity-Diseases, Conditions, & Treatments

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■1 □0	■2 □0	■1 □0	Y-3 N-36
Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	Sufficient	Sufficient	No
Nutritional	Sufficient	Sufficient	Sufficient	No
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	■ Insufficient	Sufficient	Yes
Pulmonary	Sufficient	Sufficient	Sufficient	No
Cataracts, Glaucoma, or Macular Degeneration	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	Sufficient	No
Radiation	Sufficient	Sufficient	Sufficient	No

Oxygen	Sufficient	Sufficient	Sufficient	No
Suctioning	Sufficient	Sufficient	Sufficient	No
Tracheostomy	Sufficient	■ Insufficient	■ Insufficient	Yes
Invasive Mechanical Ventilator (ventilator or respirator)	Not Applicable	Not Applicable	Not Applicable	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Not Applicable	Not Applicable	Not Applicable	No
Dialysis	Not Applicable	Not Applicable	Not Applicable	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	■ Insufficient	Sufficient	Sufficient	Yes
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No
Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No

Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Our strategic business plan includes current clinical capabilities as well as identified opportunities in the market. The labor team evaluate the capacity and competence of staff and needed training/competencies needed to provide the service. Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing and the acuity in the center.

2. Staff training and competency program- NPE spear heads the staff training and competence program. Through collaboration with IDT program is modified to meet the current needs/acuity trend. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process. When new service opportunities present through market analysis and collaboration with community partners staffing patterns/sufficiency is evaluated from the perspective of the proposed new service.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. As part of the SBP and the QAPI service gaps are identified and PIP/IA are developed.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business- SBP/market analysis and Safety Excellence Improvement activities and PIPs are identified.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place

	■0 □0	■0 □0	■0 □0	Y-0 N-11
Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	Sufficient	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Not Applicable	Not Applicable	Not Applicable	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Scheduler and clinical team meet for labor meeting to evaluate staffing needs, hires, terminations and all activities/reports that link directly to the adequate staffing in the center. Additional service gaps with contracted service are also evaluated by the IDT to develop plan to ensure services are provided during the identified gaps.

2. Staff training and competency program- NPE spear heads the staff training and competence program. This includes upon hire, annual and with any identified gaps in performance. Gaps identified through performance appraisals is included in individual development plan for staff.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments.- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process.

C.2. Cognitive - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams complete analysis of data (data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the teams identification of Opportunities for Improvement.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance. The Hey Team Leader program provides a vehicle for feedback and efficient process to implement corrective action. Competency of staff while "in progress" a dedicated action plan may or may not be developed.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Overall Staffing	Staff Competencies	Services	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-11
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No
D. Cultural, Ethnic, & Religious Factors				
Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	No
Other	Sufficient	Sufficient	Sufficient	No

D.1. Cultural - Sufficiency Analysis Summary

1. Staffing and scheduling systems- Understanding the unique needs of each resident and their preference provides the guide for determining capacity and competence of staff. This includes seeking support service which include but not limited to clergy, religious groups, LBGT/inclusion groups.

2. Staff training and competency program- NPE spear heads the staff training and competence program. Programs such as Trauma informed care.

3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments.- Clinical team collaborate with direct care staff to evaluate assignments and needed adjustments. Staff utilize center Hey Team Leader program to communicate needs, suggestions for process changes or creation to impact overall quality of care and efficiency of process. Being sensitive to what matters to the customer- for example no male caregivers, doesn't take showers, or is a night owl.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- Center has a QAPI plan. The plan is reviewed annually and amended as needed when changes occur. Center QAPI team meets monthly, with adhoc meetings throughout the month as needed. Our Hey Team Leader program is a process that links and engages all staff and stakeholders to our QAPI program.

2. Performance Improvement Projects (PIP)- Through the IDT collaboration and monthly excellence meetings- Clinical, Customer, People, Business and Safety Excellence Improvement activities and PIPs are identified. The excellence teams complete analysis of data (data sources include but are not limited to- satisfaction surveys, MDS, QM, turnover/retention reports, audits, monthly performance scorecards etc., evaluate critical element pathways which provide a consistent review of system and process guiding the teams identification of Opportunities for Improvement.

3. Corrective actions- QAPI team members present minutes from excellence meetings and projects being worked on. The team provides feedback and any additional suggested corrective actions required to meet the gaps in performance. The Hey Team Leader program provides a vehicle for feedback and efficient process to implement corrective action.

Supporting Documents

No records were found

III. Physical Environment, Technology, & Equipment

A. Function, Mobility, & Physical Disabilities

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-19
Activities of Daily Living (ADL)				
Daily Care (excluding Bathing)	Sufficient	Sufficient	Sufficient	No
Bed Mobility	Sufficient	Sufficient	Sufficient	No
Transfer	Sufficient	Sufficient	Sufficient	No
Walk in Room	Sufficient	Sufficient	Sufficient	No
Toilet Use	Sufficient	Sufficient	Sufficient	No

Eating	Sufficient	Sufficient	Sufficient	No
Bathing	Sufficient	Sufficient	Sufficient	No
Dressing	Sufficient	Sufficient	Sufficient	No
Hygiene/Grooming	Sufficient	Sufficient	Sufficient	No
Mobility				
Ambulation	Sufficient	Sufficient	Sufficient	No
In Chair All or Most of Time	Sufficient	Sufficient	Sufficient	No
With Contractures	Sufficient	Sufficient	Sufficient	No
Physically Restrained	Sufficient	Sufficient	Sufficient	No
Rehabilitative Services (for those receiving therapy)				
Speech-Language Pathology and Audiology Services	Sufficient	Sufficient	Sufficient	No
Occupational Therapy	Sufficient	Sufficient	Sufficient	No
Physical Therapy	Sufficient	Sufficient	Sufficient	No
Respiratory Therapy	Sufficient	Sufficient	Sufficient	No
Psychological Therapy	Sufficient	Sufficient	Sufficient	No
Recreational Therapy	Sufficient	Sufficient	Sufficient	No

A.1. Function - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and customers being served drives the type/quantity of equipment and supply. Our Central Supply coordinator collaborates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Point of care charting for direct care, PCC for EMR. This also includes migration of supporting electronic systems that include but not limited to risk management, PIP process through Insight, Abaqis for the Center Facility Assessment. The electronic screening process at the front door provides format for the requirement our infection control program.

2. Maintenance and activity logs- Maint utilizes TELS system for logging center upkeep, repairs and routine maint. Safety committee collaborates for center opportunities. Specific assessments/evaluation like the Legionella water plan and NFP risk assessment are completed

annually. Report is generated monthly to reflect completed and outstanding activities.

A.2. Function - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly. changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Additionally, our hey team leader program is designed so that 100% of all staff across all shifts and departments are able to communicate Opportunities for Improvement. OFI are brought to the QAPI committee for Review. For example phone system functionality or the aging whirlpool tubs, aging generator

3. Corrective actions- The maint. Department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Addition tasks for maint. are also entered into the system for completion/tracking. Once an OPI has been identified corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be through center budget or capital request.

B. Acuity-Diseases, Conditions, & Treatments

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-39
Cancer	Sufficient	Sufficient	Sufficient	No
Heart/Circulation	Sufficient	Sufficient	Sufficient	No
Gastrointestinal	Sufficient	Sufficient	Sufficient	No
Genitourinary	Sufficient	Sufficient	Sufficient	No
Infections	Sufficient	Sufficient	Sufficient	No
Metabolic	Sufficient	Sufficient	Sufficient	No
Musculoskeletal	Sufficient	Sufficient	Sufficient	No
Neurological	Sufficient	Sufficient	Sufficient	No
Nutritional	Sufficient	Sufficient	Sufficient	No
Psychiatric/Mood/Behavioral Health (including Trauma/SUD as applicable)	Sufficient	Sufficient	Sufficient	No

Pulmonary	Sufficient	Sufficient	Sufficient	No
Vision	Sufficient	Sufficient	Sufficient	No
Conditions	Sufficient	Sufficient	Sufficient	No
Treatments				
Chemotherapy	Sufficient	Sufficient	--	No
Radiation	Sufficient	Sufficient	Sufficient	No
Oxygen	Sufficient	Sufficient	Sufficient	No
Suctioning	Sufficient	Sufficient	Sufficient	No
Tracheostomy	Sufficient	Sufficient	Sufficient	No
Invasive Mechanical Ventilator (ventilator or respirator)	Sufficient	Sufficient	Sufficient	No
Non-Invasive Mechanical Ventilator (CPAP/BiPAP)	Sufficient	Sufficient	Sufficient	No
IV Medications	Sufficient	Sufficient	Sufficient	No
Transfusions	Sufficient	Sufficient	Sufficient	No
Dialysis	Sufficient	Sufficient	Sufficient	No
Isolation	Sufficient	Sufficient	Sufficient	No
Parenteral/IV Feeding	Sufficient	Sufficient	Sufficient	No
Feeding Tube	Sufficient	Sufficient	Sufficient	No
Mechanically Altered Diet	Sufficient	Sufficient	Sufficient	No

Catheterization	Sufficient	Sufficient	Sufficient	No
Ostomy (urostomy, ileostomy, colostomy)	Sufficient	Sufficient	Sufficient	No
Toileting Program	Sufficient	Sufficient	Sufficient	No
Injections	Sufficient	Sufficient	Sufficient	No
Immunizations	Sufficient	Sufficient	Sufficient	No
Implanted Devices (pacemakers, insulin pumps, pain pumps, etc.)	Sufficient	Sufficient	Sufficient	No
Bariatrics	Sufficient	Sufficient	Sufficient	No
Medications				
Insulin	Sufficient	Sufficient	Sufficient	No
Psychoactive Medications	Sufficient	Sufficient	Sufficient	No
Anticoagulant	Sufficient	Sufficient	Sufficient	No
Antibiotics	Sufficient	Sufficient	Sufficient	No
Diuretic	Sufficient	Sufficient	Sufficient	No

B.1. Acuity - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and customers being served drives the type/quantity of equipment and supply. Medical Director/NP/PCP collaborate with the IDT to determine if equipment needs are necessary to treat/care for specific population of customers.

2. Maintenance and activity logs- in addition to the TELS system for logging center upkeep, repairs and routine compliance, the center utilizes a weekend manager program to ensure specific tasks are validated daily- like door checks for locking to ensure resident and staff safety. This supports the acuity of wandering and cognitively impaired folks.

B.2. Acuity - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly. changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Once and OFI is identified is brought to the QAPI committee for Review. For example the training of a staff member to train and teach CPR to keep to staff to ensure ongoing competence.

3. Corrective actions- Once an OPI has been identified corrective action can be developed including identifying resources needed to

replace/upgrade the system. This could be through center budget or capital request. the procurement of the bladder scanner was through an identified need and capital requisition.

C. Cognitive, Mental, & Behavioral Status

Sufficiency Analysis Categories	Physical Environment Technology		Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-11
Cognitive Impairment (Memory, Understanding, etc.)	Sufficient	Sufficient	Sufficient	No
Intellectual and/or Developmental Disabilities	Sufficient	Sufficient	Sufficient	No
Signs & Symptoms of Depression	Sufficient	Sufficient	Sufficient	No
Dementia: Non-Alzheimer's or Alzheimer's Disease	Sufficient	Sufficient	Sufficient	No
Wandering & Elopement	Sufficient	Sufficient	Sufficient	No
Psychotic Symptoms	Sufficient	Sufficient	Sufficient	No
With Behavioral Health Care Needs	Sufficient	Sufficient	Sufficient	No
Resident Behavior Impacting Care and/or Others	Sufficient	Sufficient	Sufficient	No
Potential For Self Harm	Sufficient	Sufficient	Sufficient	No
Hearing, Speech, Vision Impairment	Sufficient	Sufficient	Sufficient	No
Comatose	Sufficient	Sufficient	Sufficient	No

C.1. Cognitive - Sufficiency Analysis Summary

1. Equipment and Supply inventory- In partnership with our parent company product evaluation is conducted, based on the center needs and customers being served drives the type/quantity of equipment and supply. Our Central Supply coordinator collaborates with IDT to ensure that the required supplies are procured and inventory is ample to meet the day to day care requirements. Meditelicare, telehealth visits, third eye all utilize the computer and internet to connect the provider with the residents. The access to Internet, and the ability to facetime, zoom meetingsetc has supported the residents in staying connected and for the cognitive folks to be able to "see" their loved ones or provider on the screenprovides a stronger experience.

2. Maintenance and activity logs- Maint. collaborates with the vendors providing the service to our center. This includes installation and ongoing upkeep.

C.2. Cognitive - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly. changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. OFI are brought to the QAPI committee for Review. For example Accessing specialty services such as meditelicare for mental health partnering and Third eye after hours coverage by physician were created as a result of gaps in services. These gaps were identified and a plan developed to remedy the gap.

3. Corrective actions- The maint. Department utilizes the TELS system to keep all weekly, monthly, quarterly and annual tasks on point and alert is sent for date compliance. Addition tasks for maint. are also entered into the system for completion/tracking. Once an OPI has been identified corrective action can be developed including identifying resources needed to replace/upgrade the system. This could be through center budget or capital request. Upgrade of our internet router was completed in 2022 as a result of outdated technology being identified.

D. Cultural, Ethnic, & Religious Factors

Sufficiency Analysis Categories	Physical Environment	Technology	Equipment	Action/Plan in Place
	■0 □0	■0 □0	■0 □0	Y-0 N-11
Age	Sufficient	Sufficient	Sufficient	No
Race/Ethnicity	Sufficient	Sufficient	Sufficient	No
Serious mental illness and/or intellectual disability or related condition	Sufficient	Sufficient	Sufficient	No
Gender	Sufficient	Sufficient	Sufficient	No
Marital Status	Sufficient	Sufficient	Sufficient	No
Need for interpreter(s)	Sufficient	Sufficient	Sufficient	No
Life Expectancy less than 6 Months	Sufficient	Sufficient	Sufficient	No
Receiving Hospice Care	Sufficient	Sufficient	Sufficient	No

D. Cultural, Ethnic, & Religious Factors

Activities	Sufficient	Sufficient	Sufficient	No
Food & Nutrition	Sufficient	Sufficient	Sufficient	No
Other	Sufficient	Sufficient	Sufficient	No

D.1. Cultural - Sufficiency Analysis Summary

1. Equipment and Supply inventory- having laptops and wifi internet available keeps residents connected with the loved ones, religious groups and any other organization that has on line connection. Center provides a guest internet connection for residents and guests to use while in the center. Center provides local telephone services and the long term care residents provide their own phones. Center provides in room TV programming for them to use on their devises they provide. Our short term stay customers are provided with phone, and TV to use during their stay. Streaming movies and programs on smart tv.

2. Maintenance and activity logs- Interruptions in service are addressed by the maint. department for the coordination of restoring service. Excellence committees discuss ongoing issues that impact the quality of resident experience as it pertains to the environment, technology and equipment.

D.2. Cultural - QAPI Action/Plan Summary

1. Facility QAPI Plan- QAPI team meets monthly. Changes and upgrades to center physical environment, technology and equipment may be presented at the applicable excellence meeting and routed to the monthly meeting as appropriate.

2. Performance Improvement projects- Center has Customer Excellence, safety Excellence, Clinical Excellence, People Excellence and Business Excellence. These area of excellence review Key performing areas including 5 star data. Satisfaction surveys conducted annually provide additional feedback on the above cited areas. Additionally, resident council meeting, care plan meeting and 72 hour meetings provide a forum for feedback.

3. Corrective actions- PIP/IA that are identified through formal and informal means are addressed through QAPI process. For example- food and nutrition action plan to improve the quality of dining and food quality. Specific interventions may include a new electronic meal ticket process, training, auditing tray accuracy and satisfaction validated through resident food council and 1:1 interviews.

Supporting Documents

No records were found

IV. All Hazards Risk Assessment

No records were found

Supporting Documents

Name	Date Uploaded
2022 Hazard Assessment.pdf	Dec 2, 2022

V. Assessment Contributors

Medical Director/Designee

Michael Kasschau

Director of Nursing Services

David Moran

Administrator/Executive Director

Michael Johnson

Representative from the Governing Body

Jennifer Dufault

Name	Title/Role
Lisa KinnareKopcha (Lisa.KinnareKopcha@genesishcc.com)	Director of Nursing
Andrew Mackey (andrew.mackey@genesishcc.com) (andrew.mackey@genesishcc.com)	Maintenance Supervisor
Melanie Gorecki (melanie.gorecki1@genesishcc.com) (melanie.gorecki1@genesishcc.com) (melanie.gorecki1@genesishcc.com)	Nurse Practice Educator
Linda Hobitz (linda.hobitz@genesishcc.com) (linda.hobitz@genesishcc.com) (linda.hobitz@genesishcc.com) (linda.hobitz@genesishcc.com)	Recreation Director
Janice Guillet (janice.guillet@genesishcc.com) (janice.guillet@genesishcc.com) (janice.guillet@genesishcc.com) (janice.guillet@genesishcc.com) (janice.guillet@genesishcc.com)	Clinical Reimbursement Coordinator

Supporting Documents

No records were found

Additional Supporting Documents

No records were found

Langdon Place of Keene Neighborhood Relations Plan

Langdon Place of Keene maintains active and friendly relationships with our neighbors and customers both abutting the property and in the community. Langdon Place of Keene is an active participant with Monadnock Women's Crisis Center through volunteering and donations. Langdon Place of Keene provides a school for Licensed Nurse Assistants to earn their certificates through training at a sister center. Langdon Place of Keene does require emergency medical vehicles to conduct business on the property, and no sirens and or disruptions have been reported from neighbors.

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City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filled_____
Rec'd By_____
Page _____of _____
Tax Map# _____
Zoning District: _____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

- ○ Drug Treatment Center
- ○ Fraternity/Sorority
- ○ Group Home, Large
- ◉ Group Home, Small
- ○ Group Resource Center
- ○ Residential Drug/Alcohol Treatment Facility
- ○ Homeless Shelter
- ○ Lodging House
- ○ Residential Care Facility

SECTION 2: PROPERTY LOCATION

ADDRESS: 39 Summer St, Keene

SECTION 3: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: The Home for Little Wanderers	**NAME/COMPANY:**
MAILING ADDRESS: 10 Guest St, Suite 300, Boston MA 02135	**MAILING ADDRESS:**
PHONE: (617) 267-3700	**PHONE:**
EMAIL: lsuggs@thehome.org	**EMAIL:**
SIGNATURE: Lesli Suggs Digitally signed by Lesli Suggs Date: 2024.03.14 12:48:07 -04'00' **DATE:** 3/14/24	**SIGNATURE:** **DATE:**
PRINTED NAME: Lesli Suggs **TITLE:** President and CE	**PRINTED NAME:** **TITLE:**

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	**NAME/COMPANY:**
MAILING ADDRESS:	**MAILING ADDRESS:**
PHONE:	**PHONE:**
EMAIL:	**EMAIL:**
SIGNATURE: **DATE:**	**SIGNATURE:** **DATE:**
PRINTED NAME: **TITLE:**	**PRINTED NAME:** **TITLE:**

SUBMITTAL CHECKLIST

A complete application must include the following items and submitted by one of the options below:

- **Email:** communitydevelopment@keenenh.gov, with *"CLSS License Application"* in the subject line

- **Mail / Hand Deliver:**
  Community Development (4th Floor)
  Keene City Hall,
  3 Washington St, Keene, NH 03431

The submittal requirements for a Congregate Living & Social Services License application are outlined further in **Chapter 46, Article X** of the City of Keene Code of Ordinances.

Note: Additional information may be requested to complete the review of the application.

◯ **PROPERTY OWNER:** *Name, phone number and address*	◯ **POINT OF 24 HOUR CONTACT:** *Name, phone number, and address of person acting as the operator, if not owner* **Same as owner**
◯ **REQUIRED DOCUMENTATION:** *Provide all required state or federal licenses, permits and certifications*	◯ **WRITTEN NARRATIVE:** *Provide necessary information to the submittal requirements*
◯ **PROPERTY INFORMATION:** *Description of the property location including street address and tax map parcel number*	◯ **APPLICABLE FEES:** $165.00 application *(checks made payable to City of Keene)*
◯ **COMPLETED INSPECTION:** **or** *Inspection date:* _____	◯ **SCHEDULED INSPECTION:** *Inspection date:* _____
◯ **OPERATIONS AND MANAGEMENT PLAN:** Plan based on the industry standard *"Best Management Practices"* to include:	◯ **LOCATION MAP:**

◊ Security Plan
◊ Life Safety Plan
◊ Staff Training and Procedures Plan
◊ Health and Safety Plan
◊ Emergency Response Plan
◊ Neighborhood Relations Plan
◊ Building and Site Maintenance Procedures

In addition, Homeless Shelters will provide:

◊ Rules of Conduct, Registration System and Screening Procedures
◊ Access Policies and Procedures

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

See attached.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

See attached.

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS CONTINUED

Using additional sheets if needed, briefly describe your responses to each criteria:

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

See attached

Location Map - 39 Summer Street

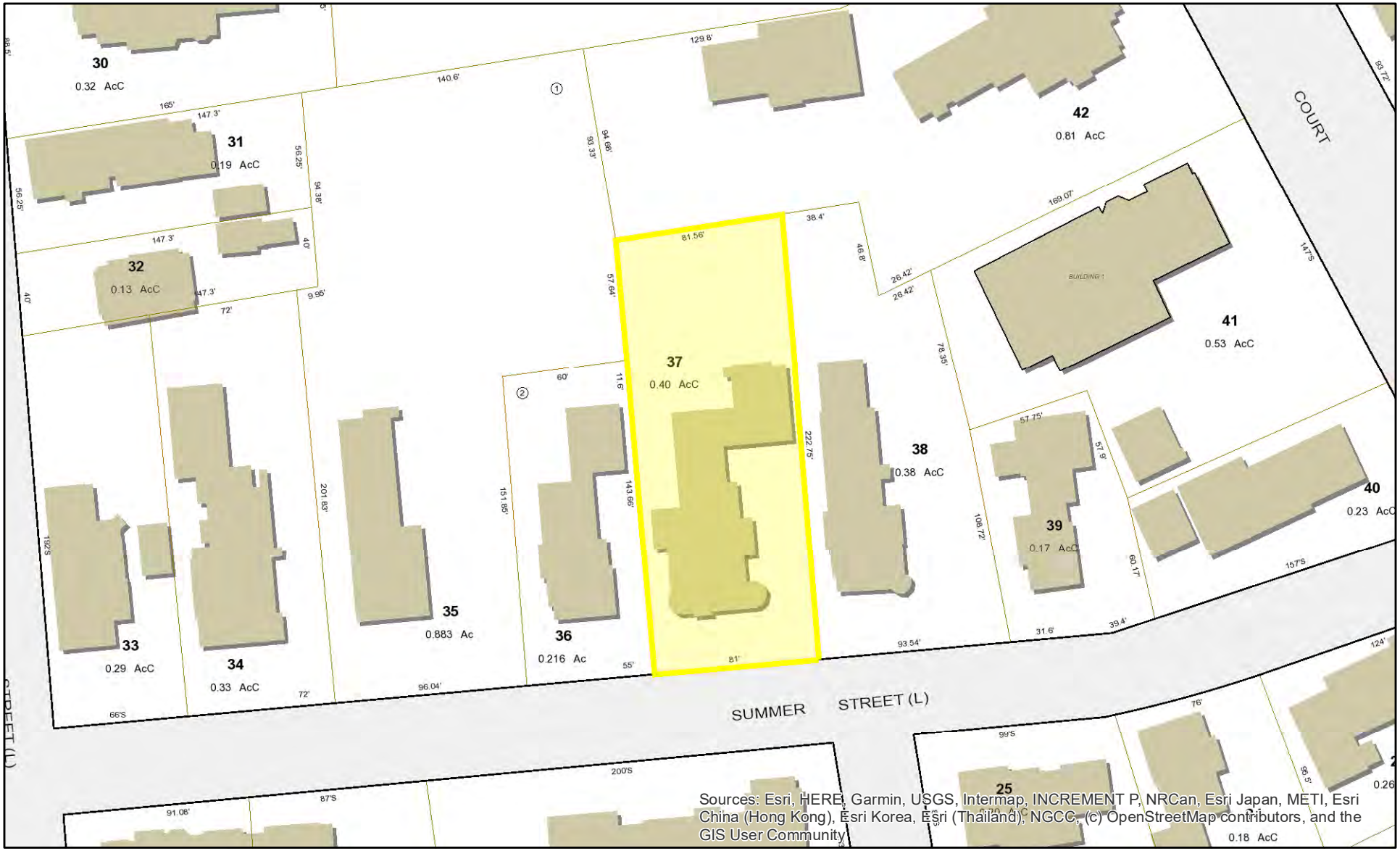
Keene, NH

September 26, 2022

1 inch = 68 Feet

0 68 136 204

www.cai-tech.com



CONGREGATE LIVING & SOCIAL SERVICES LICENSE APPLICATION
THE HOME FOR LITTLE WANDERERS, INC.
39 Summer Street, Keene, NH
TMP# 568-037-000

September 30, 2020

Section 4: Application and License Renewal Requirements Narrative

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on- or off-site.

The Home for Little Wanderers ("The Home") proposes a residential group home in the existing building for up to 8 youth, ages 12-19, who identify as members of the LGBTQ+ community. This group home, to be called "Unity House," will offer youth a safe and supportive living environment while they prepare for family reunification, independent living, secondary education paths, and future self-sufficiency. Unity House will operate as a partner program to The Home's Waltham House in Massachusetts, which was the third group home in the country specifically supporting LGBTQ+ youth. Unity House will build on the Waltham House's very successful model for delivering high quality residential care for LGBTQ+ youth for the past nearly 20 years. The Home has a contract from the New Hampshire Department of Youth and Family Services to provide this service.

Unity House will be the first residential group home in New Hampshire designed specifically for LGBTQ+ youth. For many years our Massachusetts based program has served clients from New Hampshire. The opening of this program will allow us to support New Hampshire kids in New Hampshire, keeping them closer to their community, their family, and the future surrounding of their adult lives. Our founding principles are that every child deserves to live in an environment in which they feel safe, respected, supported and cared for by those around them.

Our group home will provide a safe and supportive living environment with 24-hour staffing for up to 8 gay, lesbian, bisexual, and/or transgender youth ages 12–19. Many youth at Unity House will have experienced difficulty — at home or in placement — due to their gender expression or sexual identities. Their stay at Unity House prepares them for what is next in their plan, which may be reunification with their families, transitioning to a foster family or preparing for independent living.

In the large, Victorian-style home located in Keene, our LGBTQ+ residential program will offer an array of behavioral and mental health services to support youth and help them build the self-sufficiency they will need for their future. The Home helps to ensure healthy development of all children at risk, without regard to race, religion, gender identity/expression or sexual orientation.

PRIMARY GOALS OF UNITY HOUSE

- Provide LGBTQ+ adolescents a safe, conscientious and supportive environment in which to live and grow
- Offer families the support they need in order to become reunified with an LGBTQ+ youth
- Prepare LGBTQ+ youth for independent living by helping them to develop essential life skills
- Facilitate opportunities for LGBTQ+ youth to develop strong connections to LGBTQ+ and non-LGBTQ+ communities
- Connect LGBTQ+ youth to gender-affirming medical care providers in the community
- Help LGBTQ+ youth reach their full potential

OUR SERVICES

- Multidisciplinary team approach to treatment plan development and implementation
- Individualized and creative stabilization services and interventions
- Individual, group and family therapy and case management by mental health professionals, including licensed and Master's level clinicians
- Family outreach and permanency support services
- Life skills development and vocational training
- Opportunities to attend community-based activities, such as sports and after-school programs, including peer education programs and Gay/Straight Alliances, social/support groups and community service projects
- Integrative Treatment for Complex Trauma (ITCT)
- Cognitive Behavioral Therapy (CBT) and Motivational Interviewing
- Restorative Justice Practice

Prior to admission, each youth and family will be assigned a masters-level clinician. Clinicians provide intensive treatment and case management that is permanency-centered, strength-based and needs-driven. An initial treatment plan will be created upon admission with input from the youth, family/guardian, and referral source. The full treatment plan will be completed within 30 days of placement and updated subsequently every three months. Treatment plans are developed in collaboration with milieu staff, nurse, program psychiatrist, occupational therapist, individual clinician, youth, family, natural supports and outside collaterals. Each treatment plan is individually tailored to meet specific youth needs including social, emotional, behavioral, educational, and recreational goals.

All youth will be offered weekly individual therapy or more often if clinically indicated. Individual sessions will be designed to support the youth in meeting their identified goals, with an overall goal for them to function in a less-restrictive setting. Weekly Family therapy will be offered, either at the program or in the community, preferably in the youth's home when possible. Family therapy will focus on family communication and functioning so that if the goal of reunification can be met it can be sustained post-residential treatment. When reunification is not the current goal, therapy can be used to strengthen the bonds and communication of those in the youth's life so that these critical relationships can remain in place.

For both scenarios, treatment will focus on developing life-long connections and addressing permanency. Group therapy will be offered multiple times per week in a variety of settings and formats, and is led by a mixture of clinical, OT, and milieu staff who work together to provide consistency across all domains. Groups may be process-oriented or activity-based groups, and both types of groups are designed to provide therapeutic benefits. Examples of groups offered include: Behavioral Therapy; Anger Management; Gardening; Cooking; Substance Abuse Education; Sex Education; Vocation Skills. Social skills will be taught in formal social skills groups at the program, as well as during trips into the community with a few or more peers. It is key for youth to be able to practice skills in real life settings to reinforce the skills that they have been working on and to help build self-confidence regarding gains that they have made.

The Group home treatment model will promote positive youth development on a daily basis, with particular emphasis on opportunities to learn and practice healthy behaviors, empower youth to assume leadership roles, promote skills to support physical and emotional safety and connect with caring adults. Staff will model positive social interactions and healthy behaviors, and support youth in building educational and employment competence in both informal and formal ways (e.g., groups, job coaching, tutoring, and collaboration with schools). The program will provide youth with access to recreational and community activities that support their respective treatment goals. Care will be provided by ethnically and racially diverse staff, including those who have lived experience and reside in the communities that the program serves. They will be extensively trained in and provide treatment that includes on-site individual and family therapy, in-home therapy, educational support and advocacy; social skills and targeted therapeutic groups (based on the current population); peer and staff mentoring; therapeutic milieu services; psychopharmacology; nursing services; crisis management in the home or community; vocational assistance and coaching; community activities; assessments; treatment and discharge planning; and behavioral support.

Permanency will be at the core of all the work which stems from a belief that "with family" is always the preferred setting if they are to proceed on a healthy developmental trajectory. This work includes proactively working with families to create or strengthen sustainable, lifelong supports for themselves as well as participating in advocacy efforts to keep young people at home and reinvest in communities so that families can focus on healing and growing together. Therefore, our treatment programs engage in intensive permanency focused work. While the clinical framework recognizes that out of home treatment is sometimes necessary to build important skills and to maintain safety in the context of trauma, the core belief is that out of

home treatment can cause harm if strong connection to family is not maintained. Even more problematic is when youth lose all hope of being able to return to family because relational ruptures have been so significant and the pathway to family feels uncertain. Permanency work in this way becomes a critical component of treatment. Unity House in Keene will implement the three best practices of permanency into our work: 1. Family Search and Engagement 2. Youth Guided 3. Family Driven Teaming.

Staff will practice an approach to treatment that de-emphasizes the use of external control, where youth are given opportunities to make appropriate choices for themselves, rather than staff or other adults making their choices. Youth who live in environments where professional staff have assumed much of the ownership for their safety often need support to take greater responsibility for their own health and well-being. Youth need to build skills required to better manage emotions and may need support in making safe choices. In addition, youth benefit from real opportunities to practice skills and decision-making in the community and with family when appropriate.

The program will benefit from our Performance Quality Improvement (PQI) team, which is a standing advisory and multidisciplinary committee that is responsible for ongoing review of quality and safety related matters concerning programs and initiatives and for making recommendations for improvement. The PQI committee has broad representation from program and department staff. The Home's Clinical Quality & Outcomes department, including Evaluation & Research and Workplace Learning & Development ("WLD") staff, work directly with program staff to support any training or outcomes measurement needs related to program-level Quality Management projects and quality improvement cycles. Program leadership meets monthly with Vice Presidents and Program Operations bringing emerging best practices and challenges to the attention of senior leadership as well as problem solving around how to address challenges in programs and bringing client and program needs to the attention of agency departments; and reviewing PQI-related findings.

The Home measures core outcomes across our programs that are tied to the agency's mission and theory of change. Core Outcome Domain measured are:

• change in mental health functioning

• progress towards permanency

• incident trends

• discharge disposition

• youth, parent/caregiver, and caseworker feedback

• post discharge outcomes.

Specifically, The Home uses the Child and Adolescent Functional Assessment Scale (CAFAS) to assess youth's functioning at intake to inform treatment planning and to reassess youth's functioning during service to evaluate progress on treatment goals. The CAFAS measures functioning in eight domains:

• School

• Home

• Community

• Behavior Towards Others

• Moods & Emotions

• Self-Harm

• Thinking

• Substance Use.

Demographic, clinical information, and treatment/intervention session dates are recorded in our electronic health record (Evolv NX). Program level data collection is currently conducted for other areas such as school and work attendance and hospitalization. Dates of pre-admission meetings are also tracked at the program level. Any additional data collection needs related to Intensive Community Services quality measures will be incorporated into the Evolv NX system.

Post-discharge outcomes are assessed through an agency-wide follow-up initiative. Evaluation and research staff members call parents/caregivers/caseworkers of discharged children (birth through 17) and transition-age youth directly to complete a structured phone interview up to a year after exit. The interview includes inquiries about functioning at school, home, and in the community, which provides needed information about the extent to which clients were able to maintain successes post-discharge. This information helps program staff determine whether to continue, enhance, or replace treatment interventions and components, and inform the development of new services. Our Evaluation and Research staff have sought ways to incorporate equitable evaluation principles into our work, including looking at client outcomes by racial, ethnic, and gender identity to assess the extent to which our practice is having equitable impact across our entire client/family population.

For 17 years, we have administered agency-wide satisfaction surveys to youth, parents/caregivers, and caseworks, that assess the stakeholders' perception about whether services have been delivered in a strength-based, permanency-focused, youth and family-driven, and culturally responsive manner. The survey also assesses youth's perception of the impact on services on their functioning in a variety of domains, including at school, with peers, and in the preparation for the transition to adulthood. Information gathered from surveys is used to inform quality improvement projects as indicated by responses, and to celebrate and share successes. The survey is translated into nine languages to ensure that we are receiving feedback from as diverse of a group of stakeholders as possible and implemented a variety of efforts to promote a strong commitment of program staff to administer surveys, including both individual level incentives (e.g., coffee gift cards) and program level incentives (e.g., trophies and pizza parties).

Ongoing evaluation is an essential part of our permanency practice. A youth's permanency status is assessed on a 1 to 5 scale at intake and throughout treatment. Program staff also report which

components of the permanency practice model they have used and how often they have used them. A recent analysis found that there was statistically significant difference between initial permanency status and permanency status at reassessment for youth in out of home care; this indicates that youth were closer to permanency upon reassessment. For youth still receiving services, there were several interventions associated with progress, including individual conversations with potential permanency connections, joint conversations, and youth-guided, family-driven teaming. This information has allowed us to support and train staff on the permanency practices that result in the greatest improvement for youth.

2. Description of the size and intensity of the facility, including information about: the number of occupants, including residents, clients, staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operation; size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Unity House will house 8 residents in its group home. There will be a total of 14.53 FTE's of staff at the program, accounting for program administrators, licensed mental health clinicians, nursing, maintenance, and direct care staff. On a typical day there will be between 3-5 staff on site during the day, 2 to 3 staff on site in the evenings, and 2 staff on site on the overnights. Typically, we see between 2-4 visitors a week at our group home programs. The program will operate 24 hours a day, 365 days a year.

The building sits on a 0.4-acre parcel and has a single 6,694 square foot building. There is a large wrap around porch on the front of the building and a small back yard with a seating area. There is also a large parking area in the back and another small parking area on the side of the building.

3. For congregate living uses, the average length of stay for residents/occupants of the facility.

Our average length of stay for group home residents at our Waltham House program is 12-18 months.

Operations and Management Plan Narrative

An operations and management plan, which shall be based on industry standard "best management practices" and, at a minimum, shall address the following.

a) **A security plan that includes provisions for onsite security including lighting, security cameras, and/or other measures appropriate to provide for adequate health and safety of clients and management.**

The building will have 24/7 awake staffing to provide the majority of security for the building. In addition, The Home will be installing additional exterior lighting around the house at all entrances, exits, and areas where people can congregate, such as the picnic area and parking lot in the back of the house. Video cameras will be placed at all entrances and exits to help monitor people coming and going from the building.

b) **A life safety plan that demonstrates compliance with the state minimum building code and fire codes.**

See attachment 8.b.1 - Facilities Services Maintenance and Operations Procedures Manual

c) **Staff training and procedures plan.**

WL&D provides a comprehensive new employee orientation and training designed to ensure that new employees not only receive an introduction to our history, mission, programs and services, but also feel welcomed and valued beginning their first day. Orientation includes the agency's philosophy, goals and organization; overview of the advantages of being part of The Home; benefits and technology; onboarding overview, and completion of new employee forms. Staff ID's will also be issued. We also request professional license and any other certifications to add to their personnel file. New employees will receive immediate training in a number of areas, outlined in Attachment 8.c.1, Course and Training overview and are facilitated by seasoned employees with extensive experience in their perspective topic areas. Class sizes are limited, and a mix of live and online training is used to create a richer and more engaging experience for staff. Staff have up to 3 months to complete required trainings.

The foundational course for all our residential and group home programs is Therapeutic Crisis Intervention (TCI). The Cornell University, Family Life Development Center curriculum is incorporated in a 5-day, 30-hour TCI training for new employees, that provides staff with the skills and knowledge to become the catalyst through which the child changes old habits, destructive behaviors and maladaptive behavior patterns and provides an understanding on the effects of trauma and how to intervene with children who have experienced trauma. The goal is to train staff to help children develop new responses to their environment that will enable them to achieve a higher level of social and emotional functioning. It \also teaches therapeutic restraints, holds and releases. The TCI system provides a crisis prevention and intervention model for residential child care

organizations that will assist in preventing crises from occurring, de-escalating potential crises, effectively managing acute crises, reducing potential and actual injury to children and staff, learning constructive ways to handle stressful situations and developing a learning circle within the organization. The training is offered 1-2 times a month. All trainers are certified by Cornell University and trainings are co-facilitated with a program trainer and The Home's Agency Trainer, who is professionally certified by Cornell. Refresher trainings are held routinely and staff must complete annually 12 hours of refresher training and pass written and physical exams.

Training opportunities are available to all staff who are encouraged to not only learn about aspects pertinent to their current role, but to look at opportunities for their future growth and development. The Home hosts regular trainings in a variety of topics related to the clinical and milieu models of care led by local, national, and international experts in the child welfare, behavioral, and mental health fields.

Furthermore, we are committed to providing regular, high-quality supervision. Employees receive a weekly one-hour individual supervision with a trained supervisor who has a minimum of two years of prior experience in the field. We recently incorporated elements of reflective supervision into the training we offer to all program level supervisory staff, after a cohort of supervisors and members of WL&D participated in the Reflective Supervision training series offered through the CBH Knowledge Center. All supervisors engage in a bi-annual competency-based performance review process that begins with the employee completing their own self-evaluation. This supports open and structured dialogue around strengths and areas for growth are occurring in addition to other job performance content that might also be discussed during individual meetings. Within the reflective supervision framework, our supervision model brings forward some of the skills reviewed in our EQ2 training. EQ2 embraces the parallel process concepts that are so much a part of reflective supervision by recognizing that we must support an employee’s ability to self-regulate if they are going to be effective in using co-regulation with youth during moments of crisis. Similarly, given the critical focus our organization places on permanency, tasks that are needed to support ongoing permanency needs for each case are regularly reviewed in supervision.

Our programs conduct monthly all-staff meetings and regular, discipline specific team meetings to discuss particular areas of focus. Each program also reviews every client via a multi-disciplinary treatment team model on a monthly basis and helps support and guide the work of all team members who work directly with that youth and family.

The Home engages in a number of practices to ensure that staff are competent and maintain fidelity to the treatment model. Through extensive recruitment practices the Home hires highly qualified and diverse employees, representative of a variety of racial and ethnical backgrounds, gender identities, sexual orientations, and other identities and cultural experiences. Job descriptions have been developed for all positions, and criminal background, driving record, and educational and relevant licensing credentials are verified at the time of hire.

Group Home staff receive extensive internal and external training through WLD, including new employee orientation and training, a professional development opportunity calendar, program-specific training and consultation, and on-the-job training. Upon hire, employees participate in a comprehensive training program (up to 80 hours) that includes: healthy growth and development; mental health; behavior support; health and wellness; engaging families; boundaries; mandated reporting of suspected abuse and neglect; cultural responsiveness; the effects of out-of-home placements; domestic violence; working with Gay, Lesbian, Bisexual, Transgender and Questioning youth; safety; youth-guided and family driven care; strengths based treatment and care; care integration; risk management; medication/side effects; trauma informed care, cognitive behavioral therapy and trauma focused cognitive behavioral therapy; Therapeutic Crisis Intervention (restraint prevention); positive youth growth and development; and CPR and First Aid.

Staff in specialty programs receive additional training upon hire. Staff who work in our LGBTQ+ group home undergo trainings that have been developed to teach best practices for working with LGBTQ+ children and adolescents in a group home setting and follows the American Psychological Association's Guidelines for working with transgender and gender non-conforming individuals in treatment. Clinical staff utilize Transgender Affirmative Cognitive Behavioral Therapy (TA-CBT) to support youth with their unique needs and the challenges they face. TA-CBT is a version of CBT that has been adapted to affirm all gender identities and expressions and to ensure the delivery of CBT content within an affirming and trauma-informed framework. Clinical staff are also well-versed The World Professional Association for Transgender Health's (WPATH) standards of care. Professional development is offered to all staff via on and off-site trainings, conferences, educational opportunities (e.g., Boston University Certificate Program in Non-Profit Management, writing courses), and a rich array of offerings centered on clinical practice (e.g., TCI, CBT, TF-CBT, Motivational Interviewing, Trauma-Informed Care and Preparing Adolescent for Young Adulthood). Each program also develops an internal training and an annual staff development agenda, with regular trainings on core competencies and program specific skills and techniques. These trainings focus on tailored topics designed to meet the needs of specific programs. Program-specific trainings include Best Practices for Working with LGBTQ Children and Youth, Traumatic Stress Disorders in Children and Adolescents, Cultural Competence and Sensitivity in the LGBTQ Community, and Addressing Suicide in Adolescents and Transition Age Youth.

Fidelity to the Treatment Model: The Home has many checks and balances that promote fidelity to the treatment model. Weekly individual supervision is provided to support learning and professional growth and development. Youth-specific "mini-team" meetings are regularly scheduled to ensure that all staff levels have a shared understanding of treatment issues and agreed upon interventions. All cases are reviewed on a quarterly basis by a centralized UR team, comprised of senior clinicians from different programs and Program Operations. The team examines the appropriateness of treatment goals, if the clinician(s) are utilizing evidence-based practices and to what extent, record completeness, including consent forms, degree of collaboration with external resources,

and compliance with the Group Home treatment model. Additionally, the entire treatment team, (youth, family, program staff, DCYF workers, as well as outside providers and other natural supports) participate in quarterly treatment planning meetings.

Multi-Disciplinary Team (MDT) meetings are held weekly to review cases. For Group Homes, MDT comprises of senior clinician, clinician, the Program Director (and/or Assistant Program Director), milieu staff, nurse, psychiatrist or OT when appropriate. Staff throughout the agency and external resources can be added to provide a fresh perspective, consultation and expertise. For example, Occupational Therapist have been collaborating with all our group homes for the last 4 years on reducing a client's need for sleep medication through OT interventions. This collaboration led to a dramatic reduction in the need for sleep medication, reductions in night-terror, increased sleep per night and a general improvement in the quality of sleep.

d) Health and safety plan.

See attachment 8.d.1 - Health Services Manual

e) An emergency response plan that establishes procedures for addressing emergency situations and for coordinating with local emergency service providers.

See attachment 8.e.1 - Preparing for an Emergency

f) **A neighborhood relations plan that includes provisions for communicating with adjacent property owners and the City of Keene, including the Keene Police Department.**

Unity House will provide for multiple opportunities and methods of communication with the neighbors and abutters of the program. Firstly, all abutters and neighbors will have access to the program's phone number. This will allow 24 hour a day access to an employee of the program should an immediate concern arise. They will also have access to the on-call system to be able to contact a program administrator or executive leadership member if there are additional concerns. Email addresses for key personnel will also be provided. A post-card will be sent to all immediate neighbors and the Keene Police Department with this information for ease of access for the neighborhood.

Unity House will hold 4 neighborhood meetings a year at the property. These meetings will be an opportunity for Unity House to communicate any program announcements, concerns, or updates to the neighbors, and allow neighbors to speak directly with program and agency leadership.

g) Building and site maintenance procedures.

See attachment 8.b.1 - Facilities Services Maintenance and Operations Procedures Manual

HFLW Facility Services Maintenance and Operations Procedures Manual

The Home for Little Wanderers
John Davis, Director of Facilities and Planning

Table of Contents

Mission Statement

The Facility Services Department is committed to providing quality service to students, faculty, staff, and visitors of the Home. Maintenance is responsible for maintaining each individual house, office and campus in a manner that contributes to the attractiveness and function of the educational environment. Maintaining the physical facilities is essential to enhancing the overall educational environment along with ensuring safe and secure campuses.

Facility Services employees are committed to support the goals and vision of the Home. Employees are dedicated to the concept of improving productivity and effectiveness through more efficient use of time and materials, implementation of new technology and equipment, and improving skills through training and seminars. It is recognized that the major strengths of Facility Services are the employees and available resources used in the performance of its work. The support and commitment of the administration and board of trustees to providing well-maintained developed properties strengthen this. By this commitment, we are able to provide support to the academic excellence and educational programs of the Home.

The Facility Services Department's management team is committed to treating employees with dignity and respect; fostering positive attitudes and acceptable behavior; recognizing satisfactory employee performance; administering policies fairly; and, communicating the plans and directions of the department to all employees.

General Information Facility Services Operations

Facility Services Operations is a service organization responsible for the planning, construction, renovation, repair, and maintenance of all buildings and facilities. The department also provides and administers utilities, and grounds care, custodial services and shipping and receiving. Our goal is to provide these services in a manner consistent with the mission.

Services provided by Facility Services include but are not limited to the following:

1. General maintenance and custodial work in all academic buildings, and recreational facilities including the services of carpenters, electricians, plumbers, and HVAC mechanics to ensure a safe and adequate educational environment for academic and administrative functions.
2. Maintenance of classrooms and public spaces including furnishings.
3. Maintenance of walks, grounds, and maintenance of athletic facilities.
4. Operation and maintenance of utilities

5. Custodial services.
6. Preventive maintenance for building systems.
7. Energy conservation through education and including installation of equipment to conserve energy.
8. Moving and set-up responsibilities for campus functions.
9. Management of building and renovation projects.
10. General Contractor consultation for small-scale projects.

Any questions concerning the operation and services provided should be directed to the department at 617-585-7506

Organization

Facility Services employs a force of professional, skilled, and semi-skilled, employees. Department employee duties can include: General Maintenance, Electrical, HVAC, Preventative Maintenance, Plumbing, Locksmith, Painter, Carpenter, Custodians, Groundskeepers, Receiving, and Administrative Staff. Our employees can respond to urgent and specialized needs and provide continuity of basic maintenance and repair programs. Also, they can offer timely and efficient response on minor renovation projects.

Project Scope of Work

At times Facility Services is called upon to render services for many alteration and renovation projects by various departments. While Facility Services is a repair and maintenance organization, at times it is cost effective to take on renovation projects of a limited scope. The general rule is not to take on projects that would take any longer than 7 workdays to complete. Also, projects that require specialized equipment or are scientific or technological in scope are usually contracted out to local contractors based on the experience of the firm. Facility Services administers all contracts and provides planning and consultation services for these projects. The Administration and Facility Services determine the best means to complete each project.

Maintenance Requests

Maintenance Requests should be submitted using our Computerized Maintenance Management System (CMMS) Dude. The individuals that we have determined need access to this system are dictated by each programs individual needs.
If you are not one of these individuals submit your maintenance request to one of the above individuals.

New Service Request

A. Click on ***Campus/Facility***. Select a Campus/Facility.
B. ***Location/Room Number***. Type in the *Location or Room* where the work is required.

C. Requestor's Name. Type the Requestor's Name.
D. Click on *Select* ***Problem Type***. Select a Problem Type category.
E. Click on ***Select Priority***. Select a Priority category.
F. *Problem Description*. The requestor must fully describe the services desired and should identify any constraints such as time periods or special conditions on the service requested. All requests should be addressed to Facility Services Department.
G. Provide Schedule Information such as *Date work is needed by*. (Should correspond with priority). Facility Services reserves the right to change the date the work is needed if there is a scheduling conflict, does not cause a hardship, parts or materials are needed, or cause an event to be canceled.

Maintenance Requests are required, for all routine, major and minor repair work and set-ups for special events.

For emergency priority service work please utilize the Emergency Contact list for your individual site and call order.

Work orders should be submitted at least two weeks prior to the work request date. Event work orders should be submitted at least 10 working days before an event. Work orders are received by the Maintenance Supervisor and reviewed prior to assignment to the appropriate technician. Questionable work orders are reviewed prior to approval.

Work is assigned to the appropriate technician and orders are placed for materials if they are not in stock. The work will generally be performed or evaluated by the due date. The technicians and the Maintenance Manager are responsible for conveying information to the requestor regarding scheduling delays.

Priority of Work

Generally, requests for basic services take priority over other requests, exceptemergencies. When the time factor is critical, Maintenance may use outside contractors to complete all or part of the work. The Maintenance Supervisor prioritizes each request for services received. Priorities have been developed to ensure that Maintenance responds appropriately to a request. Therefore; the assistance of a department in detailing the nature or seriousness of the problem is important. Some conditions may override othersin case of emergency or disaster.

The priority system is as follows:

Emergency/Safety

1. Emergency conditions that affect the safety or health of persons or property, for example, broken glass, ruptured pipes, inoperable exterior locks, interior locks on sensitive space, blocked or malfunctioning toilets if no others are available.
2. Conditions that immediately affect the continued performance of academic or administrative services, the same-day non-resolution of which would

impact use or performance in the space, for example, blown circuit breakers, an outlet without power (where only one is available), inoperabledoors, or hot or cold offices or classrooms.

3. Conditions that if not immediately attended to could damage facilities or further damage the item in question, for example, ceiling drips, leaking toilets, unfastened windows.
4. Work that should be completed within eight (8) hours.
5. Conditions that must be attended to during the day (or night) they are reported.
6. Work that requires overtime or night shift, if not completed during normal work hours.

High

1. Conditions which represent a potential safety or health hazard - danger, damage, or breakage that is not an immediate hazard but could become one with more use or stress. For example, a loose handrail, loose doorknob, damaged stair tread, or cracked door glass.
2. Nuisance conditions that do not require extensive work, but which, if not remedied, failure of which to remedy would reflect poorly on the Home, for example, paint, offensive graffiti, follow-up of one trade's work by another trade.
3. Valid, dated requests by customers, which must be completed by a certain date.
4. Debris or garbage accumulations.
5. Work that should be completed within three (3) work days or less.
6. Work that can be worked into existing schedules.

Medium

1. Work that should be completed within five (5) to ten (10) workdays.
2. Work that may be scheduled in advance.
3. Work that represents most routine maintenance.
4. Resolution of "temporary fixes."
5. Work identified by building surveys, tours, or area coordinators, other than long-range or major improvements.

Low

1. Work that should be completed within one (1) month.
2. Work that can be scheduled in advance.
3. Work that represents improvements or additions to facilities such as building shelves or installing air-conditioning units work covered by most service requests.
4. Work that requires outside vendors, contractors, or procurement of materials (not off-shelf items).
5. Work that requires a coordinated and planned schedule between a requestor and a technician.

Scheduled

1. Work that can be programmed for the next season.

2. Work that can be scheduled for periods between school breaks.
3. Work that has been identified in advance but cannot be done at the time of identification because facilities are in use.
4. Jobs requiring several technicians and long-range planning.

Department Chargeback For Services

At times Facility Services receives requests for services rendered to departments and activities for which Facility Services does not receive a budget allocation. When this occurs, the requesting department must provide a budget source for funding. Facility Services charges (materials) to the Department include actual cost charges only. No profit or overhead charges are billed to departments.

Examples of Department Charged Services include:

1. Alterations to buildings or structures requested by and assigned to departments and activities.
2. Requests for materials.
3. Painting of offices and departmental spaces, or of public spaces to change colors, or painting not warranted by the condition (fading or flaking) of existing paint.
4. Alteration, repair, or refinishing of office not warranted by condition
5. Building of wooden cabinets and computer workstations.
6. Removal of unauthorized construction or materials (i.e. rooms in corridors) by a department that violates building codes.
7. Removal of wiring or equipment installed by a department that violates building codes or safety regulations.
8. Removal of plumbing or equipment installed by a department that violates building codes or safety regulations.
9. Special events that cannot be covered by assigned custodians or maintenance personnel during normal working hours (7:00 am - 4:00 pm) Monday-Friday for events.
10. Requests for manpower beyond normal working hours for events.

Technician Billing Rates

	Normal Hours	Overtime
Grounds Worker	$20.00/hr.	$30.00/hr.
Custodian	$20.00/hr.	$30.00/hr.
Maintenance Technician	$20.00/hr.	$30.00/hr.
The overtime rate applies to school activities andexternally sponsored events after normal hours.		

Limitations of Services

Labor, materials, and/or equipment cannot be used for private or personal benefit either on or off campus.

Materials and equipment cannot be loaned to departments, employees, students for on campus use without a written request and written approval from Facility Services Director.

Moving and Setups

Grounds, custodial and building personnel are responsible for limited moving of furniture and offices. Due to the scope of responsibilities of the staff, moving of furnishings outside the capabilities of each campus' custodial and building occupants is scheduled 10 days in advance**.**

Requestors are responsible for packing all belongings. Campus custodians and other Facility Services employees are not responsible for packing belongings. It is imperative that the requestor or a representative be present while the moving of belongings is taking place to ensure that materials are delivered to the correct place. A limited supply of boxes can be obtained; however, if additional boxes are needed, they can be purchased from a supplier at program cost.

Requestors are responsible for emptying all desks, horizontal or lateral filing cabinets (vertical file cabinets need not be emptied), and bookcases prior to the commencement of the moving operation.

Facility Services processes all set-up requests for special events outside the scope of the campus custodians. The party requesting the setup is responsible for all costs (rental of tables, chairs, and decorations). Set-up requests must be submitted to Facility Services at least five (5) working days prior to the event.

Storage

The Facility Services Department storage facility is **very limited**. Storage of materials and furnishings is the responsibility of each campus/department.

Funding

Facility Services Department allocates a certain amount of funding to make corrective repairs to facilities. In some cases the requesting department may be asked to provide funding if requests do not follow the criteria for normal repairs and maintenance. Please contact the Director of Facilities and Planning to verify funding.

Routine Failures

Defective or burned-out light bulbs or fluorescent tubes, broken window panes, broken classroom furniture, heating or air conditioning malfunctions, and leaking or non- working plumbing should be regarded as routine failures and reported promptly to Facility Services utilizing Dude.

Facilities Improvement Program (FIP)

Major capital projects and department requests for alterations and renovations are handled through the Facilities Improvement Program (FIP). FIP requests are reviewed and referred to the Board of Trustees for approval and funding. Requests for FIP and FMP work for the next fiscal year are distributed to the campuses the 1st week of January and due back to the Director of Facilities and Planning by the 1st week of February. Facility Services personnel are available to provide limited estimating services for all departments for inclusion on FIP requests.

Facilities Master Plan

The Facilities Master Plan has planned improvements in three phases. Phase I include major renovations and repairs to existing campus facilities. Phase I will improve the conditions of facilities and classrooms and enhance the aesthetic qualities of each campus. Phase II will include additional renovations and repairs to grounds and existing structures and Phase III will be the beginning of new buildings and facilities.

Facilities Deferred Facility Services Program (FDMP)

Funding for repairs and maintenance to all facilities is provided through the annual Facilities Deferred Maintenance Plan (FDMP). The FDMP covers costs incurred for the repairs required from normal "wear" and "tear" on the facilities such as HVAC replacement, painting, lighting, and building code upgrades.

Preventive Maintenance

Preventive Maintenance is the scheduled attention to the physical needs of a system that results in the reduction of the possibility of breakdown and the lengthening of the life of a system. Maintenance schedules routine preventive maintenance checks on building, HVAC, electrical, plumbing, and mechanical systems. Floor drains and building areaways, and roofs are periodically cleaned and inspected.

Furnishings

Facility Services can purchase desks, chairs, shelving, bookcases, special equipment,and other office furnishings. Each individual department is responsible for purchasing room furnishings funding. Facility Services has been designated as the primary point of contact to assist you when purchasing furnishings. Please contact Facility Services prior to making any furnishing purchases. This is done to ensure quality and consistency throughout the district. Some used office and classroom furnishings are available in the Facility Services storage area. Facility Services budgets funds for the repair and maintenance of classroom and common area furnishings only.

Bulletin Boards and Sign Holders

Bulletin boards, whiteboards, tack boards, and hanging strips for offices are the responsibility of the requesting department. These items will be installed when requested. Please contact Facility Services prior to making any purchases.

Special Equipment and Instrumentation

Individual departments are responsible for procuring and maintaining special equipment such as computers, printers, and all diagnostic and other equipment used for teaching purposes. Departments are required to contact Facility Services prior to purchasing special equipment.

Facility Services will determine the space needs, availability and capability of correct electrical service or HVAC equipment. Any alterations, electrical power needs, or HVAC modifications that may be required may be the responsibility of the requesting department. Facility Services will make all arrangements to perform the work. Campuses/Departments will be charged for actual incurred costs or will be responsiblefor procuring adequate funding for requested work.

Building Maintenance personnel must be consulted and prior approval obtained from them for the source of power, equipment phasing, voltage, and amperage of special equipment.

When purchasing office or laboratory equipment, the following principles of electrical characteristics should be observed.

1. All must be 60 Hz and have the Underwriter's Lab (UL) seal of

acceptance.

2. No equipment or group of equipment rated at 120 volts requiring 10 amps (1250 watts) or more of power should be purchased without prior approval of Facility Services.
3. No equipment requiring, by the manufacturer, a special or dedicated circuit should be purchased without prior approval of Building Maintenance.
4. Prior approval must be obtained for any equipment rated 208, 240, or 480 volts single or three phase.
5. Use and purchase of EPA certified energy star equipment is strongly recommended by Building Maintenance.

Contractors

Facility Services Department maintains an active list of contractors that show an interest in performing work. This list is reviewed periodically and always when a project requiring services is anticipated, planned, or approved to proceed. Contractors must be pre-qualified and evaluated for each project before they are invited to bid or provide proposals for projects.

Grounds

The Home takes a great deal of pride in the appearance of its building and grounds. Facility Services employs a grounds crew/contractor that is responsible for care of shrubs, plantings, trees, and turf maintenance; road and walk cleaning and maintenance; and snow and ice control. Hundreds of students utilize the campuses daily. It takes conscious efforts on everyone's part to help keep the campus grounds and buildings as free of litter, graffiti, and abuse as possible. Please help keep your campus clean.

Refuse Removal

Trash/recycling contractors (private contractor) provides refuse removal and disposal on a scheduled basis throughout the year. Questions regarding pick-up should be directed to your Maintenance Operations.
As a basic operational service, Maintenance Operations provides pickup of normal refuse on sites. Special pickups and disposal of extraordinary amounts of trash or building items may be arranged by submitting a work request in Dude.

Refuse Disposal (Hazardous, Infectious and Special Waste)

The disposition of hazardous waste is coordinated by Maintenance Operations. Any hazardous waste will not be placed in receptacles provided for normal, day to day refuse.

A regulated hazardous waste includes:

- Flammable Liquids (flash point less than 140 deg. F)
- Corrosives (pH less than 2.0 or above 12.5)
- Reactive (Unstable compounds)
- EP Toxic (certain heavy metals and pesticides)
- Off Specification Chemical Products (acute or toxic hazardous waste)
- Hazardous Waste from Nonspecific Sources (primarily toxic solvents)

A special waste may include a non-hazardous solid waste from a nonresidential source. Examples of special waste include waste oil, waste paint, non-hazardous chemical products, incinerator ash and asbestos. Contact Maintenance Operations to arrange for proper disposal.

Shredding Confidential Documents

The Home maintains a paper shredder/service for use by departments for shredding confidential documents and tests. Due to the confidentiality requirements, the shredding of documents is the responsibility of the requesting department. Custodians and other Facility Services personnel are not responsible for shredding documents.

Asbestos Containing Materials

From the turn of the century until the 1970s, asbestos was widely used in various building materials. It is commonly present in insulation materials found on pipes, ducts, and boilers, in acoustical insulation, and in fireproofing materials. Vandalism and abuse, as well as routine maintenance, repairs, or replacements of items that contain asbestos, may release airborne asbestos fibers that are health risks. Those areas that pose a health risk or have been evaluated, when necessary, are cleaned up. In conjunction with this cleanup, a comprehensive survey of asbestos material locations is made, along with the condition of the installations. Removal is scheduled and undertaken when necessary. Meanwhile, the Director of Facilities and Planning carefully monitors known and suspected sites and works with Facility Services personnel for the removal or repair of materials as needed and required.

Custodial Services

Facility Services provides custodial services to each campus and administrative office on a routine basis. Classrooms, offices, hallways, and stairways are cleaned on a scheduled basis. Restrooms are cleaned and serviced daily. Windows, carpets, and floors are maintained periodically depending on academic schedule. The staff controls snow and ice on entranceways and walks leading into buildings.

Pets on Campus

Because of extensive use of campus buildings and sanitation issues, bringing pets into buildings is prohibited with the exception of Service Animals.

Signage

Production and installation of room and office signage is the responsibility of Maintenance. Requests for signage can be submitted using a Maintenance Service request. The standard format for all office signage includes the room number and name ofthe office. Due to limitations and our effort to standardize room signs throughout the School District, signs will meet certain size requirements.

Inspections

Maintenance routinely inspects facilities for wear and tear and makes corrections based on these inspections utilizing a Facilities Condition Report. However, we depend on the various users to notify Maintenance Operations of problems when they are identified.

Heating, Ventilation, and Air Conditioning

Living in an area where it can be 0 degrees in March and be 80 degrees in November, it is always a challenge to determine when the weather will change. However, due to our unpredictability of the weather, Maintenance monitors conditions and will adjust systems to suit the predicted conditions.

Thermostats are calibrated on a routine basis by our Maintenance staff. During the air conditioning season, thermostats are set at 72 degrees F. with a fluctuation expected at 3 degrees F. In the event of extremely hot weather, most systems will provide a 15-degree F. differential inside. During the heating season, thermostats are set at 70 degrees F. with an expected variation of 3 degrees F.

Building Codes

Fire and building codes are adhered to in all work performed by Maintenance. If there are specific questions about code requirements,contact the Director of Facilities and Planning .

Consultation

Members of our Maintenance staff are available and welcome the opportunity for discussion and consultation with faculty and staff members. Call or e-mail the Director of Facilities and Planning for an appointment or referral to the appropriate person for a particular problem or question.

Keys and Locks

This procedure will apply to all keys, including door keys, desk keys, filecabinet keys and storage keys:

1. The department head or his/her designee will submit a key request in Dude listing all keys needed.
2. Maintenance will deliver the keys to the Department Head. Each campus or department must maintain an inventory of all keys for their facility.
3. A key control log should be maintained by listing all key holders and the keys they have been issued on the log.
4. The employee will sign the *Key Control Log* and pick up keys from the Department Head.
5. All master keys and building keys require approval from the appropriate Department Head.
6. All keys must be returned to the Department Head upon termination of a position, change or designation, or any movement, which requires different keys, or no keys.
7. Keys turned in by employees to Department Head will be returned to the campus key inventory.
8. Keys are issued to authorized employees and **should not** be duplicated by users.
9. Maintenance, upon request by the department head can provide duplicate keys.
10. Maintenance is the only department allowed to cut and issue keys. Duplication of keys by an outside locksmith is strictly prohibited.
11. Maintenance requests for a lock and key changes or repair should be directed to Maintenance Operations. Maintenance Operations will determine if any associated costs will be charged to the department/office making the request.
12. Requests for master keys to a building must be submitted to and approved by the Department Head of the requesting department before processing by Maintenance.
13. Loss of keys must be reported immediately to Maintenance. In the event rekeying is necessary, the requesting campus or employee will be charged for all new keys and locks.

14. Expenses incurred for lost keys $25.00 or failure to have keys returned by departing employees is the responsibility of the department and handled through Human Resources and Maintenance. Core changes are $100 per lock and are performed by the Locksmith/Key Control Manager. The number of doors that have to be changed will determine the expense incurred for the loss of a Master key. Payment must be made to the finance department and a copy of the receipt turned into Maintenance Operations before a duplicate key is made or issued.

Equipment Lockout Procedures

Purpose

This procedure establishes the minimum requirements for lockout of energy sources that could cause injury to personnel. All employees shall comply with the procedure.

Responsibility

The responsibility for ensuring that this procedure is followed is required by all employees. The Maintenance Supervisor shall instruct all employees in the safety significance of the lockout procedure. Each new or transferred affected employee will be instructed by the Maintenance Supervisor in the purpose and use of the lockout procedure.

Preparation for Lockout

Employees authorized to perform lockout shall be certain as to which switch, valve, or other energy isolating devices applies to the equipment being locked out. More than one energy source (electrical, mechanical, or others) may be involved. *The employees shall clear any questionable identification of sources with their supervisor.*

Sequence of Lockout Procedure

a. Notify all affected site personnel that a lockout is required and the reason therefore.
b. If the equipment is operating; shut it down by the normal stopping procedure (such as: depress stop button, open toggle switch).
c. Operate the switch, valve, or other energy isolating devices so that the energy source(s) (electrical, mechanical, hydraulic, etc.) is disconnected or isolated from the equipment.
d. Stored energy, such as that in capacitors, springs, elevated machine members, rotating flywheels, hydraulic systems, and air, gas, steam or water pressure, must also be dissipated or restrained by methods such as grounding, repositioning, blocking, bleeding down.
e. Lockout energy isolating devices with an assigned individual lock.
f. After ensuring that no personnel are exposed and as a check on having disconnected the energy sources, operate the push button or other normal operating controls to make certain the equipment will not operate. *CAUTION: Return operating controls toneutral position after the test.*
g. The equipment is now locked out.

Restoring Equipment to Service

a. When the job is complete and equipment is ready for testing or normal service, check

the equipment area to see that no one is exposed.

b. When equipment is clear, remove all locks. The energy isolating devices may be operated to restore energy to equipment.

Procedure Involving More Than One Person

In the preceding steps, if more than one individual is required to lock out equipment, each shall place his/her own personal lock on the energy isolating device(s). One designated individual of a work crew or a supervisor, with the knowledge of the crew, may lock out equipment for the whole crew. In such cases, it may be the responsibility of the individual to carry out all steps of the lockout procedure and inform the crew when it is safe to work on the equipment. Additionally, the designated individual shall not remove acrew lock until it has been verified that all individuals are clear.

Rules for Using Lockout Procedure

All equipment shall be locked out to protect against accidental or inadvertent operation when such operation could cause injury to personnel. Do not attempt to operate any switch, valve, or other energy-isolating device bearing a lock.

Roofs

No one is permitted on the roof of any building without prior authorization from Facility Services. This is necessary because of bonds or guarantees present with many of our roofs, the potential damage to the building and its contents from roof damage leaks, and because of the great initial expense of roofing and repairs that might be necessary if uncontrolled roof traffic is permitted.

Cameras, television cameras, television antennas, or other equipmentsupported by tripods or stands may not be placed on any roof without prior coordination with Facility Services.

Alterations and/or additions to roofs are not permitted without prior approval of Maintenance.

Building Plans and Maps

Facility Services maintains a file for all building plans. The objective is to convert these plans and maps to a digital library.

Restrictions for Use of Property (Land)

No one is permitted to use or gain access to any property without proper authorization from Facilities Dept.

Facility Use/Room Reservations

Facility Use Requests should be submitted using our Computerized Facility Scheduling System Dude for each site as needed.

Tobacco

Tobacco use and e-cigarettes use is prohibited in/on buildings, vehicles, and grounds.

Storage of Materials

No equipment or materials of any sort may be stored in stairways or public corridors or placed to block fire exits. These conditions constitute Fire Department and Occupational Safety and Health Administration (OSHA) violations. Equipment and materials stored or placed in violation of Fire Department and OSHA regulations will be removed and discarded and the owning department charged for all removal costs.

Equipment and materials may not be stored in mechanical equipment rooms or electrical closets.

Telephone Installation

Facility Services provides installation of telephones and other phone services in coordination with IT Dept.

Architectural/Engineering Service

Facility Services is responsible for all architectural and engineering functions at the Home, including engineering services, plant development, and mechanical and electrical systems overview.

Facility Services provides consultation to various departments on the maintenance and operations aspects of proposed capital improvement projects. It represents the Home during the design and construction phases for capital improvement projects, which are implemented by outside architects and engineers. Facility Services also prepares plans and specifications for capital improvement projects when the development of the design for such a project is the responsibility of Maintenance.

In addition, Facility Services is responsible for feasibility studies that determine the direction campus planning systems should go. It is also responsible for general surveillance of the Homes energy conservation program, developing new programs and plans for conservation, keeping Facility Services advised on program areas,costs, and the like, and advising other departments in the field of energy conservation.

Emergencies

In the event of an emergency between the hours of 7:00 AM and 4:30 PM, all calls for service should be made per the Emergency Contact list for each specific site.

In the event of an emergency between the hours of 4:30 PM and 7:00 AM, all calls for services should be made to the individual listed on the Emergency Contact List, and they will contact the appropriate Facility Services personnel.

Summary of Trades and Services

General Maintenance

The General Maintenance performs general maintenance repairs and provides assistance with the repair of building structures and their mechanical, electrical, and sanitary systems throughout the sites. Including repairing woodwork; replacing electrical switches, fixtures, and motors; painting, repairing, and replacing plumbing fixtures and drainage systems, flooring ceiling grid; and replacing broken glass. This shop also inspects and repairs the building exterior and interior, playground equipment, and grounds (fencing and gates).

Custodial Services

Custodial Services is responsible for routine cleaning, paper waste removal, and pre-scheduled work such as window washing, floor care, and rug shampooing, and pest control.

Preventative Maintenance

The preventative maintenance staff provides maintenance that is regularly performed on a scheduled basis on an equipment to lessen the likelihood of it failing. Examples are changing HVAC filters on a scheduled basis, lubricating equipment, changing equipment belts as well as cleaning downspouts and roof gutters. Performing scheduled preventative maintenance helps extend the life of mechanical and building systems.

Grounds Maintenance

This unit is responsible for the care and maintenance of campus grounds, including mowing, seeding, fertilizing, and watering lawns, maintaining established shrubbery and trees on the campus, snow removal, and maintenance of athletic facilities.

Paint Shop

The paint shop provides services related to painting needs, and sheetrock repair throughout the sites

Attachment 8.c.1

THE HOME FOR LITTLE WANDERERS
BETTER, BRIGHTER FUTURES FOR KIDS

The Home Courses and Trainings

- Agency Directives
- Harassment (Employee Rights & Responsibilities)
- Employee Development
- Trauma 101
- Professionalism in the Workplace
- Workplace Safety
- Cultural Humility
- Therapeutic Boundaries
- HIPAA for Behavioral Health
- Blood-borne Pathogens
- Mass Privacy Law
- Nutrition & Physical Activity Basics I
- Cultural Competence
- Workplace Harassment
- Discrimination in the Workplace (supervisors only)

For all employees in Residentials, Group Homes and TASP

- Therapeutic Crisis Intervention
- Adult & Child CPR/AED/First Aid
- Nutrition & Physical Activity Basics II
- Defensive Driving: The Basics
- Trauma Informed Care
- EvolvNX (client information system)
- CBT Trauma-Focused (residential staff; master level only)
- CAFAS (Clinical Staff Only)
- CANS (Clinical Staff Only)

Health Services Manual
Unity House

Version 1.0 2022

The Home for Little Wanders
Unity House Health Care Manual of Policies and Procedures
Statement of Review

I have reviewed this manual for the school year 2022-2023.

The information contained in the Health Care Manual has been approved for accuracy with current laws and regulations and HLW policies and procedures. It is understood, that any new changes or additions shall be approved by Program Director, The Home for Little Wanderers Program Operations Team and the Unity House Program Nurse.

Signature:
Title:
Date:

The Health Care Manual serves as a resource and is available in the administrative main office and Health Services for all state agencies and school personnel to utilize in supporting the Health Services at Unity House. The Health Care Manual is reviewed annually and updated as needed with approval.

Table of Contents

I. Introduction

A. The Purpose of the Health Services Manual

This manual is a resource book providing basic information and recommended best-practices related to health services and wellness initiatives at The Home for Little Wanderers (HLW). It reflects the importance of general health to constructive functioning. It also reflects the growing emphasis on wellness and health promotion and the partnership of agency, school, and family in promoting health and client's self-efficacy in health matters.

This manual seeks to:

- ✓ Increase caretaker's awareness of health issues affecting the client in HLW's care.
- ✓ Provide guidelines for practice on issues relating to health.
- ✓ Reflect the responsibility of all staff to promote wellness.
- ✓ Serve as a tool for orienting personnel to health-related issues and guidelines.

The Health Services department reflects the mission of HLW. It is based on the belief that specific health promoting interventions lead to desired outcomes and contribute to the health and Well-being of client, families and communities. It incorporates the theories of self-efficacy and social support, the concepts of resilience (the potential for healing) and vulnerability (the potential for injury) innate in the human condition.

We believe that the family, caregivers and/or client natural network, know the client best and are in the best position to hold potentially powerful solutions to the presenting problems requiring referral. These individuals are encouraged to be involved extensively in the care of the client. Client benefit from involved families/caregivers, whether they live at home or in residential care. At HLW, all individuals and families are welcomed, empowered, and respected throughout the therapeutic process as they are essential to success in the care planning. We assist the client and families/caregivers in exploration of their existing relationships and in developing an understanding of how they interact with one another and facilitate the strengthening of these connections. We acknowledge that the community in which the family or natural network lives offers accessible and appropriate recourses for care and that "it takes a village to raise a client."

B. Organization of Health Resources and Provision of Services

The health and safety of client at The Home for Little Wanderers is the responsibility of all staff. All direct care staff and nurses are trained in Standard Precautions, CPR, First Aid, and epinephrine auto-injector administration.

Selected staff are also trained and certified in the administration of medications in accordance with state regulations.

In collaboration with the client's parent/guardian and clinician, the nursing staff at the program coordinates the client's health care and are available to client for their health education needs.

With the agency's Wellness Initiative, which began in 2004, the shift is moving toward seeing and treating the clients' health needs in a prevention model. The support of each program's Wellness Committee aids in the shift and implementation of improved and sustained health awareness and practices.

Each client has an identified Primary Care Provider, and is seen for annual physicals, postural screening, eye exams, routine lab work, updating of immunizations, dental exams, and other health appointments as needed. All client are admitted to a program with health insurance, and if for some reason they do not have it, the case manager assists the family or guardian in obtaining health insurance.

The client/parent handbook serves as a resource for important health-related information for client, families, and caregivers. The handbook is provided upon admission and available through Health Services upon request.

PHYSICIAN CONSULTATION

Each New Hampshire program within The Home for Little Wanderers that is licensed under DHHS has a local physician who is available for consultation. The school physician will consult on matters such as direct service, clinical consultation, policy consultation, health education, public relations, advocacy, system development, and act as a liaison to community physicians.

The Program Physician will be appointed by the Medical Director of The Home.

Pediatrician Consult
TBD

NURSE STAFFING

HLW employs a nurse in each program who is:

- A graduate of an approved school for professional nursing;
- Currently licensed as a Registered Nurse

Unity House employs a part-time program nurse working 20 hours a week at the program. The nursing hours listed above are sufficient for the needs of the populations served at Unity House. The Director of Nursing is on call 24 hours per day, 7 days per week and supervises all program nurses.

Program nurses onsite during school hours are responsible for the following:

- Direct nursing services (triage, injuries/illnesses, providing first aid & emergency response, conducting screenings & preventative assessments)
- Collaboration with outside medical personnel, medical facilities, and guardians
- Health education and staff training regarding medical needs of the population
- Community health
- Emergency planning
- Oversight of delegation of medication administration following New Hampshire Department of Public Health regulations (for approved program)
- Address health issues impacting learning
- Maintain health records: immunization, vision, hearing, postural, height & weight, physical exams, medical history

The priority is always the health and safety of each client.

Director of Nursing
Peggy Andreas, RN, DON
617-615-9024
pandreas@thehome.org

Unity House Program Nurse:
TBD

All program nurses' New Hampshire License numbers are on file with The Home for Little Wanderers' Human Resources Department. Available upon request.

C. Notice of Privacy Practices

The Home for Little Wanderers
10 Guest Street
Boston, MA 02135

Tel. 617-267-3700
TTY 617-927-0699
www.thehome.org

The Home for Little Wanderers takes your privacy seriously. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

INTRODUCTION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

"Protected health information" means health information (including identifying information about you) we have collected from you or received from your health care providers, health plan, your employer or a health care clearinghouse. It may include information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services.
We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

HOW WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION

We will use and disclose your health information as described in each category listed below. For each category, we will explain what we mean in general, but not describe all specific uses or disclosures of health information.

Uses and Disclosures That May Be Made
For Treatment, Payment and Operations

For Treatment. We will use and disclose your health information without your authorization to provide your health care and any related services. Your health information is routinely shared among the clinicians and direct care staff involved in your care to ensure they all understand your treatment needs. We will also use and disclose your health information to coordinate and manage your health care and related services. For example, we may need to disclose information to a clinician who is responsible for coordinating your care. In addition, with your permission, we will disclose your health information to other health care providers (e.g., your primary care physician, a laboratory, the pharmacist) working outside of The Home.

For Payment. We may use or disclose your health information without your authorization so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third-party payer. We may need to disclose your health information to permit your health plan to take certain actions before they approve or pay for your services. These actions may include:

- making a determination of eligibility or coverage for health insurance;
- reviewing your services to determine if they were medically necessary according to your health plan's rules;
- reviewing your services to determine if they were appropriately authorized or certified in advance of your care;
- reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

For example, your health plan may ask us to share your health information in order to determine if the plan will approve additional visits to your health care provider.

For Health Care Operations. We may use and disclose health information about you without your authorization for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, by way of example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training clients in clinical activities, licensing, accreditation, business planning and development, and general administrative activities.

We may combine health information of many of our consumers to decide what additional services we should offer, what services are no longer needed, and whether certain new services are effective. We may also combine our health information with health information from other providers to compare how we are doing and see where we can make improvements in our services. When we combine our health information with information of other providers, we will remove identifying information so others may use it to study health care or health care delivery without identifying specific client.

We may also use and disclose your health information to contact you to remind you of an appointment.

Uses and Disclosures That May be Made Without Your Authorization, But for Which You Will Have an Opportunity to Object

Persons Involved in Your Care. We may provide health information about you to someone who helps pay for your care. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may also use or disclose your health information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care.

In limited circumstances, we may disclose health information about you to a friend or family member who is involved in your care. If you are physically present and have the capacity to make health care decisions, your health information may only be disclosed with your agreement to people you designate to be involved in your care.

But, if you are in an emergency situation, we may need to disclose your health information to other individuals such as a relative, significant other, or close friend, so that such person may assist in your care. In such situations, we will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care. And, if you are not in an emergency situation but are unable to make health care decisions, we will disclose your health information to:

- if applicable, the state agency responsible for consenting to your care, or
- your guardian or medication monitor if one has been appointed by a court.

Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Object

Emergencies. We may use and disclose your health information without your authorization in an emergency treatment situation. For example, we may provide your health information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and staff have attempted to obtain your authorization but have been unable to do so, staff may nevertheless use or disclose your health information to ensure you get necessary treatment.

Research. We may disclose your health information to researchers when their research has been approved by an Institutional Review Board or a similar privacy board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

As Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health or safety, or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to an organ procurement organization or to an entity that conducts organ, eye or tissue transplantation, or serves as an organ donation bank, as necessary to facilitate organ, eye or tissue donation and transplantation.

Public Health Activities. We may disclose health information about you as necessary for public health activities including disclosures to:

- report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- report vital events such as birth or death;
- conduct public health surveillance or investigations;
- report child abuse or neglect;
- report certain events to the Food and Drug Administration (FDA) by a person subject to the jurisdiction of the FDA including information about defective products or problems with medications;
- notify consumers about FDA-initiated product recalls;
- notify a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition;
- notify the appropriate government agency if we believe an adult has been a victim of abuse, neglect or domestic violence. We will only notify an agency if we obtain your agreement or if we are required or authorized by law to report such abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies such as the New Hampshire Department of Public Health that oversee the health care system, government benefit programs such as Medicaid, other government programs regulating health care, and civil rights laws.

Disclosures in Legal Proceedings. We may disclose health information about you to a court when a judge orders us to do so. We also may disclose health information about you in legal proceedings without your permission or a judge's order when:

- you are a party to a legal proceeding and we receive a subpoena for your health information. Normally, we will not provide this information in response to a subpoena without your authorization if the request is for substance abuse records or for information relating to AIDS or HIV status or genetic testing;
- your health information involves communications made during a court-ordered psychiatric examination;
- you introduce your mental or emotional condition in evidence in support of your claim or defense in any proceeding and the judge approves our disclosure of your health information;

- you sue any of our clinicians or staff for malpractice or initiate a complaint with a licensing board against any of our clinicians;
- the legal proceeding involves custody, adoption or dispensing with consent to adoption and the judge approves our disclosure of your health information;
- one of our staff brings a proceeding, or is asked to testify in a proceeding, involving foster care of a client or commitment of a client to the custody of the New Hampshire Department of Social Services.

Law Enforcement Activities. We may disclose health information to a law enforcement official for law enforcement purposes when:

- you agree to the disclosure; or
- when the information is provided in response to an order of a court; or
- we determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
- the disclosure is otherwise required by law.

We may also disclose health information about a client who is a victim of a crime without a court order or without being required to do so by law. However, we will do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

- the law enforcement official represents to us that: 1) the victim is not the subject of the investigation, and 2) an immediate law enforcement activity necessary to address a serious danger to the victim or others depends upon the disclosure; and
- we determine that the disclosure is in the victim's best interest.

Medical Examiners or Funeral Directors. We may provide health information about our consumers to a medical examiner. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our consumers to funeral directors as necessary to carry out their duties.

National Security and Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.

Uses and Disclosures of Your Health Information with Your Permission

Uses and disclosures not previously described in this Notice of Privacy Practices will, in general, only be made with your written permission called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that

authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

Your Rights Regarding Your Health Information

Right to Inspect and Copy. You have the right to request an opportunity to inspect or copy health information used to make decisions about your care, regardless of whether they are decisions about your treatment or payment of your care. Generally, this would include clinical and billing records, but not psychotherapy notes.

You must submit your request in writing either directly to The Home's program from which you are currently receiving services, or to Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request.

We may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

Right to Amend. For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care – whether they are decisions about your treatment or payment of your care. Generally, this would include clinical and billing records, but not psychotherapy notes.

To request an amendment, you must submit a written document to The Home's program from which you are currently receiving services, or to the Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131 and tell us why you believe the information is incorrect or inaccurate.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that:

- was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
- is not part of the health information we maintain to make decisions about your care;
- is not part of the health information that you would be permitted to inspect or copy; or
- is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request.

If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that are the subject of your request.

Right to an Accounting of Disclosures. You have the right to request that we provide you with an accounting (i.e. a list) of disclosures we have made of your health information. However, this list will not include routine disclosures we have made for purposes of treatment, payment, and health care operations. To request an accounting of disclosures, you must submit your request in writing to The Home's program from which you are currently receiving services, or to the Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131. For your convenience, you may submit your request on a form called a "Request For Accounting," which you may obtain from your program, or from our Privacy Officer. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003.

The first accounting you request within a twelve-month period will be free. For additional requests during the same 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before we incur any costs.

Right to Request Restrictions. You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You may also ask that any part (or all) of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes, as previously described in this Notice.

You must request the restriction in writing and addressed to the Privacy Officer at 10 Guest Street, Boston, MA 02135. The Privacy Officer will ask you to fill out a Request for Restriction Form, which you should complete and return to the Privacy Officer. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by e-mail. To request such a confidential communication, you must make your request in writing to The Home's program from which you are currently receiving services. We will accommodate all reasonable requests. You do not need to give us a reason for the request, but your request must specify how and where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy. To obtain a paper copy, ask The Home's program from which you are currently receiving services, or contact the Privacy Officer at 617-267-3700.

Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care. You may also obtain a copy of the current Notice of Privacy Practices by calling us at 617- 585-7502 and requesting that a copy be sent to you in the mail or by asking for one any time you are at one of our offices or programs.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer. All complaints must be submitted in writing.

The Home's Privacy Officer can be contacted at 10 Guest Street, Boston, MA 02135, by telephone at 617-267-3700, or by email at HIPAA@thehome.org, and will assist you with writing your complaint if you request such assistance. We will not retaliate against you for filing a complaint.

D. Procedure for Informed Consent for Treatment

Informed Consent for Treatment		No. 1-11
Scope: All programs of The Home for Little Wanderers providing treatment to registered Client		
Effective Date: May 8, 2001	Revised:	Last Review: January 16, 2016

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In the Policy on Informed Consent for Treatment and herein, these definitions apply:

"Routine, general, and preventative treatment" shall mean standard medical examinations, clinical tests, standard immunizations, treatment for minor illnesses and injuries, and the standard treatment modalities of the Home's programs, e.g., individual, group, family, occupational, and milieu therapies.

"Emergency treatment" shall mean a treatment provided as necessary on an emergency basis by a physician licensed to practice medicine or other employees or emergency personnel trained in emergency care.

"Non-routine treatment" shall mean psychopharmacological treatment or treatment that is rarely used, highly intrusive or high risk, e.g. forced tube feedings or ECT.

"Clinician" shall mean the person providing therapeutic and case management services to the client and family. Clinicians include Licensed Mental Health Counselors (LMHC), Licensed Independent Clinical Social Worker (LICSW), Licensed Clinical Social Worker (LCSW), masters level mental health counselors and social workers, interns currently enrolled in an accredited masters level program in mental health counseling, social work or marriage and family therapy.

1.0 Consent to Treatment

1.1 ***Consent to Routine, General, and Preventative Treatment.*** Informed consent is to be obtained and documented for routine, general and preventative treatment.

Informed consent is the knowing consent, given in a manner that is free of coercion, by a client and/or their parent/legal guardian who can weigh the indications, risks, and benefits of the particular treatment being proposed by the health care provider. Persons who have given consent are at any time free to withdraw their consent. In some cases, the withdrawal of consent can

have serious consequences for the client's treatment. The HLW Informed Consent Policy and Procedures shall comply with the requirements of New Hampshire law and the standards of all licensing agencies responsible for regulating the services provided by the HLW. At the outset of routine, general and preventative treatment or upon admission to a Program of the HLW, the client and/or parent/legal guardian shall be informed of the indications, risks, and benefits of the routine, general and preventative treatment that is ordinarily performed at, or arranged by, the program or facility. The informed consent of the client and/or parent/legal guardian will be documented on a *Consent for Routine, General, and Preventative Treatment* form (see Appendix).

Medication will not be administered to a client without written authorization from a parent/guardian. Such authorization shall be renewed annually.

A. The health care provider will obtain informed consent from the parent/legal guardian. Informed consent would include the purpose of the medication, potential benefits, and potential side effects and adverse effects.
B. The health care provider will complete an informed consent form, with copies filed in both the client's medical record and clinical record.
C. The health care provider will inform the client of the purpose, potential benefits, potential side effects and adverse effects of the medication and will encourage the engagement of the client in monitoring the effectiveness and side effects of the medication.
D. The HLW or outside health care provider will provide the transcribing nurse client-specific information about the indication, side effects, and adverse effects. The program nurse will communicate this information to appropriate staff and provide the information in written form in an accessible place for staff reference.
E. The program nurse will obtain information about all medications prescribed for each client and the date of the next scheduled visit with the prescribing physician for review of the medication.
F. The program nurse and clinical supervisor will ensure that an *Authorization for Medication Administration* form (see Appendix) signed by the parent/legal guardian is in the client's record before any medication is administered to the client in the program. A copy of the form will be kept in or in proximity of the *Medication Log* for reference. If a client's medication regime includes an antipsychotic medication and if a minor is the under the guardianship of DCF, the nurse or clinical supervisor will ensure that a current court order and treatment plan are on file in the client's record (Rogers order). If the court order is not on file or is outdated, the medication will not be administered, and the nurse will contact the program director and program psychiatrist immediately.
G. The program shall create and maintain a "tickler" system, which keeps track of the expiration dates of medication prescriptions, and

court issued medication orders, so that timely action can be taken to insure extension of administration of medication without interruption.

1.2 ***Consent to Non-Routine Treatment***. For non-routine treatment, more specific informed consent must be obtained and documented. This higher level of informed consent must be obtained and documented in the following situations:

1.2.1 Psychotropic Medication. When treatment with a psychotropic medication is to be initiated, informed consent must be documented on The HLW's *Consent Form for Psychotropic Medications* (see Appendix). If psychotropic medication is to be administered, a signed copy of the *Consent Form for Psychotropic Medication* shall serve as the primary documentation unless a Rogers order has been issued by a court of competent jurisdiction, in which case it shall replace the *Consent form for Psychotropic Medication* as the principal document. The court review date of the Rogers order shall be prominently recorded in a tickler system designed to ensure adequate time to prepare documents and evidence for the Rogers review hearing. The client and/or parent/legal guardian shall be provided with a signed copy of the consent form. The informed consent process and the use of the *Consent Form for Psychotropic Medication* shall also be recorded in the health care provider's progress note. Documentation of ongoing informed consent discussions concerning questions about and/or changes in the client's status shall be included in the progress notes of the health care provider as they occur. When treatment with a psychotropic medication is to be initiated, informed consent must be documented in the health care provider's progress note. If non-routine prescription medications are to be administered, informed consent should also be documented in the health care provider's progress note. Where indicated, the note should contain a statement as to the capacity of the client and/or parent/legal guardian to give informed consent.

1.2.2 Other High-Risk, Rare Medication. When a rarely used, unusual, highly intrusive, or high-risk intervention is to be implemented, informed consent must be documented on a written consent statement specifically created for that treatment. For other treatments that exceed the scope of routine treatment, the health care provider must conduct discussions with the client and/or parent/legal guardian as delineated in Paragraph 1.2 above, and document such discussions in detail in the progress notes.

1.2.3 Treatment Protocol. When any research treatment protocol is to be implemented, informed consent must be documented on a *Consent for Participation in Research* form.

1.2.4 HIV Antibody Testing. When HIV antibody testing is to be conducted, informed consent must be documented on an HIV antibody testing consent form (M.G.L. Chapter 111,§70F). If HIV testing is to be conducted, documentation of consent for HIV antibody testing from the client's health care provider will be included in the client's record.

2.0 Knowledge Required/Given for Informed Consent

2.1 ***Clinician or Clinical Supervisor's Responsibility***. Ensuring the provision of information necessary for informed consent is primarily the responsibility of the clinician or the clinical supervisor. If necessary, this information shall be provided in the language of the client and/or parent/legal guardian, and the information shall be provided in terms that they can understand.

2.2 ***Discussion of Options and Risks***. Because the knowing exercise of the right to accept or forego treatment requires knowledge of the available, appropriate treatment options and the indications, risks and benefits attendant on each, the clinician and/or clinical supervisor must fulfill their duty to inform by discussing the indications, risks and benefits of all appropriate treatment options to the client and or parent/legal guardian.

3.0 Information Given by Health Care Provider for Non-Routine Treatment

3.1 ***Discussion Topics***. For all treatment exceeding the scope of routine, general, and preventative treatment, the health care provider shall discuss with the client and parent/legal guardian the following:

(a) the condition(s) for which treatment is being recommended;
(b) the recommended medication(s) and/or treatment(s);
(c) the dosage range of medication(s), and how it will be administered (i.e., by mouth or injection, etc.);
(d) the anticipated duration of treatment;
(e) the indications (i.e., the reasons that this medication is appropriate for the client's condition(s);
(f) the benefits and the desired outcomes of the proposed medication(s) and/or treatment(s), including prognosis with treatment;
(g) the risks, including significant, common, and possibly serious or life-threatening side effects of the recommended medication(s) and/or treatment(s);
(h) the dangers of abruptly discontinuing the medication(s) and the methods of safely discontinuing the medication(s) and/or treatment(s);
(i) appropriate alternative treatments, including a discussion of the indications, benefits, risks and probable effectiveness of each reasonable alternative treatment;
(j) possible outcomes if no treatment is received (prognosis without treatment);

(k) the rights of the client and/or parent/legal guardian to ask questions about the recommended treatment, before or during or after treatment;
(l) the rights of the client and/or parent/legal guardian to refuse treatment; and,
(m) the rights of the client and/or parent/legal guardian to revoke consent at any time and its consequences.

3.2. ***Written Information***. Written information about the proposed medication(s) and/or treatment(s) shall be made available, when requested.

3.3 ***Informing Minor Client***. While informed consent for the HLW clients who are under the age of eighteen (18) is, in most cases, legally obtained from the client's parent/legal guardian, it is the HLW policy to inform minors of the indications, risks, and benefits of the recommended treatment and treatment options, in a manner consistent with the client's age and capacity to understand.

4.0 Assessment of the Competence of Client and/or Parent/Legal Guardian

Based on his/ her discussions with the client and/or parent/legal guardian, and other information available, the health care provider shall make and document an assessment of the ability of the client and/or parent/legal guardian to understand the information presented and to give competent informed consent. For psychotropic medication treatment, competency assessment shall be documented on the *Consent Form for Psychotropic Medications*. If the health care provider determines that the client or parent/legal guardian is not competent, and the client or parent/legal guardian takes the opposite position, then a formal competency evaluation shall be conducted.

5.0 Informed Consent: An Ongoing Process

Providing information to a client and/or parent/legal guardian is an ongoing responsibility of the health care provider and is necessary to allow the client or parent/legal guardian to determine whether to continue to consent, or to withdraw their consent.

5.1 ***Substantial Changes Require New Consent***. Whenever substantial changes in the client's treatment are indicated, or in the event that the client's mental and/or physical status changes in such a manner as to substantially change the indications, risks, benefits, or appropriate options for his or her treatment, informed consent for changes in medication(s) and or treatment(s) shall be obtained and shall be documented on a new *Consent Form for Psychotropic Medications*.

5.2 ***Ongoing Consent Discussions***. Discussions about informed consent, regarding psychotropic medications, do not stop with the initial consent, but continue through the course of treatment as the client experiences the medication, its benefits and side effects, or when the client's care is transferred to a new health care provider.

5.3 ***Periodic Reviews and Renewed Consent***. Even if there are no changes indicated in a client's medication and/or treatment, periodic review, discussion, and documentation of informed consent shall occur in periodic reviews and/or in progress notes at minimal intervals:

(a) For psychologically stable client being served on an outpatient basis, annual review is sufficient.

(b) For client in residential settings, documentation of informed consent discussions shall be included in the periodic review process, minimally at three (3), six (6), and twelve (12) months after admission, and annually thereafter. This review may be covered in a brief statement or check box on a periodic review form, though any significant new information should be covered in a progress note or a new consent form.

c) For client returning to program from an admission to a hospital or outside facility, for any length of time, should be reviewed by team upon return within 72 business hours.

6.0 Documentation of Informed Consent in the Client's Record

The client's clinician shall be responsible for collaborating with Health Services to ensure documentation of informed consent is received and updated, with all necessary signatures from the authorized prescribing clinician, including but not limited to the following:

6.1 ***Consent Documentation***. Documentation indicating that the client and/or parent/legal guardian has been provided information in accordance with the policy, including information about the indications, risks, and benefits of recommended treatments, appropriate treatment options, and indicating whether the client and/or parent/legal guardian has assented to or refused treatment.

6.2 ***Documentation of Capacity to Give Consent***. An assessment of the capacity of the client and/or parent/legal guardian to give informed consent should be noted on the *Consent Form for Psychotropic Medications* or noted in a progress note for non-routine treatment. The assessment should include discussion of the ability of the client and/or parent/legal guardian to process the information given to them by the health care provider, to understand the nature of the illness/problem to be treated, and to evaluate treatment options presented. The assessment should note important questions and comments offered by the client and/or parent/legal guardian.

7.0 Those Who May Give Informed Consent

7.1 ***Legal Adults***. Legal adults, i.e., individuals over the age of 18, are presumed to be competent to give informed consent, unless a court has decided otherwise. A legal adult's informed consent is necessary, and is sufficient, to comply with this policy. Given the HLW goal of supporting

optimal family health and functioning, we generally advise, when a competent adult client gives his or her permission, that the client's family is contacted so that important treatment decisions can be made in conjunction with informed family involvement, unless to do so would not be in the best interest of the client or would violate client confidentiality or privilege.

7.2 ***Minors and Incompetent Adults***. For those client incapable of making an informed decision to accept or forego certain forms of treatment, including, with certain legal exceptions, minors (those under the age of 18), New Hampshire law provides alternate means to protect their interests.

7.2.1 Guardianship of Incompetent Adults. If a legal adult is adjudicated by the Court as incompetent to give informed consent, the Court will appoint a guardian from whom informed consent shall be obtained. Note: a Court-appointed guardian must be specifically granted the "authority to admit" in the mittimus (Order of Guardianship). If authority to admit is not included in the mittimus, a separate Order must be obtained from the court before the client may be admitted (M.G.L Chapter 201 §6B).

7.22 Parents or Guardians of a Minor. Informed consent to the treatment of a minor shall be obtained from the parent/legal guardian. The parent/legal guardian is presumed to be competent to give informed consent unless otherwise determined by a court. The informed consent of a minor's parent/legal guardian is required and is sufficient to comply with the policy unless the parent no longer has legal custody of their child.

7.2.3 Exceptions to a Guardian's Right to Consent. However, a court-appointed guardian, such as the DCF guardian, may not give consent for certain highly intrusive or high-risk interventions, including, but not limited to psychotropic or antipsychotic medications, ECT, psychosurgery, sterilization, or abortion. A separate court order is required for these treatments, and consultation with The Home's legal counsel, via the Operations staff, should be sought in cases requiring such permission.

7.2.4 Informing Minors. While informed consent to the treatment of a minor is legally obtained from the parent/legal guardian, it is the policy of The Home to inform the minor, in a manner consistent with their capacity to understand about the indications, risks, and benefits of the recommended treatment and treatment options.

7.3 ***Questions as to Authority to Give Consent***. Sometimes questions will arise as to who has the authority to give informed consent to a client's treatment. If there is a question as to whom has legal guardianship of the client, or as to the scope of guardianship, the court mittimus, or order of guardianship, should be reviewed, and the HLW's legal counsel should be consulted. If a client has two guardians with appropriate authority to give consent whom

The HLW believes to be in conflict over consent (for example, parents involved in a custody dispute), the HLW's policy is to obtain consent from both parties. The clinical director and the HLW's legal counsel should be consulted if the clinician and prescribing physician determine that it would be in the client's best interest to obtain consent from only one of the client's parents/legal guardians in such a conflict. If the HLW's clinician or prescribing physician believe that a parent/legal guardian is, or has become, incompetent, it may be that Court intervention is necessary to seek appointment of a new guardian. Consultation with the HLW's legal counsel, via the Program Director and HLW Senior Administration, should be sought to assist with seeking the appointment of a new guardian.

7.4 ***Client in the Custody of DCF***.

7.4.1 Client in the Physical Custody of DCF. In cases in which DCF has been awarded only physical custody of a minor, the client's parent/legal guardian retains the right to consent to medical treatment. In such cases, consent to the use of psychotropic medications and all other medical treatments must be obtained from the client's parent/legal guardian.

7.42 Client in the Full Custody of DCF. In cases in which DCF has been awarded both physical and legal custody of a client, informed consent to medical treatment must be obtained from the client's DCF guardian, except for psychotropic medications (see 7.4.3 below).

7.4.3 Consent to Administration of Antipsychotic Medications. New Hampshire law requires that consent to treatment with psychotropic medication, even for those minors in the full custody of DCF, may only be obtained through a Rogers order issued by the Court. (DCF 110 CMR 11.14(4)).

7.5 ***Minors Authorized to Consent to Treatment***.

7.5.1 Emancipated Minors. If the client is an Emancipated Minor (a client under the age of 18 who is married, widowed or divorced; the parent of a child; pregnant or believes herself to be pregnant; a member of the Armed Forces; or living separate and apart from their parent/legal guardian and managing their own financial affairs) the client may give consent for medical or dental care, including psychiatric care, in the same manner as a legal adult (defined above in 7.1) provided, however, that no consent under this paragraph may be accepted for abortion or sterilization.

7.5.2 Drug Dependent Minors. If the client is a minor 12 years of age or older who is found to be drug dependent by two or more physicians, they may give consent to treatment related to the diagnosis or treatment of such drug dependency.

7.5.3 Contagious Diseases. A minor may consent to care if the minor reasonably believes that they suffer from or have come in contact with any disease defined as dangerous to the public health under Chapter 111, Sec.6 of New Hampshire law; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease. If a facility or program determines, pursuant to applicable New Hampshire law, that a minor is an Emancipated or Drug Dependent Minor (as defined in Sections 7.5.1 and 7.5.2), and is therefore able to provide consent to treatment, the program may decide, in certain circumstances, not to notify the minor's parent/legal guardian. Such a determination must be made in consultation, via the Program Director, with the HLW's legal counsel.

7.5.4 Documentation. Documentation of informed consent obtained from minors should also be done in consultation with legal counsel.

7.6 ***Changes in Custody of the Client During Treatment***.
If, after consent for a particular treatment has been given by a parent/legal guardian, and there is a subsequent change in a client's legal/physical custody and/or guardianship, the informed consent of the new guardian must be obtained and documented in order to continue that treatment. If the treatment involves the use of psychotropic medications, changes in guardianship may require that a Rogers order be obtained from the Court.

8.0 How to Proceed When Consent for the Treatment is Denied

Refer to The HLW's policy on *Refusal of Treatment*.

9.0 Procedures for Which Informed Consent is Not Needed

9.1 ***Emergency Treatment***. Under New Hampshire law, the HLW's medical personnel cannot be held liable for failing to obtain the informed consent of a client and/or parent/legal guardian to emergency examination and treatment, including blood transfusions, when delay in treatment would endanger the life, limb, or mental well-being of the client. Nonetheless, the client's parent/legal guardian should be informed of the HLW's authority to provide emergency treatment to the client as part of a review of routine and preventative treatment at the outset of treatment. Similarly, if such emergency treatment is rendered to a client, the parent/legal guardian should be informed as soon as possible, in keeping with the HLW's practice of fully informing the parent/legal guardian about the treatment of the client.

10.0 Withdrawal of Consent

Persons who have given consent are at any time free to withdraw their consent by giving written notice to their, or their client's clinician or prescribing physician, or

other appropriate HLW personnel. A withdrawal of consent shall become effective immediately upon receipt by the clinician or prescribing physician, whether received directly from the client or through other appropriate HLW personnel. Consequences of withdrawing consent are discussed in the HLW's policy on *Refusal of Treatment*.

11.0 The Responsibility of the Administration of the HLW

11.1 ***Information to be Provided Upon Admission***. As soon as possible after admission to the Home (preferably within 72 hours of admission for inpatient and 24-hour residential programs the client and parent/legal guardian shall be informed of the client's rights, including informed consent, and the right to accept treatment, refuse treatment, or request alternatives to recommended treatment. At the HLW's in-patient and 24-hour residential programs, this information shall be provided by a human rights officer or clinical supervisor and by providing the client and parent/legal guardian with a copy of the written handbook on client's rights information (the "Handbook"). The Handbook is intended to supplement, and not replace, discussion with the client and/or parent/legal guardian.

11.2 ***Posting Consent Form for Psychotropic Medication***. A blank copy of the *Consent Form for Psychotropic Medication* shall be posted in client areas. Similarly, copies of written material on psychotropic medications will be made available, translated into the appropriate language, whenever possible.

11.3 ***Posting Information Regarding Informed Consent***. A separate document on *Informed Consent Rights* shall be posted in client areas. This posting shall reflect the values and principles embodied in this policy and shall convey that client and their parent/legal guardian have the right to consent to or refuse recommended treatment (without coercion, retaliation, or punishment), unless a court has ordered the treatment, or unless treatment is administered in an emergency situation.

11.4 ***Information Regarding Medications***. Programs and facilities of the HLW that prescribe or administer medications shall have methods appropriate to clients' needs to provide, ongoing information and education about medication including, but not limited to, medication groups.

11.5 ***Implementation and Annual Review of the Policy***. All health care providers who provide services at the HLW's programs and facilities shall review the requirements of informed consent annually. All staff involved in the delivery and dispensing of medication as well as human rights officers, will also review this annually. Implementation of this policy and its annual review is the responsibility of the Program Director of each of the HLW's facilities or programs.

12.0 Situations in Which Clinical and Legal Counsel May be Sought

Whenever questions arise as to the specific rights of a client and/or parent/legal guardian, appropriate supervisors and management personnel should be contacted for clarification and supportive second opinions. Staff should not hesitate to request consent to contact the HLW's legal counsel for advice on such questions. The HLW Counsel may, where necessary, contact the appropriate DMH/DCF legal offices.

E. Protection of Cultural and Religious Rights of Consumers

Purpose: To ensure that client in residential treatment have access to and are allowed to practice their sincere religious and cultural beliefs.

The Home respects diversity and the inherent right of client and families to practice religious beliefs. Each program shall allow for and take reasonable steps to arrange for the client to exercise their right to practice their religious beliefs. However, if the safety of the client or of other client is jeopardized, the agency reserves the right to cancel or restrict participation.

At the time of intake, parents/guardians shall be asked if the client will be attending religious services.

A client may elect to attend religious services at any time during their stay in the program.

If a client is restricted from religious observance for clinical reasons, those must be documented in the client's record and the client's parent/guardian must be informed.

If approved by the parent/guardian, a member of the clergy may visit the client in the program with proper notice. This does not mean the religious activity will occur in the program.

In accordance with M.G.L.c76 (15) a parent/legal guardian may object in writing to the administration of medical treatment to the client on the grounds that such treatment conflicts with their sincere religious beliefs. In such an instance, HLW will not require a client to receive medical treatment except in the case of an emergency or epidemic of disease declared by the DPH.

F. Policy on Refusal of Treatment

Purpose: To preserve the general rights of client of The Home for Little Wanderers ("The Home") and their parent/legal guardian to make informed decisions about treatment, including the right to refuse treatment.

Statement of Policy: Client of The Home and their parent/legal guardian have the right to refuse any services, treatment, or medication unless law or court order has limited such rights of refusal. In each instance, The Home informs a client and their parent/legal guardian of the consequences, if any, of such refusal. The Home reserves the right not to provide services or to terminate services if, in The Home's clinical judgment, such service refusal substantially interferes with the client's best interest, The Home's ability to treat the client, or otherwise prejudices The Home's ability to run the program.

Non-compliance with medication is a common issue in all areas of psychiatric and medical care. In the context of behavioral health care for children and adolescents, medication non-compliance may reflect a host of issues and concerns. The clinical team providing care to the client and family will consider the implications of medication non-compliance in their clinical formulation.

In the context of a therapeutic residential school program, medication non-compliance generally implies that the client has refused the medication that is offered. Client in residential programs frequently refuse prescribed medications. The current practice guideline provides a framework to guide the clinical response to such events.

1. The Development of the Initial Treatment Plan

   After admission and the signing of the Placement Agreement, the assigned clinician develops an initial treatment plan with the family. The assigned clinician provides a full explanation of the risks and benefits and requests informed consent (hereafter "consent") to the treatment. If medication is part of the treatment plan, the prescribing physician obtains consent for medication. When consent or a court order of substituted judgment is given, staff may proceed with treatment. Observations of treatment modalities are to be documented and placed in case records.

2. When a Parent/Legal Guardian Refuses to Accept the Treatment Plan

   If consent is refused by the parent/legal guardian, the assigned clinician/prescribing physician attempts to negotiate acceptable changes to the treatment plan with the parent/legal guardian. If such a modified plan is developed, the assigned clinician/prescribing physician provides a full explanation of risks and benefits and requests consent.

   If the parent/legal guardian continues to refuse consent to treatment even of the modified plan, the assigned clinician and Clinical Director convenes a meeting of the treatment team to determine whether the treatment that is being refused is an essential component of the treatment without which the program cannot meet the client's treatment needs, or if the presence of the untreated client in the program prejudices The Home's ability to operate the program in the interest of other children in the program.

If the treatment team determines that the needs of the client can be met without the proposed treatment, or with an alternative treatment approach, and that the program is not prejudiced thereby, such approach is proposed to the parent/legal guardian.

a. If accepted, treatment proceeds.
b. If not accepted by the parent/legal guardian, the assigned clinician and Clinical Director shall consult the Program Director, the Vice President for Placement Services, and the consulting physician, depending on the nature of the treatment refused, regarding whether the treatment refused is an essential component of the treatment plan for the client.

If these people at The Home agree with the assessment of the treatment team that effective treatment cannot be provided without the refused treatment component, or that there is unacceptable prejudice to the program, the Vice President for Placement Services will document this assessment and recommend options, in writing, to the Program Director. Options include, but are not limited to, termination of services, seeking a court order for treatment, and/or filing a 51(a) report of neglect. The Program Director will then instruct the Clinical Director, or designee, to implement the decision. If the decision is to terminate services, the treatment team will develop and implement a termination plan.

3. <u>When a Minor Refuses Treatment</u>

When a minor refuses to accept treatment, services, or medication consented to by their parent/legal guardian, staff shall respectfully listen to the client's wishes and concerns regarding treatment. If a client refuses to take a prescribed medication, the nurse, clinician or milieu staff will discuss the issue with the client. Staff should offer the medication/treatment three times, 15-20 minutes apart before considering it a refusal. The client should be given an opportunity to voice their concerns about the medication. The importance of consistent medication treatment and planned medication changes should be emphasized in a positive light. The client should be given time to review and possibly reconsider their decision. Client should NEVER be coerced into taking medication against their wishes. Refusals should be reported to Health Services and as directed, the client's health care provider according to orders (if not otherwise specified, the health care provider should be notified immediately). There should be a determination of whether the client is placed at a significantly heightened risk of an immediate medical event or complication because of medication non-compliance. Refusal of medications prescribed in conjunction with 1) a Rogers order, issued by a court of competent jurisdiction or 2) medications ordered pursuant to a substituted judgment decree on other than Rogers matters can constitute a medical emergency, and the health care provider shall be immediately informed. Non-emergency refusals are discussed in treatment team meetings and an effort is made to incorporate the client's thinking into adjusting and further developing the treatment plan.

If the treatment team determines that the proposed treatment component is essential to effective treatment, and the client continues to refuse the treatment, a behavior plan may be developed in collaboration with parent/legal guardian to encourage the client's participation. Parent/legal guardian must also consent to this behavior plan.

During this interim period, the client is not forced to receive treatment except authorized restraint (to which parent/legal guardian must have given consent), court ordered treatment, or emergency treatment ordered by a physician.

4. When a Client Refuses Medication

Medication refusal is NEVER an indication for a client to lose privileges within a program. However, medication refusal may occur in the context of a clinical presentation that may indicate the appropriate reduction in privileges. In such an instance, the clinical indications for the reduction in privileges (apart from the act of medication refusal) need be documented.

Medication refusal may place a client at heightened risk for a medical complication. This scenario may indicate a reduction in privileges to assure the health and safety of the client. The determination for a reduction in privileges to assure health and safety in this context must be established by a licensed health professional. Staff must document in the client record the process of determination, including the identity of the health professional consulted.

5. When Refusal of Treatment Leads to a Client's Termination from the Program

In a case where the refused treatment component is considered by the treatment team to be essential to treatment (or essential to assure that the untreated client does not materially prejudice the program), and inadequate progress is made in the collaborative effort among the program and the client and/or parent/legal guardian, The Home retains the right to terminate the client's treatment, such termination to be effectuated in an expeditious manner that also considers the client's needs for an orderly and clinically appropriate transition.

6. Procedure for Treating on an Involuntary Basis

Staff or parent/legal guardian may initiate a request for court approval to administer treatment involuntarily. Documentation of the order from a court of authorized jurisdiction is to be placed in the client's record.

7. Grievances

Client and parent/legal guardian may pursue grievances about treatment plans and processes, and management of The Home will monitor such grievances according to the *Client Grievances, Incident Reporting,* and *Critical Incident Investigations* policies and/or procedures of The Home.

II. Intake

A. Intake

Purpose: To meet the agency's commitment for quality, comprehensive and timely health care for client, the following intake components are required.

Unity House receives referral packets from sending school districts or other agencies (DCF or DMH). Prior to any consideration of acceptance to Unity House, an admissions application must be completed by the referring school district or referring agency and parent or guardian. Below is the needed information and attached is the *Admissions Application* form.

- *Admissions Application* form (which includes current diagnosis and medications list)
- Signed copy of the *Request for Residential Treatment*
- Current signed IEP
- Current DCF or DMH Service Plan
- Paperwork confirming Educational Surrogate Parent

The admissions team (comprised of clinical, education and health services personnel) meets as necessary to screen all referrals who have completed the admissions application process to ensure that each client meets eligibility requirements. If a client is found to meet requirements, an interview is scheduled with the prospective client.

An interview and tour onsite with the client and parent/legal guardian is preferred, but Unity House can send a representative to the client's current location if they are unable to tour in person. During the tour, a designee from health services will be available to meet with the client and/or parent/guardian to discuss any relevant health concerns.

After the interview, the admissions team convenes to further review the information obtained and to decide on acceptance or rejection of the referred client. Decisions are based on the compatibility of needs and services. If a client is deemed appropriate and their parent/legal guardian chooses the program, further paperwork is requested to complete the intake requirements.

Health Documentation Required:

- Copy of health insurance card
- Copy of birth certificate
- *Health History Form* (see Appendix)
- Results of the most recent physical, dental and vision appointment conducted not more than 12 months prior to the potential admission date
- Immunization information and TB test
    - 5 doses of DTaP/DPT
    - 4 doses of Polio
    - 3 doses of Hepatitis B
    - 2 doses of MMR
    - 2 doses of Varicella or record of chicken pox disease with written verification by the client's physician

    - 1 dose of Meningococcal or waiver
- Rogers order signed by the court for administration of antipsychotic medication for a client in DCF Custody (Seroquel, Abilify, Zyprexa, Risperidal, Geodon, Clozaril)
- Rogers guardian information
- Updated *Medical Passport*, if available

Health Services will review serious or potentially serious health concerns related to the admissions information prior to intake into the program. With parent/guardian written consent, contact may be made with the client's primary care physician for additional information.

At or prior to intake, the clinician will ensure that the following informed consent documents are on file to ensure quality and legally sanctioned delivery of health services (see Appendix):

- ☐ *Admission Criteria Requirements*
- ☐ *Consent for Medication Administration*
- ☐ *Documentation Requirement Notification*
- ☐ *Authorization and Consent for Routine Health Care*
- ☐ *Consent for Emergency Medical Treatment*
- ☐ *Consent for Psychotropic Medication Administration*
- ☐ *Consent for Administration of Over-the-Counter PRN Medication*
- ☐ *Pelham Community Pharmacy Consent* (For residential client only)
- ☐ *MassHealth Authorized Representative Designation Form*
- ☐ *Signed Physician Medication Orders*
- ☐ *Consent to Request Records & Approval for Communication with Physicians*

B. Nurse Intake

At the time of intake, the parent/guardian will bring signed physician orders for current medications or treatment and the name, dose and time of the last medications(s) given. The parent/guardian will bring a 14-day supply of medications with them to the intake. The nurse will facilitate completion of the *Home for Little Wanderers Admission Health Assessment* with all available information within 72 hours of admission (see Appendix).

Prior to or at intake, Health Services will:

- Inform parent/guardian of all health-related services provided at the program.
- Review with guardian medication administration requirements regarding over-the-counter medications, delivery of medications to campus, and regular scheduled medications.
- The prescribing physician/psychiatrist will obtain written informed consent for each medication to be administered to the client while in The Home's care. See *Informed Consent for Treatment* practice guideline.
- Start the *Medication Administration Plan* for each prescribed medication with the guardian (see Appendix).
- Create *Individual Health Care Plan* (IHP) to become part of the medical record for each client with a chronic medical condition diagnosed by a physician. The IHP describes the chronic condition, symptoms, prescribed medication, potential medication side effects, and potential consequences to health while the client is in care (see Appendix).
- Inform staff of health-related information pertinent to care. If a nurse in not available that day, the intake will be rescheduled.
- Check all medications delivered by the pharmacy and received from home against the prescriber's orders.
- Ensure safe storage of all medications, including controlled substances.
- Enter countable substances in the *Countable Substances Log* to be signed by nurse and parent/guardian

C. Integrated Health Care

The nurse is a key member of an integrated team of direct staff working to promote the health and safety of client. The nurse coordinates and oversees each client's health care in coordination with the client, physician, clinician, state agencies, and parent/legal guardian.

Within one month of intake, the nurse will work with the client, parent/guardian, and staff to address the following:

- Promoting wellness: health goals, health education, growth and development, nutrition, BMI, exercise and other health habits
- Prevention: screenings, immunizations, routine health care, education
- Chronic health concerns including allergies and asthma
- *Emergency Action Plans*, as needed
- *Medication Administration Plan* for each prescribed medication
- *Traveling Medical Binder*

The nurse will schedule and ensure that vision, hearing, postural and other screenings are conducted according to M.G.L. regulations. When screenings are not conducted on program site they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record.

The nurse or clinician will prepare an *Emergency Fact Sheet* for each client. This sheet will be kept in a page protector in the front of each client's section of the medication administration book and travel binder and will include:

- Client's name and date of birth
- MA Health or other insurance info
- List of known allergies
- Photo
- Parent/guardian contact info
- Emergency back-up contact info
- Chronic medical conditions of the client
- Medication List
- GAL info
- Health care providers' contact information

The nurse will participate in the multidisciplinary team meetings; part-time nurses will participate as possible. The nurse will report on health status to include (but not limited to) current medications, medication changes, medication compliance, observed tolerance and effectiveness of medications, new allergies and conditions, nutritional status, hygiene, and exercise.

The Program Director in coordination with Director of Workforce Learning and Development and the nurse will ensure that direct care staff is up-to-date for health-related training requirements, e.g., CPR, first aid, standard precautions/blood borne pathogens, and medication administration.

The Director of Educational Services in coordination with Director of Workforce Learning and Development and the Principal will ensure that all HLW school staff receives mandated annual 766 health-related training.

The Director of Human Resources will ensure that records are maintained of all required trainings.

D. Return to Unity House after Admission to Outside Facility

While at Unity House, it may be necessary for a client to require outside assistance for either a physical ailment or psychiatric crisis. If a client is admitted to an outside facility for either medical or psychiatric needs, the Clinical Department and Health Services will work closely together to ensure a thoughtful transition back to Unity House. Prior to returning the Unity House, a meeting at the outside facility is recommended to ensure that all aspects of the transition are discussed (medications, discharge paperwork, transportation after discharge, etc.).

Prior to returning to Unity House, the discharging facility must fax or send electronically any new HCP orders for review along with medical clearance for school return specifying activity limitation along with the date of the next follow-up appointment to Health Services.

When the client returns to Unity House, the client will have a re-entry meeting with Health Services, the Clinical Department, and the school (if necessary). The Clinical Department will complete a risk assessment within 8 hours of returning to Unity House. If necessary, an email will be sent to all Unity House personnel with any additional plans or interventions.

III. Health Services

The ultimate goal of Health Services is to create a healthier, more teachable client population & healthier community.

A. Health Services Office Procedure and Guidelines

The nurse will schedule and ensure that vision, hearing, postural and other mandated screenings are conducted in a timely manner according to 105 CMR 200.100 (B) (1). Per MA 105 CMR 200.000, the purpose of mandated screenings is to identify and take appropriate actions with respect to disabilities and medical conditions of school children in public schools as soon as possible so as to enable all children to obtain the fullest benefit of their educational opportunities. The screenings are a tool used for referral and further follow-up and are not considered diagnostic. When screenings are not conducted on the program site they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record. A dated copy of request is kept in medical record until copies are obtained. If guardian requires help obtaining any screenings, the nurse can assist in this process.

HLW staff (direct care staff, clinicians, nursing staff) are often called upon to accompany client to medical and dental appointments. Only staff trained in TCI may accompany client to appointments. It is important that only staff members who know the client are assigned to this task. It is essential that staff accompanying client to appointments take the Traveling Medical Folder to the appointment and to ensure that client are returned to the program with clear written guidelines for care and follow-up. The written guidelines for care and follow-up must be given directly to the nurse or shift supervisor.

Traveling Medical Folder
The Traveling Medical Folder contains all the information needed for a client to be treated by a health care provider outside of Health Services. The folder will include:

1. Client's name, date of birth, known allergies, current medications, dates of immunizations, chronic health problems
2. Copies of recent *Health Encounter* forms
3. A copy of parent/guardian *Authorization for Treatment* forms
4. A blank *Health Care Report* form
5. A blank *Health Encounter* form
6. The MA Health or other insurance card

Health Service Visit / Office Guidelines
When clients request to be seen by the school nurse, teachers should call first to schedule a visit whenever possible. In the case of an emergency, nursing staff will be available by walkie during school hours.

Activity Restriction

The nurse must be informed of any activity restriction. A physician's note, detailing restriction, end date and physician follow-up date is required for any prolonged activity restriction when a client would miss more than one week of physical education. A screening by the school nurse is conducted for a client to return with a cast, sling, ace-wrap, or crutches. This screening, aids in assessing anticipated needs and resources. Physician's notes clearing clients to return to "restricted activity" is required in cases of concussions, other acute conditions/injuries, and continued follow-up, where there is no activity restriction end date specified.

B. General Management of Common Illnesses and Health Conditions

Staff will employ the Emergency Guidelines for all life-threatening or potentially life-threatening illness. In other situations, the following guidelines apply.

Assessment:

1. Staff will contact the nurse to assess the client following concerns of illness, injury, change in behavior, and/or complaint of pain/discomfort. The Nurse will assess the client, determine if a physician consult is required, then document the findings and actions. Following assessment, the nurse or physician will provide guidelines to staff for treatment and monitoring.

2. If the nurse is not on duty, staff reports symptoms to the shift supervisor. The staff refers to guidelines for the general management of certain common illnesses and health conditions outlined in this manual to help determine the seriousness of the situation and for minor illness interventions. If the situation warrants, the shift supervisor will call the on-call administrator to request that the health care provider be contacted. The shift supervisor and attending staff follow the treatment advice of the physician. To ensure follow-up, staff notifies the nurse ASAP of the illness and the steps that were taken to address the situation.

3. If you are unable to have a nurse or prescriber evaluate the client or consult with you by phone in a timely manner, call 911 and transport to nearest emergency room for assessment and treatment

1. Fever

The symptom of fever in client is extremely common. The degree of fever does not always correspond to the severity of the illness; neither does the absence of fever indicate absence of infection.

Normal ranges in body temperature are between 97.8 degrees F and 99.6 degrees orally. Normal ranges in body temperature can vary as much as 1.5 degrees, depending on amount of activity, emotional stress, type of clothing worn and temperature of the environment, and the time of day. Body temperatures in older client and adults fluctuate, the lowest peak occurring between 2 and 6 AM and the highest peak between 4 and 7 PM.

Most fevers are the result of an infectious process. A slight elevation in temperature may indicate dehydration.

Consult the nurse or physician if:

✓ Fever is greater than 100 degrees and/or persists for longer than two days.
✓ The client has symptoms of other illness, e.g. headache, stiff neck, irritability, light sensitivity, lethargy, loss of appetite, vomiting, and/or symptoms relating to ears, throat, lungs and abdomen.
✓ Do not hesitate to consult the nurse or physician if you have concerns in addition to those listed above.

General Management of Fever

✓ Increase oral fluid intake to prevent dehydration as tolerated.
✓ Ensure that the room temperature is comfortable, and that air can circulate.
✓ Monitor fevers at least every 2-4 hours when awake. Observe and monitor the sleeping client every 2 hours. Do not hesitate to awaken to check temperature if you have any concerns about the condition of the client.
✓ The nurse or physician may recommend that the client be given PRN medication for fever of 101 degrees or above (check the client's individual PRN Order sheet). Do not give a fever PRN medication without consulting the nurse. Never give aspirin with a fever.

Upper Respiratory Infection

✓ Control of fever (see fever instructions).
✓ Rest.
✓ Instructions in frequent hand washing.
✓ Increase fluid intake, especially water and fruit juice. Caffeine in soda may present problems; milk can often cause thickening of mucus in the throat.
✓ Cool mist humidifier may be used to relieve stuffy nose or troublesome cough. Check with the nurse for appropriate use.
✓ Check the medication book for standing orders for lozenges, cough syrup, decongestant and Tylenol. Follow the PRN order medication guidelines for the client. Consult the nurse prior to giving PRN medications.

2. The Common Cold

Colds are the most common infectious disease in client. Susceptibility to colds is universal. The average client has from three to eight colds per year. Colds are caused by a variety of viruses and antibiotics will not have an effect on the virus. The most frequent symptom of a cold in school age and older client:

✓ Temperature between 99-101 degrees that lasts from a few hours to a few days.
✓ Stuffy and runny nose.
✓ Sneezing.
✓ Sore throat.
✓ Decreased appetite.
✓ Irritability.
✓ Sometimes achy muscles and joint pains (flu-like symptoms).

A cold usually lasts three to ten days with a low-grade fever (less than 101 degrees) on the second or third day, after which symptoms gradually disappear.

When a client has symptoms of a cold and any of the following consult the nurse or physician. Do not hesitate to consult the nurse or physician if in doubt about the client's condition.

✓ Fever on 100 degrees or higher.
✓ Symptoms are not improving by the fourth day.
✓ Client is having difficult or rapid breathing, or chest pain cough is producing yellow, green or gray sputum.

3. Sore Throat

Viruses most often cause sore throats, although 30-50 percent of the acute Pharyngitis in school age client is caused by streptococcal infection. The only accurate way to distinguish between a strep infection and a viral sore throat is by throat culture. It is better to err on the side of caution and refer to a physician for a throat culture if:

✓ The client's sole or predominant complaint is sore throat
✓ Client has associated elevated temperature
✓ Client has other complaints such as abdominal pain, headache, vomiting, malaise
✓ Client has been in close contact with someone with diagnosed strep infection.

4. Vomiting and Diarrhea

Vomiting and Diarrhea are common in client. They can be caused by many illnesses such as ear infections, colds, stomach viruses, allergies and urinary tract infections. **Client tend to lose body fluids rapidly when they are ill, so they must be watched carefully.** Signs of dehydration are dry mouth and lack of urination for 7-8 hours. If the following signs are present, it is important to contact the client's primary care provider, and the nurse:

✓ Signs of dehydration (dry mouth, lack of urination)
✓ Severe abdominal pain
✓ Any blood in stool
✓ No improvements with 48 hours
✓ Persistent fever for more than 12 hours

General Management of Vomiting and Diarrhea:
Dietary modifications are the major treatment. It is important to replace fluids, not calories, and to give foods and fluids that be easily digested.

✓ Do not offer the client anything to eat for 2 hours after vomiting and begin with only sips of clear fluid after 1 hour. If the client is asking for something to eat or drink, avoid carbonated beverages, e.g. soda.
✓ Begin sips of clear fluid gradually every 15-30 minutes; large amount of fluid may cause the client to vomit again. Avoid all milk and dairy products; they are hard to digest. Examples of clear fluids are ice chips, water, popsicles, jello, ginger ale, clear chicken or beef broth with fat removed.
✓ Continue to give clear fluids for 12-14 hours.
✓ If there has been no further vomiting and the client wishes to eat, begin with a soft solid diet (see following for soft solid diet).
✓ If diarrhea is the only problem (no fever, no vomiting, no abdominal pain) a bland diet can be generally be given. Five clear fluids if other symptoms are present.
✓ If client manages a bland diet for 24 hours without difficulty, return to regular diet, adding raw fruits, vegetables, dairy products and fried foods last.

Other complaints:
Consult the nurse or the client's health care provider immediately or call 911 for complaints of severe abdominal pain, chest pain, headache, or sudden sensory/motor disturbance.

Dietary Recommendations
Clear Liquid Diet: Clear liquid diets are recommended for client who are experiencing vomiting and diarrhea. Clear liquid is any liquid you can see through. There should be no particles. Examples of clear liquids are:

✓ Ginger Ale
✓ Clear chicken or beef broth
✓ Water of ice chips, cubes
✓ Jello

✓ Popsicles (DO NOT USE juice bars)
✓ **No** milk or dairy products

Bland Diet: Bland diets are often recommended for one to several days after a client's vomiting has stopped and the client is beginning to feel better. Spices are eliminated in a bland diet. For breakfast, cooked cereals and toast are good choices. Foods to avoid are: juice, bacon, sausage, seasoned eggs, granola, bran and high fiber cereals. At lunch and dinner, rice, mashed potatoes, vegetables, baked meat or fish, as well as soups, sherbet, jello, crackers, skim milk, applesauce, and bananas. Fried foods, salads, and raw fruit should be avoided.

Extra Fluids: Extra fluids (more than 6-8 glasses per day) are often recommended for those on medications, with current illness or infection, and during times of hot weather and exercise. Offer and encourage increased fluid intake during these times. Fluids should be decaffeinated to prevent dehydration.

Increased Fiber Diet: Increased fiber diets may be recommended for constipation and to promote regular emptying of the bowel. Fiber is the part of the food not digested by the human body. High fiber foods include raw fruits: apples or pears with the skin on, whole oranges, dried fruits such as prunes, apricots, raisins, cooked or raw vegetables including broccoli, carrots, green beans, cauliflower, corn, baked potatoes, spinach, sweet potatoes, whole grain breads and cereals (for example, oat bran, whole wheat, granola and raisin bran).
*Extra fluids taken with high fiber foods aid in bowel cleansing. *

5. Allergies

Unity House is committed to providing a safe and nuturing environment . Recognizing the increasing prevalence of life-threatening allergies in the population, Unity House will work in cooperation with parents, guardians, client and physicians to minimize risks and to provide a safe educational environment for all client. The focus of allergy management will be prevention, education, awareness, communication and emergency response. All HLW schools and residential programs are peanut and tree nut free. Unity House will make efforts to utilize latex free products.

Responsibilities of the School Nurse

- The nurse will obtain allergy information from referral materials and from parents/guardians during the intake health assessment.
- The nurse will meet with the client and parent/guardian to identify ways the program and the client will contribute to the management of the allergy.
- The nurse will obtain written recommendations for allergy management from the diagnosing or primary care physician.
- The nurse will develop an individual allergy action plan based on physician recommendations and discussion with the client and guardian and review this with program staff. The plan will include specific information about the client's allergy, past reactions, associated symptoms, measures to reduce exposure to client-specific allergens, and client-specific directions for responding to an allergic episode. A copy of the plan will be placed in the client's record.
- The nurse records allergy information onto the Medication Administration Log, the Physician's Order Sheet and the Health Service Treatment Plan. A brightly colored allergy alert sticker will be adhered to the cover of the client's record.
- The nurse supplies and regularly updates a list of current client with known allergies to the program director and site supervisors, along with measures to reduce exposure to allergen.

Responsibilities of Staff

- Staff will familiarize themselves with the allergy action plan of each client.
- Staff will know signs and symptoms of severe allergic reactions as provided in client's emergency action plan.
- Staff will participate in in-service training about client with life-threatening allergies.

6. Asthma

Asthma is a disease that affects the lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medication and avoiding triggers which aggravate asthma. Removing triggers from the environment which make asthma worse can help to improve it.

Triggers for asthma include dust mites, tobacco smoke, outdoor air pollution, cockroach allergen, pets, mold, smoke from burning wood or grass, infection, strong emotions that lead to hyperventilation, and exercise. Limiting or avoiding when possible exposure to asthma triggers helps decrease incidence of asthma exacerbations.

Goals of asthma treatment focus on:

- Reducing impairment: The frequency and intensity of symptoms and functional limitations currently experienced by a client
- Reducing risk: The likelihood of future asthma attacks, progressive decline in lung function, or medication side effects.

The goals of asthma management are for the client to enjoy an active life, to participate in normal activities, to sleep uninterrupted through the nights, and to minimize side effects from asthma medication.

At Intake:
The nurse will meet with the parent of guardian at or prior to admission to obtain a comprehensive health history. If the client is currently being treated for asthma or has a history of asthma, the nurse will:

- ✓ Obtain from the parent/guardian information specific to the client about the conditions that are likely to trigger an asthmatic episode, the frequency and severity of the asthmatic attacks, and the steps to be taken should attack occur.
- ✓ The nurse will request the parent/guardian to obtain the asthma action plan from the diagnosing or prescribing physician to guide management while the client is in the program. If the client is not currently being followed by a physician for the condition, a referral is scheduled.
  - If the prescribing physician order includes instructions that the client carries the inhaler, the school nurse will assess the youth's ability to self-administer inhaler and the plan will be discussed in multidisciplinary team meetings (MTD).
  - The nurse will ensure that the inhalers are labeled with a pharmacy label including the client’s name, name of medication, dose, frequency of administration, route of administration, any specific directions for administration (e.g., every four hours as needed for wheezing) and the name of the prescribing physician.
- ✓ Obtain a written prescription order from the prescribing physician for any inhaler medication administered to the client in the program.

✓ Obtain written order for the use of a peak flow meter, if included in the physician's guidelines.
✓ Obtain a written order for a spacer, if recommended by the prescribing physician.
✓ Inform all staff who will be working with the client of the asthma condition, the specific triggers, symptoms of episodes, guidelines for management, location of inhaler and specific instructions for emergencies.

The nurse will enter the asthma medication order on the *Medication Administration Record*.

Integrated Care:

The nurse will develop an asthma episode prevention, monitoring and management plan as part of the client's *Asthma Action Plan*. This plan will be a part of the client's *Individual Health Services Plan*.

This list will include:

✓ A list of medications, dose, time and route of administering and any other pertinent medication information
✓ Plans for daily management
✓ Environmental safeguards
✓ A specific plan of action of staff in case of an acute episode
✓ Location of inhalers
✓ List of staff instructed in the specific use of the inhalers for the client
✓ A clearly defined emergency plan, including instructions for transportation
✓ Field trip guidelines
✓ A specific plan for staff members to educate, counsel, and support the client toward self-management of asthma, in collaboration with the parent/guardian

Asthma Action Plans:

An asthma action plan is specific to the client and used as a guideline to monitor and control a client's asthma symptoms and improve overall function and well-being. An asthma action plan includes daily treatment, such as what kinds of medications to take and when to take them. The asthma action plan includes instructions on how to recognize early signs, symptoms, and includes peak flow meter parameters individual to the client which aid in identifying worsening asthma. It describes how to control asthma long-term and how to handle worsening asthma, asthma attacks, and when to call the doctor or go to the emergency room. It also describes how to give the client medications and remove or withdraw from them environmental factors which may trigger an asthma exacerbation. The asthma action plan should be developed with the client's health care provider, in partnership with the client and/or client's guardian to help control their asthma. All of the people who care for the client should know about the client's asthma action plan, so that they can help the client follow his or her action plan. Specific instructions of whom and when to call should be included in the asthma treatment plan. The client plays a central role in the management of their asthma by learning

to identify the early warning symptoms, knowing who to notify and the locations of inhalers.

Link to Asthma Action Plan:
http://www.lung.org/assets/documents/asthma/asthma-action-plan-for-home.pdf

Management of Acute Asthma Exacerbations:

✓ It is essential to teach client how to monitor signs and symptoms of worsening asthma, and to take appropriate action. This shall be done by the nurse in conjunction with the health care provider responsible for overseeing management of the client's asthma.

✓ Staff working with the client shall be trained by the nurse which includes an overview of the condition, education on goals of asthma treatment, asthma triggers, implementing asthma action plans, and proper inhaler administration, management of acute asthma exacerbations, and emergency asthma situation instructions, if an approved DPH program. The purpose of this training is to enable staff to pro-actively recognize the onset of acute and chronic asthmatic symptoms for referral to the school nurse to further assess. A copy of this training and information should be available at every program site for reference. Direct care staff is trained in the General Protocol for Management of an Acute Asthma Exacerbation, so they are prepared to assist a client experiencing an exacerbation in an emergency situation when a client's asthma action plan is not readily available for reference and the school nurse is not readily available.

✓ The client's *Asthma Action Plan* shall be utilized by program staff in the management of an acute asthma exacerbation when possible.

✓ Symptoms of a serious acute asthma exacerbation include, but are not limited to:

- Marked breathlessness
- Inability to speak short phrases
- Drowsiness
- Increased breathing effort

General Protocol for Management of an Acute Asthma Exacerbation:

✓ Initial treatment: Give asthma medication as prescribed and separate client from trigger if possible.

- A good response is characterized by absence of wheezing, no shortness of breath, and/or no rapid breathing after proper administration of the prescribed rescue inhaler by school nurse or trained staff, if approved DPH program, or by the client when possible. It is also characterized by the client returning to baseline function.
    - Staff will notify Health Services and/or if not available their staff supervisor. The school nurse will continue to monitor client for recurrent symptoms.
- An incomplete response is characterized by persistent wheezing, shortness of breath, and rapid breathing after proper administration of the client's prescribed rescue inhaler by trained staff or by the client when possible.
    - Staff will contact Health Services immediately for further instruction and notify the staff supervisor. The nurse will be notified and will assess the client when available. A client's health care provider shall be notified.
- A poor response is characterized as continued marked wheezing, rapid breathing, shortness of breath, or cessation of breathing.
    - If distress is severe and non-responsive to initial treatment, Health Services shall be notified immediately, and staff will call 911.

The nurse will provide a list of staff members trained in administering inhalers in an emergency to the Program Director and site supervisor. The nurse, in consultation with the Program Director will determine inhaler storage location for easy access and will inform staff of the location.

The staff member who has administered the emergency medication will ensure that the asthma inhalers are returned to their designated storage location following their use. In all instances a description of the asthmatic episode will be documented in the client's record. The staff member who has administered the medication will inform the shift supervisor of the episode and will document it in the daily log.

7. Seizures

When the normal workings of the brain are disrupted by injury, disease, fever, or infection, the electrical activity of the brain becomes irregular. This can cause a loss of body control known as a seizure. The location of the disruption of electrical activity in the brain, how it spreads, how much of the brain is affected, and how long it lasts all may have profound effects. These factors determine the characteristics of a seizure and its impact on the individual. The symptoms of a seizure can affect any part of the body.

Seizures may be precipitated by extreme heat, a diabetic condition, an injury to the brain, high temperature, or a drug reaction or overdose. Sometimes the cause of a seizure is unknown. Other commonly reported triggers of seizures include but are not limited to: a specific time of day/night, sleep deprivation, fever or other illness, flashing bright lights or patterns, alcohol or drug use, hormonal changes, not eating well or having a low blood sugar, specific foods such as excess caffeine, and use of certain medications.

Seizures may be caused by a chronic disease. The chronic disease is known as epilepsy. Epilepsy is a neurological disease which effects the nervous system. Epilepsy means the same thing as “seizure disorder”. Epilepsy is characterized by unpredictable, recurrent, unprovoked seizures and can cause other health problems. Epilepsy is a spectrum condition with a wide range of seizure types and control which vary from person to person. Epilepsy may be controlled with medication. Some people with epilepsy have seizures from time to time even when medication is effective in controlling most of their seizures.

A client with seizures may experience an aura before the seizure occurs. An aura is an unusual sensation or feeling such as a visual hallucination, strange sound, taste, smell, or an urgent need to get to safety. If the client recognizes the aura, they may have time to tell others and get to a safe place before the seizure occurs. Seizures range from mild, short blackouts that others may mistake for daydreaming to sudden and uncontrolled muscular contractions (convulsions) which may last several minutes. It may be frightening to see someone unexpectedly having a seizure.

There are many different types of seizures. These include seizures with altered awareness, seizures without any change in awareness, and seizures with loss of consciousness. During a seizure without any change in awareness, the client may remain fully awake and alert and remember everything that occurred during a seizure. During a seizure with altered awareness, a client may look awake, but they are not aware or only partly aware of what is going on around them. In this situation, the client may walk around during the seizure but not know what they are doing and may not be able to protect themselves. A client with altered awareness during a seizure may have difficulty talking about or remembering what happened during the seizure afterwards. During a seizure with loss of consciousness, the client will not remember what happened during the seizure and may not be aware of what happened afterwards. In any type of seizure, the most important objective

is to keep the client safe and provide general comfort measures until the seizure resolves itself and seek emergency medical help if necessary; as outlined in Seizure Protocol Guidelines below.

It is important to be aware of the impact epilepsy may have on someone's life. There are some health problems or symptoms which are seen more often in people with seizures than people without seizures. This could be related to the seizures, or it could be due to whatever is causing the epilepsy. Awareness of these symptoms can help them be addressed promptly by the client's health care provider, so they can receive the appropriate treatment if necessary.

A seizure is considered an emergency when it lasts greater than 5 minutes (if not otherwise stated) or when seizures occur close together and the client doesn't recover between the seizures. Just like there are different types of seizures, there are different types of seizure emergencies. Being aware of the different types of seizure emergencies is important in order to recognize them and get the appropriate medical help.

At Intake:
The nurse will meet with the parent or guardian at or prior to admission to obtain a comprehensive health history and review current health conditions. If a client is known to have seizures, the nurse will:

- ✓ Obtain from the parent/guardian information specific to the client about the condition. The program nurse will request that the parent/guardian obtain written guidelines from the client's neurologist to guide management while the client is in the program.
- ✓ Obtain a written order for any medication the client is currently taking to control seizures.
- ✓ Inform all staff who will be working with the client of the condition, the possible triggers, and guidelines for management.
- ✓ The nurse will inform the client's health care provider of the seizure medication for review in relationship with other medications prescribed for the client.
- ✓ The nurse will enter the anti-seizure medication order on the *Medication Administration Record*.

Integrated Care:
The nurse will include guidelines for epileptic seizure prevention, monitoring, and management in the *Individual Health Services Plan*.
This plan will include:

- ✓ Anti-seizure medication
- ✓ *Seizure Action Plan*: a specific plan of action for staff in case of a seizure (see Appendix)
- ✓ A clearly defined emergency plan
- ✓ Field trip guidelines
- ✓ A specific plan for staff members to educate, counsel and support the client in self-management of the condition, in collaboration with the physician, parent and guardian

The nurse will promote opportunity for the client, staff and guardian to develop a working partnership in management of the seizure disorder.

Seizure First Aid Protocol:
CDC Guidelines - First aid for generalized tonic-clonic (grand mal) seizures:
When most people think of a seizure, they think of a generalized tonic-clonic seizure, also called a grand mal seizure. In this type of seizure, the person may cry out, fall, shake or jerk, and become unaware of what's going on around them.

Steps for what to do if someone is having a generalized tonic-clonic seizure:

✓ Ease the person to the floor.
✓ Clear the area around the person of anything hard or sharp. This can prevent injury.
✓ Loosen ties or anything around the neck that may make it hard to breathe.
✓ Time the seizure. Pay attention to how long it takes someone to become fully aware after the seizure has ended.
✓ Put something soft and flat, like a folded jacket, under his or her head.
✓ Remove eyeglasses.
✓ Turn the person gently onto one side. This will help the person breathe.
✓ Always stay with the person until the seizure is over and the person is fully aware.
✓ Keep onlookers away and stay calm.

Never do any of the following things:

✓ Do NOT hold the person down or try to stop his or her movements.
✓ Do NOT put a pillow under someone's head who is having a seizure. This can cause suffocation.
✓ Do NOT put anything in the person's mouth. This can injure teeth or the jaw. A person having a seizure cannot swallow his or her tongue but may choke on objects placed in their mouth.
✓ Do NOT try to give mouth-to-mouth breaths (like CPR). People usually start breathing again on their own after a seizure.
✓ Do NOT give the person anything by mouth (food, water, medication, etc.) until they are fully awake and alert. If they have never had a seizure before or you are unsure, do not give them anything by mouth until emergency assistance arrives.

Call 911 if:

✓ The person has never had a seizure before.
✓ The person has difficulty breathing or waking after the seizure.
✓ The seizure lasts longer than 5 minutes.
✓ The person has another seizure soon after the first one.
✓ The person is hurt during the seizure.
✓ A head-strike is observed or suspected during the seizure.
✓ The seizure happens in water.

✓ The person has a health condition like diabetes, heart disease, or is pregnant.

General First Aid for All Seizure Types:
The first line of response when a person has a seizure is to provide general care and comfort, and to keep the person safe. There are many types of seizures. Most seizures end in a few minutes. Seizures may vary from one person to the next.

These are *general* steps to help someone who is having any type of seizure:
✓ Stay with the person until the seizure ends and he or she is fully awake.
✓ Comfort the person and speak calmly.
✓ Check to see if the person is wearing a medical bracelet or other emergency information.
✓ Keep yourself and other people calm.
✓ Keep onlookers away to give the person experiencing the seizure privacy and space.
✓ After it ends, help the person sit in a safe place. Once they are alert and able to communicate, tell them what happened in very simple terms.
✓ Make sure the person is fully aware of what is going on before they are left alone.

First aid for seizures without any change in awareness:
Characteristics: A person remains fully awake, aware, and alert during a seizure and may remember everything that has occurred. During these types of seizures, pay attention to the following:
✓ You may not need to do anything.
✓ Stay calm and reassure the person they are safe.
✓ If the person is frightened or anxious, encourage them to take slow deep breaths.
✓ Stay with the person until the seizure is over. Make sure they are fully awake and alert before they are left alone.

First aid for seizures with altered awareness:
Characteristics: A person may look awake during a seizure, but they are not aware of what is going on around them. They may not remember what happened during the seizure, or may have difficulty talking about it during or after it. The person may walk around during the seizure, but have no control of where they are going, and they may not be able to protect themselves. These behaviors may be seen with complex partial seizures or clusters of absence seizures, which can also present as "daydreaming." During these episodes, in addition to basic first aid, pay attention to the following:
✓ If the person has an aura, or 'warning' before they lose awareness, help them to a safe place.
✓ Stay with the person and do not let them wander away. Let them walk in an enclosed, safe area if necessary.
✓ Keep the person away from sharp objects or dangerous places, such as heights, stairs, or sharp objects.

✓ Time the seizure - these seizures are usually longer than convulsions or tonic-clonic seizures. It may be hard to tell when the seizure ended, or when the recovery period begins and ends.
✓ If the seizure turns into a convulsive seizure, follow first aid steps for tonic-clonic seizures.

First aid for seizures with loss of consciousness:
Characteristics: A person may lose awareness completely and be considered unconscious. They are not able to talk, are not aware of what is going on around them and may not realize what occurred afterwards. If they have a warning at the start of the seizure, they may be able to get to a safe place. They are at risk for injury during and after the seizure. *Follow the steps for care and comfort first aid and generalized tonic-clonic seizure first aid* with attention to the following:
✓ Watch how long the seizure lasts - Call 911 for emergency medical help if a generalized or tonic-clonic seizure lasts 5 minutes or longer.
✓ Watch their breathing - turn them on their side to help keep their airway open.
✓ If breathing problems occur or if the person appears they are choking, call 911.
✓ Don't put anything in their mouth.
✓ Do not give the person anything by mouth after the seizure until they are fully awake, alert, and oriented.
✓ Always stay with the person until they have regained consciousness and are fully awake, alert, and oriented.

Epilepsy and Associated Impact:
To provide holistic care, we must consider associated consequences that epilepsy may have on a person's life. Some health problems or symptoms are seen more often in people with seizures than in people without seizures. These may be related to the seizures, related to whatever is causing the epilepsy, or completely unrelated to the seizures. Recognizing when any of these concerns occur can help them be addressed promptly by a health care professional. Some related conditions include:
✓ "Not doing well" at home, school, work, or with friends
✓ Cognitive or learning problems that require special help or accommodations
✓ Symptoms of depression, anxiety, or other changes in mood or behavior
✓ Problems sleeping
✓ Unexplained injuries, bruises, falls, or other illnesses

Seizure Emergencies:
A seizure is considered an emergency when it lasts greater than 5 minutes (unless otherwise stated by emergency action plan), or when seizures occur close together and the person doesn't recover between seizures. Just like there are different types of seizures, there are different types of emergencies. Certain risk factors may increase someone's chances of having a seizure emergency.

Types of Seizure Emergencies:
✓ *Seizure clusters*: These may not be an emergency by itself, but a cluster of seizures that occur close together or get longer could develop into an emergency situation. By recognizing a cluster or group of seizures, appropriate

medical help can be obtained, and the development of an emergency may be prevented.

✓ *Status epilepticus*: This is a **medical emergency** when seizures last longer than 5 minutes or occur too close together. Status epilepticus can be convulsive or non-convulsive. The person may be confused, not fully aware of what is going on, or unconscious. **This can be life threatening - everyone should know how to recognize what status epilepticus is, and when to call for emergency help.**

Signs of status epilepticus:

- Any seizure lasting longer than 5 minutes
- A person goes into a second seizure without recovering consciousness from the first one
- A person is having repeated seizures for 30 minutes or longer
- A person who has non-convulsive seizures has seizures which last longer and occur more often than their typical seizure

✓ *Injury or illness:* The most common types of injuries from a seizure are cuts, bruises, and burns. Seek prompt medical attention for the following serious seizure-related injuries:

- Serious cuts, bruises, burns, or swelling
- Head trauma which is observed or suspected
- A seizure occurs in water - get the person out of the water and call 911

If problems or new symptoms occur days or hours after a seizure, do not ignore them. These include: fever, pain, shortness of breath, cough, headache, or other changes.

<u>Epileptic Seizure Triggers and Prevention:</u>

There are many triggers of seizures, which may vary from person to person. Some common triggers of epilepsy and the best ways to prevent them are outlined below:

✓ Illness: Being sick with an acute infection or illness is a common trigger for seizures in people with epilepsy. These may include head colds, lung infections, or sinus infections.

Steps to avoid seizures related to illness:

- Keep a 'seizure diary' and note any triggers that occur, such as infection, cold, or other illness.
- Get an adequate amount of sleep.
- Stay hydrated and receive adequate nutrition. Dehydration related to vomiting and diarrhea can worsen seizures.
- Continue to take seizure medication as prescribed by the health care provider. Contact the prescriber if nausea and vomiting is present to determine appropriate dosing.
- Handwashing is the best way to avoid becoming sick and spreading infection.
- Photosensitivity (Photosensitive epilepsy): Some people with certain types of epilepsy may be triggered by exposure to television screens, computer monitors, video games, strobe lights, and visual patterns. Not all of these stimuli trigger seizures, and the frequency and speed of flashing light differs from person to person. If a person is suspected of having photosensitive epilepsy, they should check with their physician.

- Avoid watching television.

✓ Sleep deprivation: A lack of "good sleep" makes most people more likely to have seizures, and can increase the intensity of length of seizures. Sleep deprivation may be a trigger alone, or when combined with other triggers.
Steps to avoid sleep deprivation:
  - Avoid caffeine at least 6 hours before bedtime
  - Keep a regular sleep and wake schedule
  - Make sure the sleeping environment is quiet and dark
  - Exercise regularly

C. Medication Follow-Up Protocols (labs, EKGs, vital signs, etc.)

The following are protocols for monitoring individual medications:

Psychostimulants

Methylphenyldate and Dextroamphetamine
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG, clarify any history of tic disorder
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC

Pemoline
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG
Stabilizing Dose: VS, ht/wt, BMI
q. 2 weeks: ALT (SGPT)
q. 3 months: LFT's

Antidepressants

SSRI's
Baseline: ht/wt, BMI, VS, CBC, LFT's
q. 6 months: ht/wt, BMI, VS
q year: CBC, LFT's

Tricyclics
Baseline: ht/wt, BMI, VS, CBC, LFT's, EKG
Stabilizing Dose: Vital signs, ht/wt, BMI, TCA level(s), EKG
q. 3 months: Vital signs, ht/wt, BMI
q. 6 months: TCA level, CBC, LFT's, EKG

Venlafaxine (Effexor)
Baseline: ht/wt, BMI, VS, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: ht/wt, BMI, VS
q. year: CBC, LFT's

Buproprion (Wellbutrin)
Baseline: VS, ht/wt, BMI CBC, LFT's, confirm no history of seizure or abnormal EEG
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Trazadone (Desyrel)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Nefazodone (Serzone)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI, LFT's
q. year: CBC

Mirtazapine (Remeron)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI, CBC
q. year: LFT's

Antipsychotics

Typical Antipsychotic Agents
Baseline: VS, ht/wt, BMI, CBC, LFT's, prolactin, AIMS, **EKG**
Stabilizing dose: VS, EKG (thioridizine and mesoridizine)
q. 3 months: VS, ht/wt, BMI
q. 6 months: LFT's, AIMS, EKG (thioridizine and mesoridizine)
q. year: CBC

Atypical Antipsychotic Agents
Olanzapine (Zyprexa), Rispiridone (Rispiridal), Aripiprazole (Abilify)
Baseline: VS, ht/wt, BMI, waist circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, AIMS
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, waist circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, AIMS

Quitiapine (Seroquel)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, slit lamp eye exam, AIMS
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, eye exam, AIMS

Ziprasidone (Geodon)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, EKG, AIMS
Stabilizing dose: VS, EKG
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, EKG, AIMS

Clozapine (Clozaril)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, EKG, results of any prior EEG or history of seizures, AIMS
Stabilizing dose: VS
Weekly to every other week: CBC
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: LFT's, glucose, lipid profile, cholesterol, EKG, AIMS

Mood Stabilizers

Lithium (Eskalith, Lithobid)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, calcium, LFT's, TSH,U/A, EKG
Stabilizing dose: Lithium level
q. 3 months: VS, ht/wt, BMI, Lithium level, CBC, electrolytes, BUN, creatinine, LFT's, TSH, U/A
q. year: Calcium, EKG

Valproate (Depakote, Depakene)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: Valproate level, CBC, LFT's
q. 3 months: VS, ht/wt, BMI, Valproate level, CBC, LFT's

Carbamezapine (Tegretol)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, TSH, T4, U/A
Stabilizing dose: Carbamezapine level, CBC, LFT's
q. 3 months: VS, ht/wt, BMI, Carbamezapine level, CBC, electrolytes, BUN, creatinine, LFT's

Oxycarbazepine (Trileptal)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, TSH, T4, U/A
Stabilizing dose (1-2 months): VS, electrolytes, BUN, creatinine
q. 3 months: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, T4, TSH

Gabapentin (Neurontin)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Lamotrigine (Lamictal)
Baseline: VS, ht/wt, BMI, CBC, LFT's, clarify history of rash reactions to medications
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Topirimate (Topamax)
Baseline: VS, ht/wt, BMI, CBC, bicarbonate, LFT's, clarify any preexisting eye disease/tendency toward glaucoma
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, bicarbonate
q. year: CBC, LFT's

Alpha 2 Agonists

Clonidine (Catapress) and Guanfacine (Tenex)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, EKG
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's, EKG

Anxiolytics

All benzodiazapines, clonazapam. alprazolam, buspirone
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Benedryl, Atarax, Vistaril
Baseline: VS, ht/wt, BMI
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI

Beta Blockers

All beta blockers
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. 6 months: CBC, LFT's, EKG

Other Agents

Strattera (Atomoxitine)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC,LFT's

DDAVP
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, U/A
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. 6 months: CBC, electrolytes, BUN, creatinine, LFT's, U/A

IV. Preventative Health Care

A. Physical Exams & Screenings Requirements

The Home for Little Wanderers recognizes the importance of an interdisciplinary team approach when coordinating and providing preventative health care services to our clients. HLW promotes routine preventative health care services for our client to promote wellness, build healthy habits, and help our client reach their fullest potential and maximize their quality of life.

A copy of all screenings and physicals are requested annually from caregivers and kept in client's medical records. A dated copy of request is kept in medical record until copies are obtained. If guardian requires help with any screenings, the nurse can assist in this process.

Physical Exams
Unity House's nursing staff work with the client's parents/guardians to ensure that each client receives an annual comprehensive medical and dental examination as well as hearing, vision, and posture screenings in a timely manner according to M.G.L. regulations. When screenings are not conducted at the program site, they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record. Written informed consent is obtained from the parent/guardian. Parent/guardians are also asked to provide the school with a copy of all physician reports, including any recommendations for the client's care.

Physical 105 CMR 200.100(B)(1)
Every client shall be separately and carefully examined by a duly licensed physician, nurse practitioner or physician assistant 105 CMR 200.100 (B)(1):

- Upon admission (within one year prior to entrance to the program or within 30 days after program entry)
- Clients 14-16 years old requesting employment certificate
- Annually, prior to a client's participation in competitive athletics

Unity House requires a written report from the physician(s) of the results of the examination and any recommendation and/or modification of the client's activity.

Hearing 105 CMR 200.400(C)
The hearing of each client in the program is to be screened, using DPH guidelines:

- In the year of program entry
- Annually through Grade 3 (by age 9 in ungraded classrooms)
- Once in Grades 6-8 (ages 12-14 in ungraded classrooms)
- Once in Grades 9-12 (ages 15-18 in ungraded classrooms)

For any client who does not pass, a written plan for follow-up is required.

Vision 105 CMR 200.400 (B)
The vision of each client in the program is to be screened, using DPH guidelines:

- In the year of program entry
- Annually through Grade 5 (by age 11 in ungraded classrooms)
- Once in Grades 6-8 (ages 12-14 in ungraded classrooms)
- Once in Grades 9-12 (ages 15-18 in ungraded classrooms)

For any client who does not pass, a written plan for follow-up is required.

Dental 603 CMR 18.05(9)
Routine dental cleanings and exams will be completed on an annual basis or as indicated by client's dentist and/or hygienist.

Posture M.G.L. c.71, 57
Postural screenings are completed at minimum at least once annually in Grades 5-9 (ages 12-15 in ungraded classrooms). For any client who does not pass, a written plan for follow-up is required.

Height & Weight 105 CMR 200.500
The height and weight measurements of each client is to be recorded:

- In Grade 1 (by age 7)
- In Grade 4 (by age 10)
- In Grade 7 (by age 13)
- In Grade 10 (by age 16)

BMI is to be calculated by trained personnel.

B. Immunizations

HLW requires that all clients receive proper medical treatment and immunizations unless the client's parents object on the grounds that such treatment conflicts with a religious belief (except in the event of an emergency or epidemic of disease is declared by the Department of Public Health). All clients are required to present complete Immunization Records before intake. In ungraded classrooms, grade 7 requirements apply to all clients ≥12 years. Requirements apply to all clients, even if over 18 years of age. Annual renewal of religious or medical exemptions to immunizations is required. As required by the DPH, all clients shall have the necessary immunizations:

- Tdap 1 dose; and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been ≥10 years since Tdap.
- Polio 4 doses; 4th dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a 5th dose is required. 3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.
- Hepatitis B 3 doses; laboratory evidence of immunity is acceptable
- MMR 2 doses; first dose must be given on or after the 1st birthday and the 2nd dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable
- Varicella 2 doses; first dose must be given on or after the 1st birthday and 2nd dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable
- Meningococcal 1 dose; 1 dose MenACWY (formerly MCV4) required for newly enrolled full-time clients attending a secondary school with grades 9-12 (in ungraded classrooms, those with clients ≥13 years) who live in a congregate living arrangement approved by the secondary school (e.g., dormitory). Clients may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement.
    - Waiver: for clients grades 9-12 (13 yrs and up) https://www.mass.gov/files/documents/2018/02/08/meningoccal-info-waiver.pdf

Current best practices will be followed regarding administration and record of immunization history according to Center for Disease Control and Prevention General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (2011).

- Only written, dated records will be accepted as evidence of immunizations.
- If immunization status is unknown or written and dated records are unavailable, the client shall be considered disease susceptible.
- Recommended immunizations will be initiated without delay according to the disease schedule appropriate for the patient. There is no evidence in the current literature which suggests that revaccination is harmful to the patient.
- Serologic testing is an appropriate alternative for certain antigens (measles, rubella, hepatitis A, and tetanus) at the discretion of a Health Care Provider.

C. Promoting Responsible Sexual Activity/Condom Availability

Client in HLW programs are at risk of engaging in unsafe sexual activity with other adolescents in the community. In this context, clinicians and health services staff will provide client with appropriate education about sexual health as well as the medical and psychological risks of sexual activity. Client are informed that abstinence is the safest way to prevent pregnancy and sexually transmitted diseases. Client are also informed that the proper use of condoms is highly effective in preventing pregnancy and the transmission of sexually transmitted diseases including HIV. In order to help prevent the transmission of sexually transmitted diseases (STD's) as well as to help prevent unwanted pregnancy, HLW programs will make condoms available, when clinically appropriate. Client who are provided with condoms must also be provided with appropriate counseling and instruction. Parents and guardians will be informed that programs provide basic health education around sexuality and that condoms are made available in this context. Clinical practice within HLW programs endeavors to be respectful both of the desire of parents and guardians to have knowledge of their clients' health care and wishes and rights to confidentiality.

This policy applies to all residential, day school, therapeutic foster care and after school programs serving client age 12 and older.

Screening for high-risk sexual behavior is a routine part of the clinical and health assessments for client in HLW programs. This assessment includes an evaluation of each client's understanding of safe sex practices and a determination of the client's ability to maintain their safety and their partner's (or partners') safety in the context of relationships that may have a sexual component.

As part of the regular admissions process, programs will inform the parents/guardians that the program offers education around sexuality and health. In this context, parents/guardians are informed that condoms may be made available to client. Parents/guardians are also informed that health services staff provides education about the risks of sexual behavior as well as instruction in the appropriate use of condoms.

In the context of family work, clinicians and health services staff will attempt to engage client and parents/guardians and appropriate family members in discussions about sexuality and risk reduction.

Client are instructed that sexual activity is prohibited on site at HLW programs and between HLW client.

Clinical, health services and milieu staff will consult together in offering appropriate structure, guidance and resources to client at high risk to engage in sexual behavior.

D. Dangerous Substances

All toxic substances, sharp objects, medications, and matches are kept in a secure, locked location away from client access. Toxic substances are stored in a separate locked cabinet, away from medications, and each product is clearly labeled with contents and antidote. Material safety data sheets (MSDS) are available by request. The phone number for poison control is clearly posted at every phone. Sharps are stored in appropriate receptacles in the medication cabinet.

E. Illicit Substance and Tobacco Use Policy and Procedure

To ensure that client are not under the influence of alcohol or drugs while being treated by a program of The Home for Little Wanderers and to ensure that any visitors or family members do not carry, use, or sell drugs or alcohol or use cigarettes on the premises.

Substance use/abuse is common among the age group that is served by The Home. Client who are struggling with emotional and behavioral problems are less likely to benefit from treatment interventions when actively using substances. It is therefore in the interest of providing good and effective care to our client that programs have best practices and safe protocols for determining current or recent substance abuse in our client. These protocols must be grounded in a sound clinical approach involving the client and family. In addition, they are to be integrated into a larger program of substance abuse prevention and education. Drugs of abuse and un-prescribed medication may represent a heightened risk for client taking prescribed psychotropic medications. Recognizing these factors, the following guidelines have been established for use in HLW programs, in accordance with M.G.L. c71, 37H and the Education Reform Act of 1993.

The Home prohibits the use, possession, or distribution of controlled substances and the use of cigarettes, vaping, or other smoking materials within or on the premises of all of its programs, including at HLW sponsored events or in HLW program vehicles. This applies to all employees, client, and visitors.

The Home will not provide treatment when a person is under the influence of alcohol or controlled substances because it is neither safe to do so nor does it contribute to treatment.

All of The Home's facilities and campuses are smoke-free.

Definitions
Tobacco/Vape Products: Cigarettes, cigars, chewing tobacco, snuff, vape or any other form of tobacco.

Confiscation of Visible Tobacco/Vape Products: Clients
Visible tobacco or vape products (as defined above) will be confiscated and returned to the parent(s) or guardian(s) upon request.

Any violation of the Tobacco Free School policy by a client will be reported to the Principal.

This policy applies to all residential and day programs.

Protocol:
1. Education of Parent/Guardian and Client of HLW Practice

a. During the admission process, the parent/guardian will be informed of the indications and the process of substance screening through the *Authorization and Consent for Routine Health Care*.
b. The client is informed of the indications and the process of substance screening during the orientation process in the program and in an ongoing way as is clinically appropriate.

2. Outpatient and Community-Based Programs

Persons who appear to be under the influence of drugs and/or alcohol upon arrival to or during, treatment will be:

a. If an adult,
    i. evaluated for immediate safety and have their safety ensured to the extent feasible.
    ii. asked to leave the treatment session until sobriety returns, assisted in accessing substance abuse treatment if appropriate.
b. If a client,
    i. evaluated for immediate safety and have arrangements made to ensure their continued safety. The parent/legal guardian will be notified.
    ii. where possible, staff will obtain a second observer/opinion.

3. Residential Treatment Center/Group Homes

An educational program component of substance use/abuse prevention will be provided at all residential sites.

Drugs and/or drug paraphernalia and alcohol may not be carried, used, or sold anywhere on the premises of residential /programs.

a. Prohibited items will be confiscated.
b. If a resident appears to be under the influence of a controlled substance, they will be evaluated for safety and, based on this evaluation, emergency action will be taken as needed.
c. If a client is found to be carrying, using, or selling controlled substances, action will be taken on a case-by-case basis in consultation with the treatment team. Evaluation of the substance use/abuse concern will be conducted. The parent/legal guardian or funding source will be notified and will be included in the discussion of action to be taken to address the concern.
d. Actions may include, but not be limited to:
    i. Inclusion of substance use/abuse issues in the comprehensive treatment plan
    ii. Adjustment in Behavioral Management plan to provide for increased structure and support
    iii. Drug screening, e.g. testing urine, blood, or hair follicle
    iv. Room search
    v. Referral to drug use/abuse groups
    vi. Notification of law enforcement

4. Schools

a. The schools of The Home are smoke free
b. Drugs and/or drug paraphernalia, alcohol and smoking materials may not be carried, used, or sold anywhere on the premises
c. Prohibited items will be confiscated

i. The parent/legal guardian will be notified to make arrangements for the day client to be picked up from the school and supervised until sobriety returns.
ii. Staff will make arrangements for the day client to be monitored until the parent/legal guardian or their identified representative has taken over supervision of the client.
iii. In consultation with the parent/legal guardian, staff will encourage the day client to be evaluated for substance use/abuse.
iv. The client may be suspended from school.
v. Law enforcement officials may be notified.

5. <u>In Case of Medical Emergency Related to Substance Use</u>
   a. As in other medical emergencies, in the case of a medical emergency related to substance use, program staff will call emergency services (911) immediately. Program staff will inform the program director/program administrator on-call and parent/guardian as soon as possible.
   b. If the client requires transport to an emergency service, the client will be transported by ambulance.

6. <u>In Case of Non-Emergent Situations Related to Substance Use</u>
   a. If a staff member suspects that a client is actively using substances, he or she will inform the supervisor responsible for the shift.
   b. The supervisor will then inform the Program Director or the Administrator-On-Call. The Program Director or the AOC will consult the nurse or on-call psychiatrist to determine the appropriate action. Urine screens will be used in all situations unless otherwise ordered by psychiatrist or on-call psychiatrist. The following are indications for considering either a urine or serum toxic screen:
      i. When a client is AWOL from the program in which there is either a past history of substance abuse or the current presentation is suggestive that the client may have used substances directly prior or during the elopement,
      ii. The client presents with the odor of alcohol or another substance,
      iii. The client appears intoxicated or under the influence, such as slurred speech, appears disoriented, uninhibited, pupil dilation,
      iv. The client presents with a marked and sudden change in behavior,
      v. The parent or guardian expresses concern regarding the client's recent substance use,
      vi. The client, who is considered at high risk of substance abuse, might be routinely screened upon return from LOA, or randomly tested as part of a treatment plan,
      vii. The client is found in possession of any alcohol, drugs, or substances of abuse.
   c. The AOC/shift supervisor will inform the parent/guardian of the events, the plan, and the results, as clinically appropriate.
   d. If it is determined to get the sample at the program, the psychiatrist or the on-call psychiatrist will order the tests.
   e. Staff should not complete a full body search with client. Staff will search client's pockets, shoes, and socks for possible adulterants (contaminants) just prior to the client providing the urine sample. In general, client searches are to be in accordance with Commonwealth of New Hampshire EEC regulations.

f. The nurse will develop programs-specific guidelines for obtaining and storing urine samples.
g. The staff member directly connected with the event will document the incident in the Incident Reporting system.

V. Emergency Management

A. General Statement

Informed Consent and Written Authorization
Emergency first aid or medical treatment will not be administered to a client without written authorization from a parent or guardian. Any preexisting conditions or allergies should be noted in addition to associated emergency treatment the client may have been prescribed (i.e. rescue inhaler or epinephrine auto-injector). Health care provider orders for these emergency treatments and the authorization to provide such treatment should be completed upon admission and renewed annually or as needed. Medications should be checked regularly for expiration.

Local emergencies numbers are posted by all telephones. Individuals' emergency contacts numbers are kept up to date. List of persons CPR /First Aid trained is available.

Emergency Supplies
Comprehensive first aid supplies will be kept in the nursing office. First aid kits will be easily accessible and kept in major activity areas (i.e. floor supervisor's office, residences, gymnasium, kitchen, classrooms and program vehicles). The first aid kits will include, but will not be limited to bandages, exam gloves, gauze, adhesive tape, and cleaning solutions. All first aid kits will be marked conspicuously.

First aid kits will be checked and replenished monthly and as needed as directed by Health Services.

Emergency Procedures
Emergencies can be classified into three major categories based on client's signs & symptoms:

1. Emergency Medical Conditions (Life-Threatening): Life-threatening or potentially disabling situations that require immediate intervention are outlined in Red Cross training. **911 must be called immediately** to activate the Emergency Response System (ambulance)**.** The nurse should be contacted as soon as possible to support the situation. The nurse will contact parent/guardian as soon as possible to communicate the emergency.

   Examples of emergency medical conditions may include, but are not limited to:
   - Cardiac and/or Respiratory Arrest
   - Unconscious or Unresponsiveness – not due to known seizure
   - Anaphylaxis – life-threatening allergic reaction such as difficulty breathing, etc.

- Seizure lasting longer than 5 minutes unless there is a specific physician's order or protocol that gives other instructions
- Severe Bleeding
- Chest Pain (unexplained or cause unknown)
- Breathing Difficulty as demonstrated by:
  - Rapid breathing (greater than 40 breaths per minute)
  - Labored or difficulty breathing or "catching one's breath"
- Any Seizure experienced by someone who has no seizure history
- Choking even if immediately resolved by chest thrusts
- Suspected Poisoning Incident
- Major Trauma/Injury
- Temperature of 94°F or below. Apply blankets and keep person warm until EMS (ambulance) arrives.

2. Urgent Medical Conditions (Potentially Life-Threatening & Requiring Immediate Medical Evaluation): Urgent medical conditions are serious, potentially life-threatening, or potentially disabling and because these may soon result in a life-threatening situation or may produce permanent damage, medical help is sought immediately. The **nurse and/or the physician should evaluate the client as soon as possible**. The nurse will contact parent/guardian as soon as possible to communicate the situation. When an urgent condition is observed, the individual's **physician/HCP should be contacted immediately**. If the physician/HCP cannot be contacted, there should be no delay in the evaluation or treatment of the individual. They should be **taken to the nearest Health Care Facility or Emergency Room**.

   Examples of urgent medical conditions may include, but are not limited to:
   - Temperature of 103°F or greater
   - Known Diabetic with Blood Sugar of 60 or below, or as indicated in diabetic protocol, and not responding to sugar, orange juice, glucose tablets, etc.
   - Profuse (large, frequent amounts) vomiting or diarrhea; vomiting which is followed by a change in respiration- choking, unable to "catch his/her breath"
   - Vomiting of fluids that look like coffee grounds or containing red blood
   - Taking a medication not intended for that individual or in an amount that exceeds the therapeutic dose, Note: physician/HCP or Poison Control Center (1-800-222-1222)

3. Non-Life-Threatening Injury or Illness: These are defined as any injury or illness that may affect the persons' general health, i.e. sprains, minor cuts. The **nurse and/or the physician should evaluate the client as soon as possible**. Medical

staff performing the onsite assessment will consult with the client's health care provider as needed. Onsite staff will follow physician recommendations. If transport to a medical facility is required, attending staff will also ensure that the client's medical information accompanies him/her. When signs & symptoms of a potentially health-threatening condition have continued for more than 24-48 hours or there are additional concerns, staff should contact their immediate supervisor and Health Services, which will notify the client's physician/HCP.

Examples of non-urgent medical conditions may include, but are not limited to:

- Temperature 100°F – 101°F by mouth OR Temperature of less than 97° but greater than 94°F
- Mild diarrhea, nausea or occasional vomiting
- Cold symptoms such as cough, runny nose, and congestion
- Any physical or behavioral signs and/or symptoms which lead you to believe the health and/or safety of the person is at risk.

4. Medication Occurrence Procedure: A Medication Occurrence is defined as a breach of one of the five "R's", namely Right individual, Right medication, Right time, Right dose, and Right route.

   There are five types of reportable occurrences: wrong individual, wrong medication (which includes administering a medication without an order), wrong time/ omission (which includes a forgotten dose), wrong dose and wrong route. (Refer to the Training Curriculum, for additional information).

   Follow this procedure for a Medication Occurrence:

   a. Check that the person is okay
   b. Call 911 as needed- as described in emergency health manual section
   c. Contact the Prescribing Physician / Poison Control
   d. Follow recommendations
   e. Notify the Program Director, Principal and Director of Nursing
   f. Document medication occurrence
   g. Fill out a Medication Occurrence Form (see Appendix)
   h. Notify Guardian
   i. Notify DPH as required: MDPH School Health Medication Error Report Form

Condition-Specific Emergency Protocols:

Note: If you are unsure whether a condition is urgent, call Health Services, Shift Supervisor, or Administration-On-Call to assist with evaluation.

Falls: When a person falls, the following protocol should be implemented:

1. If the person does not get up on their own, *do not move* the individual unless they are in danger of further injury if not moved, (e.g. fire, in the middle of a busy street, etc.)
2. Assess the individual for any emergency conditions as outlined in this policy. **If any emergency condition is present, immediately call 911** to activate the Emergency Response System (ambulance) and provide any First Aid measures needed, (e.g. keeping airway open, CPR, pressure to bleeding wound, etc.) while waiting for emergency personnel.
3. If no obvious emergency condition exists, **examine the individual from head to toe** for signs of any injury (bruising, swelling, redness, bleeding, cuts, abrasions etc.)
4. As soon as the above steps are completed, call your supervisor for further instructions. If any fall resulting in the need for medical/evaluation/treatment by either Primary Care Physician/urgent care or emergency room physician, the legal guardian will be notified.
5. Document what happened, what the findings were, what action was taken, and what follow-up instructions were given in the incident report.

Head Injury/Head Banging: Injury to the head, with or without loss of consciousness or other visible signs is to be reported to Health Services, the Shift Supervisor and the Administrator-On-Call for further instructions. The presence or absence of swelling at the injury site is not necessarily related to the seriousness of injury. External trauma to the head is capable of damaging the brain, even if there is no external evidence of damage.

1. Staff should monitor the individual for the following signs and symptoms and **call 911** if any of the following is observed:
    - severe head or facial bleeding
    - seizure
    - repeated vomiting
    - blood/drainage from nose or ears
    - unequal pupils or difficulty seeing
    - slurred speech
    - difficulty walking or using arms
    - change in breathing (labored or sporadic)
    - unusual behavior (agitation/confusion)
    - new or worsening neck pain
    - loss of consciousness
    - any new or severe symptoms including balance loss
    - difficulty being awakened
    - bruising especially below the eyes or behind the ears
2. Following a head injury, the individual should be monitored closely for the next 24 hours.
3. Staff should keep individual awake and check for symptoms every 2-4 hours.
4. Any signs and symptoms as noted above should be reported immediately to the individual's physician, Health Services, and shift supervisor.
5. Document observations for a minimum of 24 hours in a *Narrative Note* (see Appendix).

Staff Responsibilities During Any Medical Emergency:

- Attending staff will ensure that the client's *Travelling Medical Binder accompanies them to the emergency facility*.
- *As soon as initial emergency needs are met, contact Health Services and the program director or shift supervisor*. If person is being transported to a hospital, obtain the name of the hospital from EMS and convey the information to Health Services, the Program Director, Shift Supervisor and Administrator-On-Call.
- The *parent/guardian will be contacted at the time of the emergency*. The information will include the nature of the emergency, location of the client, name of hospital if transported to such, and name of the staff member accompanying the client. If the parent/guardian cannot be reached or the parent-designated person to contact cannot be reached, calls made and attempts to reach them will be documented and filed in the client's record. In all cases, the parent/guardian will be notified as soon as possible. Attempts to contact the parent/guardian or designee will continue until either is reached.
- The staff person accompanying the client to the Emergency facility must request the facility staff to *complete the Health Care Provider Orders form* if needs are prescribed.
    - In the case of a new prescription for an epinephrine auto-injector, that prescription must be filled right away before the client returns to the program. This will require the staff to advocate for obtaining the epinephrine auto-injector with the Emergency Room physician to fax it to the local pharmacy in order to have available for a client who may have a rebound response within hours of returning to the program.
- Upon return to the program the staff member will give these forms; the Health Care Provider Orders, the emergency facility's evaluation report, and prescriptions *directly to the nurse, program director, or his/her designee*.
- The parent/guardian, Health Services, Shift Supervisor, Principal, Program Director or Administrator-On-Call will be notified of the incident and any actions taken. Necessary health care documentation will be completed by nursing. Attending staff will *complete an incident report*, if needed.

B. Psychiatric Emergency

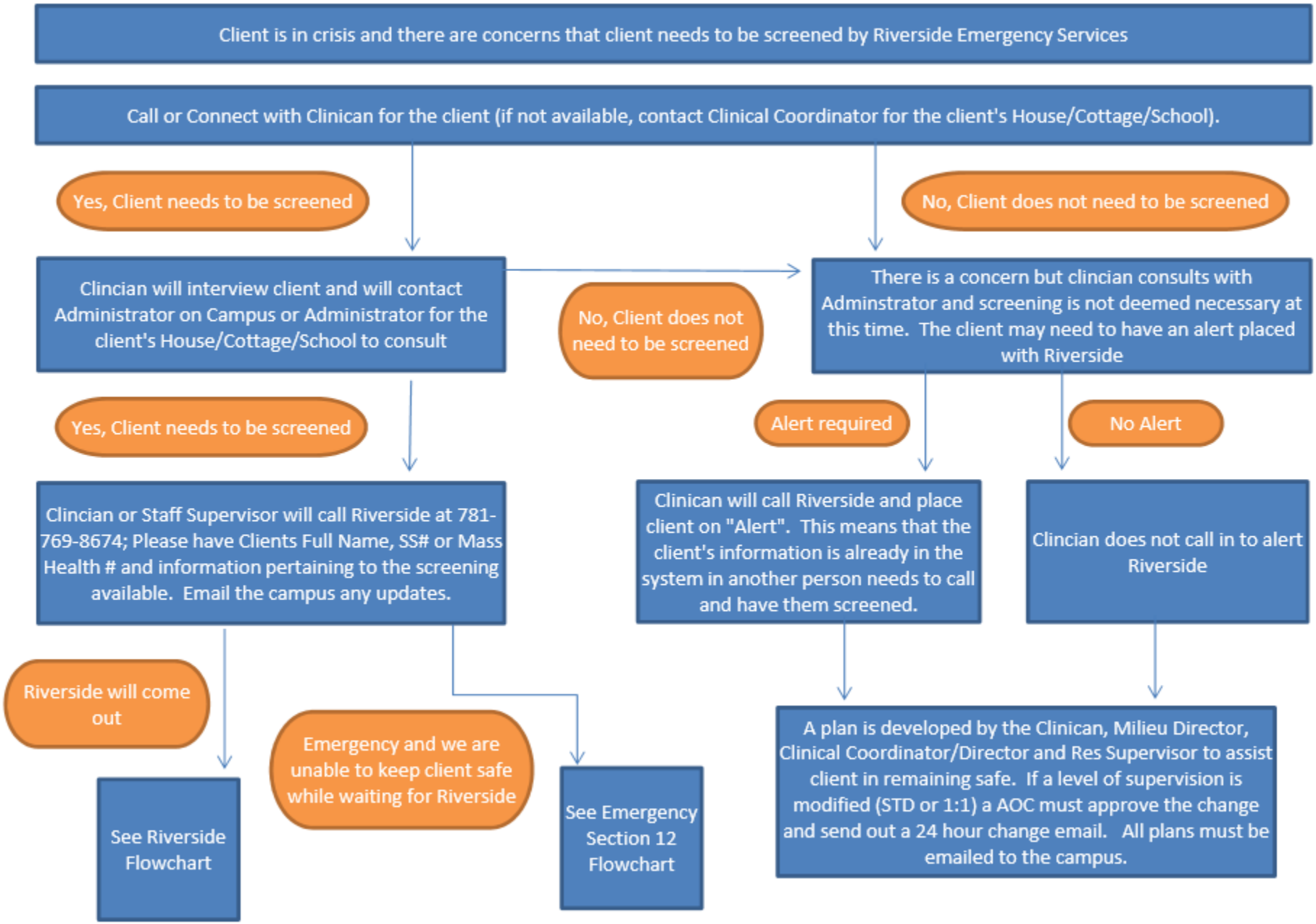
Client presenting with high risk crisis behaviors outside of their typical baseline could be experiencing a psychiatric emergency. Direct care staff and the client's primary clinician will proactively maintain open lines of communication. The clinician can meet with the client to assess the severity of the symptoms and work with staff to develop a support plan or modify the level of supervision provided as appropriate.

If the client's primary clinician has continued concerns about the client's presentation following assessment or if staff identifies that there is an emergent threat to the client's safety, a licensed clinician (LICSW, LMHC, or psychiatrist) will be contacted to conduct a risk assessment. If the licensed clinician or psychiatrist finds that the client can remain safely on campus, a detailed plan to help assist the client will be sent out and Riverside Emergency Services may be called and the client placed on an "Alert Status". An Alert can assist Riverside to facilitate a quick screening response if the client's status changes in the near future. If the licensed clinician or psychiatrist finds that the client is in a psychiatric emergency and may require a higher level of care due to the severity of risk, Riverside Emergency Services (1-781-769-8674) will be contacted.

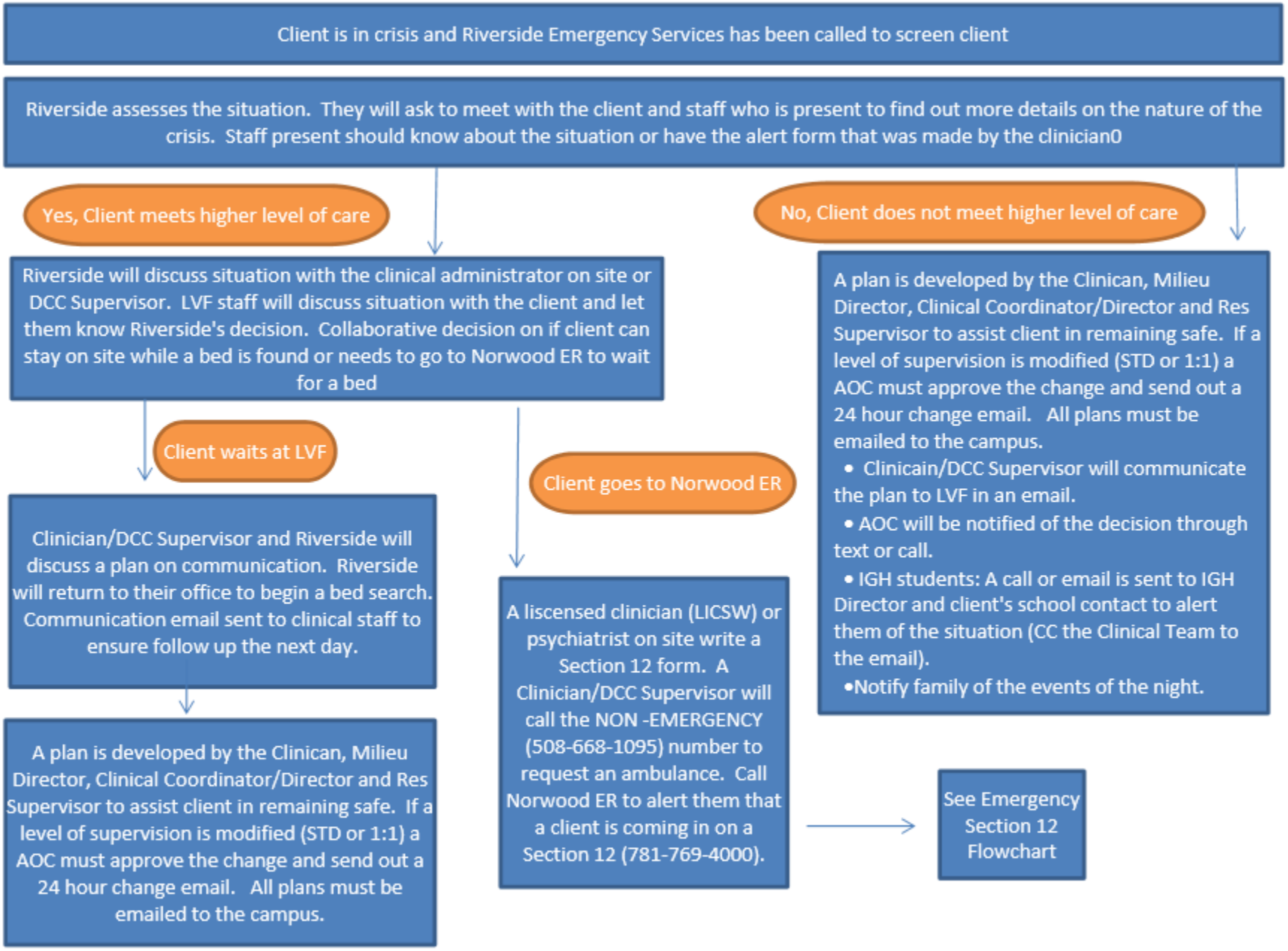
Riverside can come out to conduct an in-person assessment and determine whether the client requires a higher level of care. In the event that the client does not meet criteria for a higher level of care, Riverside may continue to monitor the situation and check in by phone or in person for up to 72 hours. Client requiring a higher level of care but can be safely maintained on campus while Riverside searches for a bed in an inpatient or Community Based Acute Treatment (CBAT) Center will have a specific plan communicated to the rest of the campus to ensure safety for the client and others. Client requiring a higher level of care but who are unable to safely remain in their current environment while waiting for an in-patient or Community Based Acute Treatment bed will follow the procedure for a Section 12 and be transported to Norwood ER via ambulance.

See below for detailed psychiatric emergency flowcharts regarding Client in Crisis, Riverside, and Section 12 procedures.

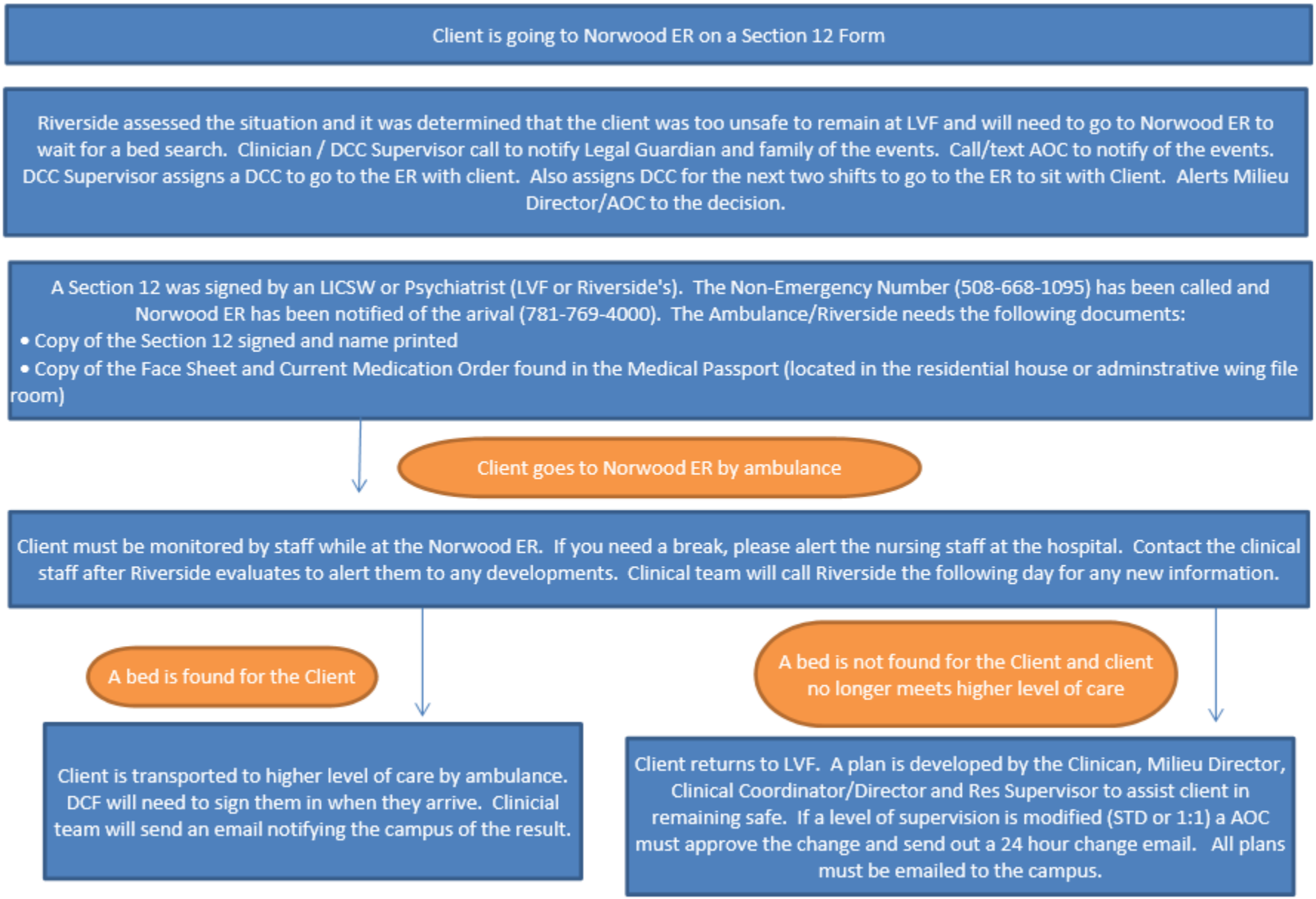
Client In Crisis



Riverside


Client is in crisis and Riverside Emergency Services has been called to screen client
Riverside assesses the situation. They will ask to meet with the client and staff who is present to find out more details on the nature of the crisis. Staff present should know about the situation or have the alert form that was made by the clinician0
Yes, Client meets higher level of care
No, Client does not meet higher level of care
Riverside will discuss situation with the clinical administrator on site or DCC Supervisor. LVF staff will discuss situation with the client and let them know Riverside's decision. Collaborative decision on if client can stay on site while a bed is found or needs to go to Norwood ER to wait for a bed
A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.
• Clinicain/DCC Supervisor will communicate the plan to LVF in an email.
• AOC will be notified of the decision through text or call.
• IGH students: A call or email is sent to IGH Director and client's school contact to alert them of the situation (CC the Clinical Team to the email).
•Notify family of the events of the night.
Client waits at LVF
Client goes to Norwood ER
Clinician/DCC Supervisor and Riverside will discuss a plan on communication. Riverside will return to their office to begin a bed search. Communication email sent to clinical staff to ensure follow up the next day.
A liscensed clinician (LICSW) or psychiatrist on site write a Section 12 form. A Clinician/DCC Supervisor will call the NON -EMERGENCY (508-668-1095) number to request an ambulance. Call Norwood ER to alert them that a client is coming in on a Section 12 (781-769-4000).
See Emergency Section 12 Flowchart
A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.

Section 12


Client is going to Norwood ER on a Section 12 Form
Riverside assessed the situation and it was determined that the client was too unsafe to remain at LVF and will need to go to Norwood ER to wait for a bed search. Clinician / DCC Supervisor call to notify Legal Guardian and family of the events. Call/text AOC to notify of the events. DCC Supervisor assigns a DCC to go to the ER with client. Also assigns DCC for the next two shifts to go to the ER to sit with Client. Alerts Milieu Director/AOC to the decision.
A Section 12 was signed by an LICSW or Psychiatrist (LVF or Riverside's). The Non-Emergency Number (508-668-1095) has been called and Norwood ER has been notified of the arival (781-769-4000). The Ambulance/Riverside needs the following documents:
• Copy of the Section 12 signed and name printed
• Copy of the Face Sheet and Current Medication Order found in the Medical Passport (located in the residential house or adminstrative wing file room)
Client goes to Norwood ER by ambulance
Client must be monitored by staff while at the Norwood ER. If you need a break, please alert the nursing staff at the hospital. Contact the clinical staff after Riverside evaluates to alert them to any developments. Clinical team will call Riverside the following day for any new information.
A bed is found for the Client
Client is transported to higher level of care by ambulance. DCF will need to sign them in when they arrive. Clinicial team will send an email notifying the campus of the result.
A bed is not found for the Client and client no longer meets higher level of care
Client returns to LVF. A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.

C. Anaphylaxis Emergency & Epinephrine Auto-injector Training

Anaphylaxis is a life-threatening health emergency. The American Academy of Pediatrics in School Health: a Guide for Health Professionals (1993) defines anaphylaxis as "an allergic reaction that may be triggered by an insect bite, a drug allergy, or a food allergy." This generalized whole-body allergic reaction requires prompt intervention, proper management, and prompt transportation to an appropriate health care facility. A client may exhibit any or all of the signs and symptoms outlined in this section within minutes of exposure to the allergen, or the reaction may be delayed for several hours after exposure to the allergen.

ANAPHYLACTIC EMERGENCY PROTOCOL

If the exposed client is known to have a severe sensitivity or severe allergic reactions to the allergen, **call 911 immediately**. Do not wait for symptoms to occur.

If the client has had a serious allergic reaction in the past, there should be a physician's order for an epinephrine auto-injector. Please note: trained staff administer the epinephrine auto-injector only with a written directive from a physician, at DPH approved programs.

- An auto-injector administered to a client must be prescribed specifically for the client, unless directed otherwise by a physician. Epinephrine is available in two different dosages and two different types of auto-injectors.
- Following administration of an epinephrine injector, the client must be taken to an emergency facility. The effects of an injection of epinephrine begin to wear off in 10-20 minutes: Therefore, it is essential to call 911 immediately. The auto-injector should be immediately capped following use and brought to the emergency facility with the client.
- Care should be taken when handling an auto-injector. Accidental injection into the hands or feet may result in loss of blood flow to the affected area and will require immediate treatment in the Emergency Room.
- Staff attending to an anaphylactic emergency will document a comprehensive description in the client's record, record the epinephrine administration on the MAR, and complete an Incident Report describing the emergency.

Nurse and Staff Responsibility in Preventing Anaphylactic Emergencies:

- If a client has been diagnosed with a history of severe allergic reaction and an epinephrine auto-injector has been prescribed by a physician, the program nurse will develop an emergency plan for the client based on the guidelines of the prescribing physician for management of the allergy. It is each staff member's responsibility to know the allergy status of each client for whom they are responsible, to be familiar with the individual plan and to follow the specific plan in an allergic emergency.
- The program nurse will notify staff of (1) the client's allergy, (2) past reactions and associated symptoms, and (3) measures to reduce exposure to the allergens in the residence, school and off-campus settings, and physician recommended responses.

- The program nurse shall be responsible, if approved by DPH, for staff delegation of proper epinephrine auto-injector administration. All direct support staff dealing with supported individuals who require assistance with epinephrine auto-injectors shall be familiar with the emergency action plan. Staff training and competency must be renewed annually. If a client has been deemed to be capable of self-administering their epinephrine auto-injector by prescribing health care provider and assessed for such, by the school nurse. The program nurse shall also ensure there is a physician's order on file for epinephrine auto-injector self-administration. The program nurse shall teach the client how to self-administer their epinephrine auto-injector and document competency. Documentation of the client's ability to self-administer their epinephrine auto-injector shall be signed by the prescribing health care provider, kept in the client's record and be readily available for reference by staff.

EPINEPRHINE AUTO-INJECTOR CURRICULUM

What is Anaphylaxis?
Anaphylaxis is one of the most serious and life-threatening medical emergency situations to which staff may have to respond. The American Academy of Pediatrics in School Health: a Guide for Health Professionals (1993) defines anaphylaxis as "an allergic reaction that may be triggered by an insect bite, a drug allergy, or a food allergy." This generalized whole-body allergic reaction requires prompt intervention, proper management, and prompt transportation to an appropriate health care facility. Anaphylaxis is always an emergency. Appropriate intervention usually results in a positive body response, while a delayed intervention can be fatal.

A person may exhibit any or all of the following signs and symptoms within a short time (within five minutes), or the reaction may be delayed for several hours. If a client is known to have a severe sensitivity and severe allergic reactions, don't wait for signs and symptoms to become worse. Call 911 immediately. Staff will follow the Emergency Guidelines in the Health Service manual to activate the emergency medical system, and to activate agency help and communication. The effects of an injection of epinephrine begin to wear off in 10-20 minutes; therefore calling 911 immediately is essential even if the client's emergency plan indicates that epinephrine may be administered.

Signs and symptoms of anaphylaxis may include any or all of the following:

Skin:	Cold to touch, may be clammy and moist, itching, hives, and swelling of lips
Color:	Pale at first, then mottled or bluish
Respiration:	Wheezy, change in voice quality due to swelling of larynx, feeling of fullness in throat, difficulty breathing, shortness of breath, breathing may cease
Pulse:	Rapid, weak
Blood Pressure:	Low, progressively lower, or unattainable

Other: Restlessness, severe headache, nausea, vomiting, diarrhea, loss of consciousness, swelling of eyelids/lips/neck, difficulty swallowing

Common causes of allergic emergencies:
Insect bites: wasps, bees, hornets, spiders, fire ants, among others
Drugs: Antibiotics and many other categories of medication
Foods: shellfish, peanuts, and many other foods
Anaphylactic shock has also been known to be triggered by exercise in some people.

Prevention of allergic emergencies:
The Home for Little Wanderers strives to provide a safe environment for all client and implements a peanut and tree nut free campus at its school and residential programs and will make efforts to be latex free for the safety of client.

To avoid insect bites:

- Cover bare skin: do not go barefoot, wearing long sleeve shirts and pants, socks in insect inhabited areas.
- Do not use scented soaps, shampoos, perfumes, etc.
- Put picnic foods in covered containers as soon as possible after eating.

To avoid drug emergencies:

- Ensure that client and all those prescribing and administering medications are informed of specific known drug allergies.
- Ensure that drug allergy information is brought to medical appointments and communicated to outside providers and to attending staff when client are seen for medical emergencies.
- All staff take responsibility for knowing about all known allergies among the client they supervise.

Role of Epinephrine Auto-Injectors (i.e. Epi-Pen):
Epinephrine is the treatment of choice for severe allergic emergencies because it quickly constricts blood vessels, relaxes smooth muscle in the lungs to improve breathing, stimulates the heartbeat, and works to reverse hives and swelling around the face and lips.
Epinephrine is available in two different dosages and two different types of auto-injectors. For client with known anaphylaxis response to an allergen, it is important to use the client's individual injector. This will be labeled with the client's name, the name of the medication, and the dose. A copy of the client's individual allergic reaction response plan will be kept with the injector at all times. The location of injectors will be accessible and known to all trained staff who provide direct care and/or accompany a client on an off-site trip. Staff responsible for taking a client on an off-site trip must be trained by the nurse in the specifics of the client's allergic response and in the use of the client's individual auto-injector, if approved by DPH. Training would include identification of:

- the right individual
- the right medication
- the right dose

- the right route and location of injection
- The right time (based on client's symptoms, and/or time since exposure to the allergen, e.g., hives spreading over the body, wheezing, difficulty swallowing or breathing, swelling in face or neck, tingling/swelling of tongue, vomiting, signs of shock such as extreme paleness/gray color, clammy skin, loss of consciousness or any other client-specific known symptoms following the client's exposure to the allergen)

The prescribing physician may instruct the client in self-administration. However, the school nurse will further assess the client's capacity with multidisciplinary input, along with feasibility in safe school health practice. Approved staff trained in epinephrine administration under nurse delegation, if approved by DPH, would still assist and observe the client as they administer the medication. The staff member holding the client's medication for the trip must be accessible and known to the client.

After use, place the auto-injector in an impermeable container, if available, and give to Emergency medical personnel to take to the hospital. Inform them of the time of injection.

How to handle and store epinephrine:
The auto-injector is quite durable but may be damaged if mishandled. The medication is stable at room temperature until the marked expiration date, it should not be refrigerated, frozen or exposed to extreme heat or sunlight. Exposure to light and heat cause epinephrine to oxidize and turn brown. Before administration, make sure that solution is clear and colorless; if brown, replace immediately. Health Services and/or trained staff should check at least monthly to be sure that the epinephrine prescription is current, and it is not expired, damaged, oxidized, and/or unusable.

Note: Accidental injection into the hands or feet may result in loss of blood flow to the affected area and will require immediate treatment by emergency services.

Client with no known allergies:
It is possible that a client with no known allergies experiences an anaphylactic reaction or that a client with previously milder response to a bee sting or other allergen develops an anaphylactic reaction. If a client previously unknown to have an allergy is displaying any of the symptoms described above, **call 911**, accurately report what you are seeing, and follow the emergency response team's suggestions for care. Ensure that you have a cell phone available for all off-site trips.

Observation of a client after exposure or possible exposure to an allergen is extremely important. Continue observation for an extended period. Observe client who report they have been bitten by an insect that may trigger an allergic reaction even if the client had not had a previous severe allergic reaction.

For any individual with no previous history of life-threatening allergic reactions, the use of epinephrine as an emergency medication requires written protocols and a written order from the school physician. Unity House will ensure that this standing order and protocol are completed,

signed, and in place. Only a nurse may administer epinephrine to a person who has no previous history of a life-threatening allergic reaction. If the school nurse is unavailable, the school must immediately activate the EMS system, provide first aid as applicable, and then notify the school nurse and the parents/guardians. Anyone who has received epinephrine treatment must be transported by trained emergency personnel to a hospital emergency facility immediately, via ambulance. Upon the client's return to school, the school nurse should develop an *Individual Health Care Plan* and ensure that a policy for the care of the client with a life-threatening allergy is in place.

Procedure for Administration of Epinephrine via Auto-Injector:

- Follow all procedures for preparation of medications for administration according to nurse delegation, if approved DPH program.
- Inform client what is being done.
- Form a fist around the pre-filled auto-injector with the tip [usually it is an orange tip] facing down and pulls off the safety cap. (NEVER put fingers over the tip)
- Place the pre-filled auto-injector device at a 90-degree angle on the outer thigh. (It is not necessary to remove clothing since the auto-injector device is designed to work through clothing.)
- With a quick motion, push the pre-filled auto-injector firmly against the outer thigh. (Hold in place and slowly count to 10 before removing needle.)
- Even though a small amount of liquid remains inside the auto-injector after use, the device cannot be used again.
- Call 911 immediately for transportation to emergency room.
- After ER personnel arrive and individual is cared for, notify client's health care provider and Health Services, and follow all emergency procedures.
- Properly dispose of the used auto-injector.
- Document administration according to nurse delegation, if approved DPH program.

D. Asthma & Inhaler Training

Overview:

I. Asthma is a disease that affects the lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medication and avoiding triggers which aggravate asthma. Removing triggers from the environment which make asthma worse can help to improve it.

II. Triggers for asthma include dust mites, tobacco smoke, outdoor air pollution, cockroach allergen, pets, mold, smoke from burning wood or grass, infection, strong emotions that lead to hyperventilation, and exercise.

III. Goals of asthma treatment focus on:
   a. Reducing impairment – the frequency and intensity of symptoms and functional limitations currently experienced by a client.
   b. Reducing risk – the likelihood of future asthma attacks, progressive decline in lung function, or medication side effects.

Asthma Action Plans:

- Describe daily treatment for controlling asthma long-term, such as what kinds of medications to take and when to take them
- Describe early signs, symptoms, and peak flow meter measurements that can indicate worsening asthma
- Describe how to give the client medications and how to manage environmental factors contributing to exacerbations
- Describe how to handle asthma attacks, including when to call the doctor or go to the emergency room and any additional notifications that should be made
- Should be developed with the client's health care provider, in partnership with the client/family
- Should be available to all the people who provide care, so that they can help the client follow the action plan

For clients who do not have an asthma action plan, general guidelines for Management of Acute Asthma Exacerbations should be followed as outlined below.

Link to Asthma Action Plan: http://www.lung.org/assets/documents/asthma/asthma-action-plan-for-home.pdf

Asthma Triggers:

- A health care provider may recommend ways to control exposures to allergens, irritants, and pollutants.

- Avoiding or limiting exposure to asthma triggers helps decrease incidence of asthma exacerbations.
- If a client has an asthma exacerbation which may be related to an asthma trigger, consider removing the client from the trigger if possible.

Types of inhaler medications:
Quick-relief asthma medicines are bronchodilators. They work by relaxing the muscles around the airways of the lungs. This helps air to flow more freely through the lungs. Quick-relief medicines are typically used to relieve symptoms when they occur. Administer the medication through inhaler within minutes to relieve sudden asthma symptoms. If it does not relieve symptoms quickly, notify health care provider immediately.

**If the inhaler medication is a corticosteroid (commonly Flovent/fluticasone):*

- *Wash mouth out with water after administration to prevent oral infection, do not swallow the water!*

Management of Acute Asthma Exacerbations:
It is essential to teach client how to monitor signs and symptoms of worsening asthma, and to take appropriate action.

- <u>Symptoms of a more serious exacerbation:</u>
    1. Marked breathlessness
    2. Inability to speak short phrases
    3. Drowsiness
    4. Increased breathing effort
- <u>Initial treatment: Give asthma medication as prescribed.</u>
    1. Good response:
        - Characterized by no wheezing, no shortness of breath, and/or rapid breathing
        - Continue to monitor the client
    2. Incomplete response:
        - Persistent wheezing, shortness of breath, and rapid breathing
        - **Call 911**
        - Follow-up with Health Services
    3. Poor response:
        - Continued marked wheezing, rapid breathing, and shortness of breath
        - **If distress is severe and non-responsive to initial treatment, Call 911**
        - Follow-up with Health Services

Follow these steps every time you use a rescue inhaler:

Step 1. Make sure the canister fits firmly in the actuator. The counter should show through the window in the actuator.

Shake the inhaler well before each spray.

Take the cap off the mouthpiece of the actuator. Look inside the mouthpiece for foreign objects and take out any you see.

Step 2. Hold the inhaler with the mouthpiece down. **See Figure C**

Step 3. Breathe out through your mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close your lips around it. **See Figure D.**

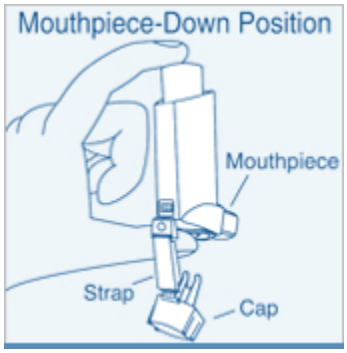
Step 4. Push the top of the canister **all the way down** while you breathe in deeply and slowly through your mouth. **See Figure D.**

Step 5. After the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth.

Step 6. Hold your breath for about 10 seconds, or for as long as is comfortable. **Breathe out slowly as long as you can.**

If your health care provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat Steps 2 through Step 6.

Step 7. Put the cap back on the mouthpiece after every time you use the inhaler. Make sure it snaps firmly into place.



E. Diabetes Mellitus Training

What is Diabetes?

- In diabetes, the body does not make or properly use insulin. Insulin is needed to move glucose from blood into cells for energy.
- If insulin isn't working on the body's cells or there is not enough of it, high blood glucose results with symptoms of low energy, dehydration, and other complications.

Definitions:

- *Glucose* - simple sugar found in the blood; fuel that all body cells need to function
- *Carbohydrate* - source of energy for the body which raises blood glucose level; includes bread, rice, pasta, potatoes, vegetables, fruit, sugar, yogurt, and milk
- *Quick-acting glucose* - sources of simple sugar that raises blood glucose levels, like juice, regular soda, glucose tabs or gel, hard candy
- *Glucose tablets or gel* - special products that deliver a pre-measured amount of pure glucose, they are a fast-acting form of glucose used to counteract hypoglycemia
- *Glucagon* - hormone given by injection that raises level of glucose in the blood
- *Hypoglycemia* - a LOW level of glucose in the blood
- *Hyperglycemia* - too HIGH a level of glucose in the blood
- *Ketones (ketone bodies)* - Chemicals that the body makes when there is not enough insulin in the blood and the body must break down fat for its energy
- *Diabetic ketoacidosis (DKA)* - An acute metabolic complication of diabetes characterized by excess acid in the blood which can be life threatening
- *Ketone testing* - a procedure for measuring the level of ketones in the urine or blood

Type 1 Diabetes:

- Autoimmune disorder where insulin producing cells are destroyed and daily insulin replacement is necessary
- Most common type of diabetes in children and adolescents
- Onset: relatively quick, usually childhood or young adulthood
- Symptoms: increased urination, tiredness, weight loss, increased thirst, hunger, dry skin, blurred vision
- Cause: uncertain, but both genetic and environmental factors are involved

Type 2 Diabetes:

- Over time the body's ability to properly use insulin deteriorates or the body fails to produce sufficient amounts of insulin, known as insulin resistance
- Age at onset: most common in adults but increasingly common in client

    - Risk factors: Being overweight, inactivity, genes, ethnicity
- Symptoms: tired, thirsty, hunger, increased urination
    - Some are symptomatic with very high blood glucose levels
- Cause: The pancreas is not able to make enough insulin to meet the body's needs, which can be related to being overweight, not getting enough exercise, a genetic predisposition, or ethnicity.

SIGNS, SYMPTOMS, AND EMERGENCY MANAGEMENT

High blood sugar: Hyperglycemia

- *Signs & Symptoms*
    - Severe: Labored breathing, confusion, profound weakness, unconsciousness
    - Moderate: Dry mouth, stomach cramps, vomiting, nausea
    - Mild: Lack of concentration, thirst, frequent urination, flushing of skin, sweet-fruity breath odor, weight loss, stomach pains, blurred vision, increased hunger, fatigue/sleepiness
- *Onset*
    - Usually slow to develop severe levels
    - More rapid with pump failure/malfunction, illness, infection
    - Can mimic flu-like symptoms
    - Greatest danger: may lead to diabetic ketoacidosis (DKA) if not treated
- *Risks & Complications*
    - If left untreated, hyperglycemia can lead to DKA (diabetic ketoacidosis), and potentially to coma/death
    - May interfere with a client's ability to participate in daily routines and activites
    - Serious long-term complications may develop when glucose levels remain above target range over time or recur
- *Possible Causes*
    - Late, missed, or too little insulin
    - Food intake exceeds insulin coverage
    - Decreased physical activity
    - Expired or improperly stored insulin
    - Illness, injury
    - Stress
    - Other hormones or medications
    - Hormone fluctuations, including menstrual periods
    - Any combination of the above

- *Prevention*
    - Follow *Diabetes Action Plan* as recommended by the client's health care provider (see Appendix)
    - TIMING is very important. Client should be encouraged to stick to schedules:
        - Meal time, insulin administration, physical activity
    - ACCURACY is very important.
        - **If client will have the responsibility for blood glucose monitoring, they must be proficient and approved for self-monitoring.** Inaccurate monitoring of blood glucose levels and/or inaccurate use of insulin can lead to an emergency situation.
        - Results of glucose monitoring should be documented and reported to the client's health care provider as indicated in their *Diabetes Action Plan*.
- *Hyperglycemia: What to do*
    - Goal: Lower the blood glucose levels to target range
        - If client exhibits **signs of severe hyperglycemia (unconsciousness, labored breathing, confusion) call 911**
        - If client exhibits **signs of moderate-severe hyperglycemia, or you are not sure, contact Health Services**
        - Action steps will follow client's *Diabetes Action Plan*, which may include:
            - Verify high blood sugar with blood glucose check.
            - Check ketones in urine
            - Allow free use of bathroom and access to water
            - Administer insulin per client's individual health care protocol
            - Recheck blood glucose per client's individual health care protocol
            - Client self-monitoring blood glucose should be encouraged to keep journal of blood glucose levels.

Low blood sugar: Hypoglycemia

- *Signs & Symptoms*
  - Mild: Hunger, shakiness, weakness, paleness, blurry vision, sleepiness, changes in behavior, sweating, anxiety, dilated pupils, increased heart rate or palpitations
  - Moderate to severe: Yawning, irritability/frustration, extreme tiredness/fatigue, inability to swallow, sudden crying, confusion, restlessness, dazed appearance, unconsciousness/coma, seizures
- *Onset*
  - Sudden, must be treated immediately
  - May progress to unconsciousness if not treated
  - Can result in brain damage or death
- *Risks & Complications*
  - Early recognition and intervention can prevent an emergency
  - Greatest immediate danger
  - Not always preventable
  - Impairs cognitive and motor functioning
- *Possible Causes*
  - Too much insulin
  - Too little food or delayed meal or snack
  - Extra/unanticipated physical activity
  - Illness
  - Medications
  - Stress
- *Prevention*
  - Timing is very important in all aspects of diabetes management
  - Physical activity, insulin, eating, checking BG, should all be per schedule
  - Client should always have a quick-acting sugar source with them
  - Treat at onset of symptoms
  - Ensure reliable insulin dosing, per client's health care protocol
  - Ensure insulin dosing matches food eaten
- *Mild/Moderate Hypoglycemia: What to do*
  - Seek assessment from Health Services
  - Follow the client's *Diabetes Action Plan*
  - Client checks blood glucose using proper blood glucose monitoring meter technique
  - When in doubt, always treat. Untreated may progress to more serious events.
  - "Rule of 15":
    - Have client eat or drink fast acting carbs (15g)

        - 15g Carbohydrate: 4 oz fruit juice, 15g glucose tablet, 1 tube glucose jel, 4-6 hard candies, 1-2 tablespoons of honey, 6 oz (half a can) regular soda, 3 tsp table sugar
        - Limit to 15 g or the client will experience high blood glucose level
    - Check blood glucose 10-15 minutes after treatment
    - Repeat treatment if blood glucose level remains low or if symptoms persist.
    - **If symptoms continue, call 911**
- *Severe Hypoglycemia: What to do*
    - Symptoms include convulsions (seizures), loss of consciousness, inability to swallow
    - **HYPOGYLCEMIC EMERGENCY**
        - **Call 911 and notify Health Services**
        - Place client on their side.
        - Lift chin to keep airway open.
        - Follow Diabetes Action Plan or client's health care protocol.
        - NEVER give food or put anything in client's mouth.
        - Client should respond in 10-20 minutes after treatment.
        - Remain with client until help arrives.
        - If the client is awake and able to swallow, give juice or other quick acting form of glucose followed by snack while waiting for EMS. *If you are not sure, do not put anything in the client's mouth!

BLOOD GLUCOSE MONITORING

Overview

- *Goal*: maintain blood glucose within target range
- *Challenge*: Many variables impact blood glucose
    - Include insulin, food, activity, stress, and injury.
- *Using glucose monitoring as a tool:*
    - Know the client's established parameters. This should be clearly identified in the client's individual health care protocol, if applicable
    - When parameters are indicated they must be specific, written parameters that are obtained from the client's health care provider

Rationale

- TIMING is very important in the management of diabetes.
- Blood glucose monitoring as recommended by a health care professional is the best way to control diabetes and avoid high or low blood sugars and long-term complications.
- *Immediate benefit*: identification, treatment, and prevention of lows and highs
- *Long-term benefit*: decrease risk of long-term complications, maximize health

Safe Glucose Monitoring Procedure for Trained Staff:

- Any change in health care provider order for glucose monitoring requires a review.
- A copy of the manufacturer's requirements for the glucometer being used for the client's glucose monitoring must be available for staff reference.

Blood Glucose Monitoring: Approved Client

1. Gather blood glucose monitoring supplies: lancet, test strip, meter.
2. Wash hands and dry them thoroughly.
3. Turn the meter on if necessary. Some meters turn on automatically when the strip is inserted.
4. Check code number that appears on meter with the code number found on the container of the test strips. Correct meter code if codes do not match.
5. Insert a strip into the meter (some meters turn on automatically when the strip is inserted).
6. Hold the lancet device to the side of the finger and press the button to stick the finger. Use the side of the finger, as the tip and pad of the finger have more sensitive nerve endings. Express an adequate drop of blood.
7. Apply small amount of blood to end of strip.
8. Wait until blood glucose level is displayed on the meter.

9. Dispose of lancet and strip in biohazard sharp container.
10. Record blood glucose result and take action per client's *Diabetes Action Plan* and Health Care Provider parameters.

Importance of gloves, clean technique and proper hand washing:

- Infection control requirements (CDC, 2016):
    - Fingerstick devices should never be used for more than one person.
    - Whenever possible, blood glucose meters should not be shared.
        - If they must be shared, the device should be cleaned and disinfected after each use.
    - Insulin pens and other medication cartridges and syringes are for single-patient-use only and should never be shared.
    - Used lancet and strips should be disposed of in a biohazard sharp container which is kept in a secured location.

F. Opioid Overdose & Nasal Naloxone Training

In the midst of the opioid overdose epidemic in the Commonwealth of New Hampshire, HLW recognizes that safe and effective management of opioid pain reliever or narcotic related overdose preparedness is necessary to avoid preventable opioid-related deaths. Every effort to prevent clients from misusing opiates will be made. Intra-nasal Narcan may prevent opioid related deaths when used properly in the event of an opiate or narcotic related overdose. When administered quickly and properly, Naloxone may restore breathing and save lives. Naloxone has no potential for abuse and has been used by paramedics in ambulances and in emergency rooms for decades (mass.gov). Use of Naloxone shall be implemented in emergency response protocols at HLW. Naloxone is not a controlled substance but does require a prescription under New Hampshire Law.

In accordance with New Hampshire Law Ch. 192 of the Acts of 2012:

- A person acting in good faith may receive a Naloxone prescription, possess Naloxone and administer Naloxone to an individual appearing to experience an opioid-related overdose.
- Naloxone may lawfully be prescribed and dispensed to a person at risk of experiencing an opiate-related overdose, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
- New Hampshire Law stipulates that a bystander or victim of an overdose cannot be charged with "possession of a controlled substance" if they seek medical attention during an overdose.

In the school setting (105 CMR 210, M.G.L. 71:54B, M.G.L. C. 94C, 19(d)):

- Given a protocol signed by the school physician, a school nurse may administer nasal naloxone to individuals who experience a life-threatening overdose in the school setting. Stock supplies of nasal naloxone may be maintained by the school nurse for this purpose.
- All nurses in all practice settings, including schools, as part of their professional responsibility may teach individuals to administer nasal naloxone in the school setting. The school nurse may manage the training program with full decision-making authority, in consultation with the school physician, in DPH approved programs.
- Nasal naloxone may be stored in any school building in an area that is secure but not locked during those times when nasal naloxone is most likely to be administered, as determined by the school nurse.

The HLW opioid overdose prevention plan is developed from the New Hampshire Department of Public Health Opioid Overdose Education and Narcan Distribution Core Competencies for Naloxone: Core Competencies.

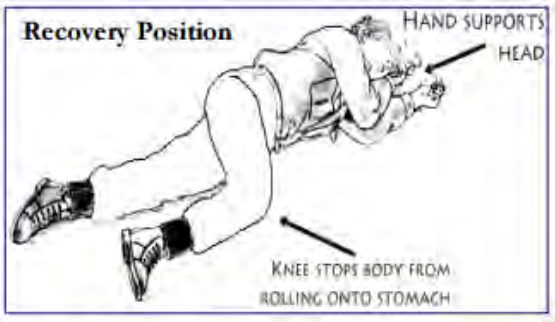
PROTOCOL FOR MANAGEMENT OF OPIOD OVERDOSE

First, determine if the person may be overdosing:

1. Signs of overdose include:
    a. Pale, clammy skin
    b. Very infrequent or no breathing
    c. Deep snoring or gurgling
    d. Not responsive to shaking, yelling, sternal rub, or other stimuli
        i. A person may not respond when you yell their name
    e. Slow heart beat/pulse
    f. Blue lips/fingertips

Then, respond:

1. Call 911 and follow general emergency protocol.
2. Perform CPR
3. Administer Naloxone (Narcan)
    a. Naloxone may work immediately or can take up to 8 minutes to take effect. Effects last for 30 to 90 minutes. Always call 911 before or after administering Naloxone.
4. Place the person in recovery position



5. Stay with the person until help arrives.

Do Not:

1. Put the victim in a bath, they could drown.
2. Do not induce vomiting. The person may choke.
3. Do not give the victim anything to drink. They may choke.
4. Do not put ice down the victim's pants or attempt to cool down their temperature.
5. Do not try to stimulate the victim in a way that may cause harm (slapping hard, kicking the testicles, burning the bottom of the feet, etc.)
6. Do not inject the victim with anything.

Possible Side Effects of Naloxone:

- Hypersensitivity (rash, worsening difficulty breathing, anxiety) is rare.
- Too much naloxone can cause withdrawal symptoms such as: anxiety, runny nose and eyes, chills, muscle discomfort, disorientation, combativeness, nausea/vomiting, diarrhea.

For further information, refer to the Protocol, Procedures, and Standing Medical Orders for the Administration of Naloxone (see Appendix).

G. Do Not Resuscitate / Comfort Care

The New Hampshire Department of Education in consultation with Department of Public Health Legal Office has promulgated a Guideline for the care of clients with Comfort Care/Do Not Resuscitate Orders. This Guideline reads as follows:

Purpose: Client with terminal illnesses are attending school in increasing numbers. As the status of a client's health declines, a family may make the difficult decision not to prolong the client's life and request a "Do Not Resuscitate" order (DNR). A DNR order is executed by a physician, authorized nurse practitioner, or authorized physician assistant, with the consent of the parent or legal guardian, and issued according to the current standard of care.

Scope: Client attending a HLW school who have a "Do Not Resuscitate" or "Comfort Care" order. If a client has a DNR order, a physician can submit a Comfort Care/DNR Order Verification to the Office of Emergency Medical Services in the New Hampshire Department of Public Health and obtain a Comfort Care form and an identifying bracelet.

Comfort Care identification (either the bracelet or the fully executed original form) is the only authorized way for pre-hospital emergency care providers (EMTs, first responders) to recognize a patient with a current, valid DNR order. EMTs and first responders called to a school will honor a DNR only if the client has a Comfort Care identification. Without a Comfort Care bracelet or original form, EMTs and other first responders who are called to a school will provide emergency treatment, including resuscitation, in accordance with standard EMS protocols, and transport to a hospital. The following website provides further information: http://www.mass.gov/dph/oems/comfort/ccprot2a.htm.

1. Special consideration must be given to meeting client and family needs, as well as the needs of the client and staff.
2. The client should be placed only in a school that has a full-time school nurse.
3. The local emergency medical services should be informed (with written permission from the parent or guardian) that there is a client in the specific building with a DNR/Comfort Care order.
4. An individualized care plan should be developed with the family in collaboration with the client's physician and the school physician. It should include:
   (a) how the client will be moved to the health room or other designated area if serious distress or death should occur at another location in the school;
   (b) What, if any, comfort measures should be given to the client;
   (c) Protocols for notification of the family; and, if the client has died in school;
   (d) Who will do the pronouncement of death (physician, nurse practitioner, or physician assistant)[1];
   (e) how the deceased will be removed from school. This may involve planning with the family's designated funeral home and include such factors as type of vehicle, where it will park, who will clear the corridors, and what kind of stretcher or other method of transport will be used. (Please note: by law, EMS providers are not permitted to move the deceased.)

5. The plan should also address what will happen if the client is in distress but does not appear to face an imminent risk of death. The response should include immediate consultation with the parents and, consistent with the plan, contact with the local EMS provider. If EMS is called, and the client has a Comfort Care bracelet or form, the EMT or first responder can provide comfort care and transport to a hospital. The type of care that EMS is able to provide in this situation is spelled out in the Comfort Care Protocol, available on the above-referenced website.
6. When a plan is in place, the school nurse should convey the plan to the appropriate school staff and administrators, answering any questions that they may have.
7. Whenever a death occurs in the school, the crisis team must be activated immediately to assist the family, staff and other client to cope with the loss. Special consideration must be made for any other client or staff who witnesses the death especially, if (per DNR orders) no treatment was performed either by school staff or EMS. Questions such as, "What if this happens to me?" and "Will they do anything for me?" may need to be addressed.

[1]Nurse practitioner (NP) and physician assistant (PA) pronouncements function as "removal permits" thereby allowing the deceased to be removed from the school grounds by a funeral director. However the NP or PA who pronounces the death must (a) before the pronouncement, try to reach the attending doctor so that the doctor can declare the death and complete the death certificate, and (b) after the pronouncement, notify the attending doctor as to the location to which the body has been removed so that the physician can complete the death certificate. State law (M.G.L. Chapter 46, section 9) requires that a physician or the medical examiner complete the death certificate.

VI. Prevention and Control of Communicable and Infectious Disease

All HFW staff are trained in infection control procedures. Any client or staff member who contracts a communicable disease will receive authorization from their physician to continue to be present at the program. The program notifies all parents/guardians and referring agencies of the reported communicable disease within the program. Also, the local board of health is notified in accordance with M.G.L. c. 111, §111. Criteria for exclusion from work and school is outlined in the attached section from the health care manual (see Appendix).

A. Preventing the Spread of Infectious Disease

Purpose: To reduce the risks of acquiring and transmitting infectious disease among clients, families, employees, volunteers, and visitors of The Home for Little Wanderers (HLW).

Statement of Policy: Infection control is a shared responsibility requiring cooperative effort, which is undertaken by all services/areas for the safety and well-being of all in the HLW environment. It is undertaken in keeping with the best practice guidelines of monitoring, regulatory, and accrediting agencies.

HLW ensures surveillance, analysis of risk, and implementation of prevention and control strategies to break the chain of transmission of infectious disease.

HLW ensures that while in its care, client will receive appropriate medical care throughout the course of the illness and will be referred for professional diagnosis and treatment as needed.

HLW is aware of, and in compliance with, laws and regulations governing confidentiality of infectious disease status.

B. Procedure for Preventing the Spread of Communicable Diseases

General Procedures:

The Home will maintain all policies, procedures, and medical records regarding communicable diseases in a manner which is consistent with requirements of local, state, and federal law.

The Home does not mandate communicable disease testing of client. If a client or parent/legal guardian requests testing or the treatment team recommends testing due to high risk behaviors, the client will receive counseling concerning communicable disease assessment and requested testing.

If a client or parent/legal guardian discloses communicable disease information about themselves or their child,

- The person to whom information is disclosed may encourage the client or parent/legal guardian to sign a release form allowing information to be shared with the client's treatment team. The members of this team have direct accountability and responsibility for the treatment and physical care of the client.
- For all DCF referred clients, the DCF social worker is considered part of the treatment team. It is the practice of The Home to work cooperatively with DCF regarding any client concerns, including any communicable disease related information, once the client or parent/legal guardian has given permission.
- If the client would prefer to designate specific people with whom the information can be shared, this shall be noted on the release form.

Infectious Disease:

1. If a case of infectious disease is expected or diagnosed, staff will implement appropriate infectious disease precautions. Among the symptoms which may indicate, and which may need to be evaluated for diagnosis of an infectious disease are: sore throat, fever, weeping or bloody skin or mouth sores, nausea, and/or vomiting, bloody or explosive diarrhea, unexplained rash, unexplained swelling, unexplained redness of the eye and persistent, painful or deep coughing. Infectious disease precautions will vary based on the type and severity of the illness. In all situations attention to handwashing will be observed. In diseases requiring isolation, every possible attempt should be made to eliminate direct contact with others during the period of communicability. Isolation shall include the least restrictive measures which will prevent the spread of disease while also addressing a client's emotional well-being. Infected client's eating utensils, bedding and bathing materials, etc. will be kept separate from others. Common diseases requiring isolation include chicken pox, hepatitis, meningitis, tuberculosis, salmonellosis, scarlet fever, and strep throat.

2. Client may not attend school and after school programs during the communicable stage of the illness.

3. Following a diagnosis of strep throat, conjunctivitis, or other contagious illness requiring antibiotic treatment, the client must be on the antibiotic for a minimum of 24 hours before returning to school, after-school programs, and close interaction with others.

4. Staff will make every attempt to ensure that separating a client from others is done in a way that considers the emotional needs of the client.

C. Practice Guidelines Dismissal from School Protocol

If a client exhibits signs or symptoms of illness, staff shall notify Health Services for further instruction. The Program nurse may exclude a client from school for health reasons if the client:

- Has a temperature of 100.5 degrees or greater. Temperature must be 98.6 for a full 24 hours prior to returning to school.
- Has an infectious disease (Strep Throat/Pneumonia, etc.) and has not been on antibiotic therapy for 24 hours or as designated by MD.
- Eye drainage yellow/green in color with pink or red eyes, eyelids, etc.
- Any undiagnosed rash.
- Has a culture(s) pending (exceptions can be made at the discretion of the nurse).
- Has Chicken Pox/Shingles, with active, draining rash (rash must be dry, non-weeping, and shingles must be covered). Clients may attend school with poison ivy as it is not contagious. It should be washed thoroughly and covered.
- Has had persistent vomiting and diarrhea; must be symptom free for 24 hours before returning to school.
- Has a condition requiring immediate medical intervention, i.e., emergency dental care, sutures, bone setting, or pending a medical diagnosis for any condition.
- Has a condition that requires on-going supervision, which cannot be supervised in the school setting.
- Is very sleepy or is experiencing excessive bleeding after a dental visit.
- Has untreated Pediculosis, Scabies or body lice.
- Poses a significant health risk to others in the normal course of school activities.

Significant health risk is defined by:

- Any client is in the infectious stage of a serious airborne transmitted disease (T.B., Viral Pneumonia, Influenza, etc.).
- Clients who are unable to hygienically manage their bowel and bladder functions and/or are in the infectious stage of an oral/fecal transmitted disease. Such diseases are, but are not limited to, Hepatitis A, Clostridium Difficile (c-diff), gastro-intestinal viruses (Salmonella, Shigella, Rotovirus) and parasites (Pinworms, Girdiasis.) and has not completed treatment.
- Clients who have a disease which may be transmitted by body fluids, and have open lesions and whose developmental level makes it difficult for them to refrain from touching lesions and others, therefore, spreading the underlying infection to others. Such diseases are, but not limited to, Herpes, Impetigo, Hepatitis B virus, Staph Aureus, Beta Hemolytic Strep, and Conjunctivitis.

D. Practice Guidelines for Client Returning to Work and School

In the interest of promoting the health and well-being of all client, there may be some cases when a client's illness or symptoms prevent them from attending school or work. The *Practice Guidelines for Client Returning to Work and School* (see Appendix) outlined below includes common symptoms and infectious diseases and criteria for exclusion.

Clients should not come to school if they are ill. General guidelines for return to school or work after illness include:

- Fever free for 24 hours, without medication
- No vomiting or diarrhea within 12 hours
- 24 hours on antibiotic prescription for conditions such as, but not limited to, strep, impetigo, conjunctivitis, ringworm, scabies

Client and staff may return to work or school when the individual conditions are met, as outlined in chart. In addition, a physician's note is required before return following surgery, concussion, hospitalization, rash with unknown origin, fracture, or sprain.

E. Reportable Infectious Disease and Response

Infectious diseases outlined in the Appendix noted with an asterisk (*) are Reportable by Health Care Providers under the New Hampshire Department of Public Health 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements. Suspected or confirmed cases should be reported to the local board of health; or if unavailable the New Hampshire Department of Public Health promptly (within 24hours). See Appendix regarding reportable. This includes both suspected and confirmed cases.

Refer to the New Hampshire Department of Public Health website for the most up-to-date information:
https://www.mass.gov/files/documents/2016/07/vo/rprtbldiseases-hcp.pdf

Animal bites should be reported immediately to the designated local authority.

F. Handwashing

Clean Hands Save Lives!

Keeping hands clean is one of the most important steps we can take to avoid getting sick and spreading germs to others. It is best to wash your hands with soap and clean running water for 20 seconds. However, if soap and clean water are not available, use an alcohol-based product to clean your hands. Alcohol-based hand rubs significantly reduce the number of germs on skin and are fast-acting.

When washing hands with soap and water:

- Wet your hands with clean running water and apply soap. Use warm water if it is available.
- Rub hands together to make a lather and scrub all surfaces.
- Continue rubbing hands for 20 seconds. Need a timer? Imagine singing "Happy Birthday" twice through to a friend!
- Rinse hands well under running water.
- Dry your hands using a paper towel or air dryer. If possible, use your paper towel to turn off the faucet.

Remember: If soap and water are not available, use alcohol-based gel to clean hands.

When using an alcohol-based hand sanitizer:

- Apply product to the palm of one hand
- Rub hands together
- Rub the product over all surfaces of hands and fingers until hands are dry

Always wash your hands:

- Before preparing or eating food
- After going to the bathroom
- After changing diapers or assisting a child who has gone to the bathroom
- Before and after tending to someone who is sick
- After blowing your nose, coughing, or sneezing
- After handling an animal or animal waste
- After handling trash
- Before and after treating a cut or wound

Information provided by: http://www.cdc.gov/cleanhands

G. Standard Precautions

Standard Precautions should be used for the care of all client, regardless of their diagnosis or presumed infection status.

Standard precautions apply to:

1. Blood
2. All bodily fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood
3. Non-intact skin
4. Mucous membranes.

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

Standard precaution measures include use of:

1. Hand washing
2. Appropriate personal protective equipment such as gloves, masks, and/or face shields whenever touching or exposure to client's bodily fluids is anticipated.

Plan for Infection Control

All staff will be trained in infection control procedures upon employment. Handwashing is the first line of defense against the spread of infections. The School shall ensure that staff and client wash their hands with liquid soap and running water using friction. Hands shall be dried with individual disposable towels.

Staff and client shall wash their hands at the following times:

- Before eating or handling food
- After using the toilet
- After coming in contact with blood or any other potentially infectious body fluids
- After handling any animals or their equipment at the School
- After cleaning
- Before giving any medications or providing First Aid Care

Standard Precautions

1. All blood and body fluids will be treated as if they were potentially infectious.
2. Latex or vinyl gloves will be worn by all staff when they come in contact with blood or body fluids. Specifically, gloves will be worn during toileting and when administering First Aid.

3. Gloves will be made available to all staff at all times. Whenever a staff person is outside the building with client, gloves will be readily available, either in a First Aid kit present in the immediate area or in the possession of the staff person.
4. If a staff member has an allergy to a specific type of glove, the program will provide another type of glove to ensure the staff member's safety without causing an allergic reaction. Gloves will never be reused and will be changed between client. Handwashing will always occur when gloves are removed.
5. Proper disposal of infectious materials is required. Any disposable materials that contain liquid, semi-liquid or dry, caked blood will be double bagged and disposed of separately from the regular trash. Biohazard containers are not necessary in the school.
6. Cloth items that come into contact with blood or body fluids will be double bagged and sent to be laundered.
7. Staff members will have a change of clothes on site in case their clothing becomes contaminated.
8. Each staff member will be trained in Standard Precautions Procedures upon employment and then annually.
9. The school will have an exposure control plan.
10. Any blood spill will be cleaned up by first using a disposable absorbent material* and then disinfecting the area thoroughly with a bleach solution. All materials will be thrown away using the double bagging method. Employees will wear gloves during this procedure and thoroughly wash their hands after removing the gloves.
    ** a commercial blood spill kit or disposable paper towels will be accepted for this procedure*

H. Maintaining Continence and Personal Hygiene

Some client will need help with managing continence and related hygienic needs while at school. Client who have social, emotional, cognitive or physical disabilities may be partially or totally dependent for all hygiene needs. IEP and treatment teams will determine clear plans for client, that meet individualized hygiene needs, and promote independence when possible.

Staff working with client with continence or other hygiene needs may be involved with:

- Changing clothing or disposable hygiene textiles (DHT), such as sanitary napkins, tampons, incontinence products, panty shields, or wipes
- Bathing or showering client
- Transferring and positioning client
- Cleaning client after a bladder or bowel movement
- Cleaning and disinfecting bathroom or change areas
- Appropriately disposing of DHT or laundering clothing
- Providing both verbal and/or physical prompting

General Principles

1. The client's treatment and educational teams will assess the client's need on a case-by-case basis to support with related individualized planning. Where possible, client should contribute to their own personal hygiene plan with their personal preferences and needs being noted. All written plans will include procedures for the client's personal hygiene routine and assistance with DHT; disposal of DHT or laundering of clothing; and FERPA compliant protections of client privacy.
2. All staff involved in personal hygiene procedures should be trained in standard universal precautions. The nurse provides oversight for implementation of these procedures. There should be sufficient staff available to ensure the safety of client and staff to meet the needs of the individual personal hygiene plan.
3. Spare clothes and DHT will be in a designated closet with a private space available to change if needed.
4. Scheduled personal hygiene routine times will be established throughout the day.
5. Each client will also have accessibility to completing their personal hygiene routine immediately when necessary. Client level of assistance will be described in their individualized plan along with plans for increasing independence as appropriate.
6. Staff must wear gloves while assisting client with their personal hygiene routine and dispose of the gloves immediately when finished. Staff will ensure routine is completed in a safe and private location.
7. Disposable wipes will be used for personal hygiene.

8. Before and after assisting client with their personal hygiene routine, staff must wash or sanitize their hands. Prior to use of latex gloves, allergies will be determined to protect client against exposure to latex when allergies are present.
9. Clothing, DHT and gloves that are soiled by feces, urine, vomit, or blood must be double bagged and disposed of or washed separately.
10. Staff and client must wash hands after completing personal hygiene tasks.

I. Disposal of Waste

Disposal Procedure & Cleaning Precautions for Regulated Waste:
Regulated waste must be disposed of according to federal, state, and local regulations. All body fluid spills should be cleaned up quickly to help protect clients, staff and visitors from potential infections and to ensure we have a safe environment. All spillages of body fluids and material used during the cleanup should be treated as 'regulated waste' and disposed of appropriately. Red biohazard bags should be used to dispose of waste and should be securely tied/sealed and disposed of in the Biohazardous bin. The bin is located in the Health Service Office in the Main School on the 3rd floor. Each primary container shall: (1) Be marked prominently with the universal biohazard warning symbol and the word "Biohazard" in a contrasting color; and (2) Be secured so as to prevent leakage and to preclude loss of contents during handling, storage, and/or transport. Discretion should be used to determine when red bags are ready for disposal.

Regulated waste is removed from HLW by contracted company, Stericycle Inc. 855-408-1982

Sharps:
Discarded medical articles that may cause puncture or cuts, including, but not limited to, all needles, syringes, lancets, pen needles, pipettes, broken medical glassware/plasticware, scalpel blades, suture needles, dental wires, and disposable razors used in connection with a medical procedure. Sharps shall be segregated from other wastes and aggregated immediately after use in red, leakproof, rigid, puncture-resistant, shatterproof containers that resist breaking under normal conditions of use and handling, and that are marked prominently with the universal biohazard warning symbol and the word "Biohazard" in a contrasting color. A sharps container may be removed when the container is filled. The closed container must be placed inside of the red-bag lined box.

Sharps are removed from HLW by contracted company, Stericycle Inc. 855-408-1982

Medications:
Discontinued or outdated medications are returned to the parent. If not picked up within one week, medications may be destroyed with the destruction recorded by supervisor with DPH, Drug Control Policy.

Non-Regulated Waste (DHT products):
Body waste products such as urine and feces without blood are not considered regulated waste. Waste such as disposables containing non-fluid blood (i.e.: soiled sanitary napkins, dressings, gauze and cotton balls with a small amount of dried blood or other body fluids) are not regulated waste. These can be disposed of in plastic bags with regular garbage.

VII. Medication Administration

A. Practice Guidelines for the Administration of Medication

This guideline outlines regulations put in place by the New Hampshire Department of Public Health and the policies adopted by the Home for Little Wanderers Board of Directors regarding the administration of prescription medications in school. The HLW Board of Directors approves the following policies under its jurisdiction. Consent forms, medication protocols, and other pertinent information are available in the Health Services office.

Unity House will not assume any responsibility for clients not in compliance with these policies. Any questions regarding medication in school should be referred directly to Health Services.

I. Management of the Medication Administration Program 105 CMR 210.003

A. The school nurse shall be the supervisor of the prescription medication administration program in the school.

B. The school nurse and the school physician/consultant shall develop and propose to the HLW Board of Directors, policies and procedures related to the administration of prescription medications.

C. Medication Orders/Parental Consent

1. The school nurse shall ensure that there is a proper medication order from a licensed prescriber which is renewed as necessary, including the beginning of each academic year. Only the school nurse shall receive a telephone order or any change in medication (see Appendix). Any such verbal order must be followed by a written order within three school days. Whenever possible, the prescription medication order shall be obtained, and the medication administration plan, specified in 105 CMR 210.005(E), shall be developed before the client enters or re-enters school. Any change of medication, dosage, or frequency must be authorized by a new order. No medications will be administered without a current order.

    a. In accordance with standard medical practice, a prescription order from a licensed prescriber shall contain: (see Appendix)
        1) The client's name
        2) The name and signature of the licensed prescriber and business and emergency phone numbers
        3) The name, route and dosage of medication

4) The frequency and time of administration
5) The date of the order and the discontinuation date
6) A diagnosis and any other medical condition(s) requiring medication, if not a violation of confidentiality or if not contrary to the request of a parent, guardian or client to keep confidential
7) Specific directions for administration

b. Every effort shall be made to obtain from the licensed prescriber the following additional information, if appropriate:
   1) Any special side effects, contraindications and adverse reactions to be observed;
   2) Any other medications being taken by the client;
   3) The date of return visit, if applicable.

c. Special Medication Situations
   1) For short-term prescription medications, i.e., those requiring administration for ten school days or fewer, the pharmacy-labeled container may be used in lieu of a licensed prescriber's order. If the nurse has a question, she may request a licensed prescriber's order.
   2) For "over-the-counter" medications, i.e., Non-prescription medications, the school nurse shall follow the Board of Registration in Nursing's protocol regarding administration of over-the-counter medications in schools.
   3) Investigational new drugs may be administered in the schools with
      a) A written order by a licensed prescriber,
      b) Written consent of the parent or guardian, and
      c) A pharmacy-labeled container for dispensing. If there is a question, the school nurse may seek consultation and/or approval from the school physician/consultant to administer the medication in the school setting.

2. The school nurse shall ensure that there is a written authorization by the parent/guardian (see Appendix) which contains:
   a. the parent/guardian's printed name, signature and a home and emergency phone number
   b. a list of all medications the client is currently receiving, if not a violation of confidentiality or contrary to the request of the parent, guardian, or client that such medications not be documented
   c. approval to have the school nurse, or school personnel designated by the school nurse, administer the medication

d. persons to be notified in case of a medication emergency, in addition to the parent or guardian, and licensed prescriber

D. Medication Administration Plan (see Appendix)

1. The school nurse, in collaboration with the parent or guardian whenever possible, shall establish a medication administration plan for each client receiving a prescription medication. Whenever possible, a client who understands the issues of medication administration shall be involved in the decision-making process and his/her preferences respected to the maximum extent possible (The Department of Education Guidelines require client consent for the 18-21 age group and client participation in planning age 14, if appropriate). If appropriate, the prescription medication administration plan shall be referenced in any other health or educational plan developed pursuant to the New Hampshire Special Education Law (Individual Education Plan under Chapter 766) or federal laws, such as the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

2. Prior to the initial administration of the medication, the school nurse shall assess the client's health status and develop a medication administration plan which includes:
   a. the name of the client
   b. an order from a licensed prescriber, including business and emergency telephone numbers
   c. the signed authorization of the parent or guardian, including home and business telephone numbers
   d. any known allergies to food or medications
   e. the diagnosis, unless a violation of confidentiality or the parent, guardian client requests that it not be documented
   f. the name of the prescription medication
   g. the dosage of the medication, frequency of administration and route of administration
   h. any specific directions for administration
   i. any possible side effects, adverse reactions or contraindications
   j. the quantity of medication to be received by the school from the parent or guardian
   k. the required storage conditions
   l. the duration of the prescription
   m. the designation of unlicensed school personnel, if any, who will administer the medication to the client in the absence of the nurse, and plans for back-up if the designated persons are not available

n. plans, if any, for teaching self-administration of the prescription medication
o. with parental permission, other persons, including teachers, to be notified of medication administration and possible adverse effects of the medication.
p. a list of other prescription and over-the-counter medications being taken by the client, if not a violation of confidentiality or contrary to the request of the guardian or client that such medication not be documented
q. when appropriate, the location where the administration of the medication will take place
r. a plan for monitoring the effects of the medication
s. provision for medication administration in the case of field trips and other short-term school events. Every effort will be made to obtain a nurse or school staff trained in medication administration to accompany clients at special school events. When this is not possible, the school nurse may delegate medication administration to another responsible adult. Written consent from the parent or guardian for the named responsible adult to administer the medication shall be obtained. The school nurse shall instruct the adult on how to administer the medication to the client.

3. The school nurse will positively identify the client who receives the medication by:
   a. Referencing the client's picture in their file
   b. Asking the client their name
   c. Confirming correct identification with support staff accompanying the client.

4. The school nurse shall communicate significant observations relating to the prescription medication's effectiveness, adverse reactions, or other harmful effects to the client's parent/guardian and/or licensed prescriber.

5. In accordance with standard nursing practice, the school nurse may refuse to administer or allow to be administered any medication, which, based on her/his individual assessment and professional judgment, has the potential to be harmful, dangerous or inappropriate. In these cases, the parent/guardian and licensed prescriber shall be notified immediately by the school nurse and the reason for refusal, explained and documented.

6. For the purposes of medication administration, the licensed practical nurse functions under the general supervision of the school nurse who has delegation authority. Prescription medication administration is within the scope of practice for the licensed practical nurse under M.G.L. Chapter 112.

7. The school nurse shall have a current pharmaceutical reference available for her/his use, such as The Physician's Desk Reference (PDR) or U.S.P.D.I (Dispensing Information) Facts and Comparisons.

E. Delegation/Supervision (this section applies to school districts or private schools which have been registered by the New Hampshire Department of Public Health to permit school nurses to delegate responsibility for administration of medication to trained nursing supervised unlicensed school personnel).

The HLW Board of Directors, in consultation with the New Hampshire Board of Health, where applicable, ___ authorizes ___ does not authorize that the responsibility for the administration of medication may be delegated to the following categories of unlicensed school personnel according to criteria delineated in CMR 210.004 (B)(2):
_____ Administrative Staff_____ Teaching Staff_____ Licensed Health Personnel
_____ Direct Care Health Aides

For the purpose of administering emergency medication to a client, including parenteral administration (i.e., by injection) of epinephrine pursuant to 210.004 (B) (4), the school nurse may identify individual school personnel or additional categories. Said school personnel shall be listed on the medication administration plan and receive training in the administration of emergency medication to a specific client.

1. The school nurse, in consultation with the school physician, shall have final decision-making authority with respect to delegating administration of medications to unlicensed personnel in school systems registered with the Department of Public Health.

2. When medication administration is delegated by the school nurse to unlicensed school personnel, such personnel shall be under the supervision of the school nurse for the purposes of medication administration.

3. A school nurse shall be on duty in the school system while medications are being administered by designated unlicensed school personnel, and available by telephone should consultation be required.

4. The administration of parenteral medications may not be delegated, with the exception of epinephrine where the client has a known allergy or preexisting medical condition and there is an order for administration of the medication from a licensed prescriber and written consent of the parent or guardian.

5. Prescription medications to be administered pursuant to p.r.n. ("as needed") orders may be administered by authorized school personnel after an assessment by or consultation with the school nurse for each dose.

6. For each school, an updated list of unlicensed school personnel who have been trained in the administration of medications shall be maintained. Upon request, a parent shall be provided with a list of school personnel authorized to administer medications.

7. Supervision of Unlicensed Personnel

   Authorized unlicensed personnel administering medications shall be under the supervision of the school nurse. The School Committee or HLW Board of Directors, in consultation with the Board of Health where appropriate, shall provide assurance that sufficient school nurse(s) are available to provide proper supervision of unlicensed school personnel. Responsibilities for supervision at a minimum shall include the following:

   a. After consultation with the principal or administrator responsible for a given school, the school nurse shall select, train and supervise the specific individuals, in those categories of school personnel approved by the School Committee or HLW Board of Directors, in consultation with the Board of Health when appropriate, who may administer medications. When necessary to protect client health and safety, the school nurse may rescind such selection.

   b. The number of unlicensed school personnel to whom responsibility for medication administration may be delegated is determined by:
      1) the number of unlicensed school personnel the school nurse can adequately supervise on a weekly basis as determined by the school nurse; and
      2) the number of unlicensed school personnel necessary, in the nurse's judgment, to ensure that the medications are properly administered to each client.

   c. The school nurse shall supervise the training of the designees consistent with the Department of Public Health's requirements in CMR 210.007 of the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

1) The school nurse shall document the training and evidence of competency of unlicensed personnel designated to assume the responsibility for medication administration.
2) The school nurse shall provide a training review and informational update, at least annually, for those school staff authorized to administer medications.

d. The school nurse shall support and assist persons who have completed the training to prepare for and implement their responsibilities related to the administration of medication.

e. The first time that an unlicensed school personnel administers medication, the delegating nurse shall provide supervision at the work site.

f. The degree of supervision required for each client shall be determined by the school nurse after an evaluation of the appropriate factors involved in protecting the client's health including, but not limited to the following:
   1) health condition and ability of the client;
   2) the extent of training and capability of the unlicensed school personnel to whom the medication administration is delegated;
   3) the type of medication; and
   4) the proximity and availability of the school nurse to the unlicensed person who is performing the medication administration.

g. Personnel designated to administer medications shall be provided with the names and locations of school personnel who have documented certification in cardiopulmonary resuscitation. Schools should make every effort to have a minimum of two school staff members with documented certification in cardiopulmonary resuscitation present in each school building throughout the day.

h. For the individual client, the school nurse shall:
   1) determine whether or not it is medically safe and appropriate to delegate medication administration;
   2) administer the first dose of the medication, if (a) there is reason to believe there is a risk to the client as indicated by the health assessment, or (b) if the client has not previously received this medication in any setting;

3) review the initial orders, possible side effects, adverse reactions and other pertinent information with the person to whom medication administration has been delegated;
4) provide supervision and consultation as needed to ensure that the client is receiving the medication appropriately. Supervision and consultation may include record review, on-site observation and/or client assessment; and review all documentation pertaining to medication administration every two weeks or more often as necessary.

II. Self-Administration of Prescription Medications 105 CMR 210.006

"Self-administration" means that the client is able to consume or apply medication in the manner directed by the licensed prescriber, without additional assistance or direction.

A client may be responsible for taking his/her own medication after the school nurse has determined that the following requirements are met:

A. The client, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which medication may be self-administered.

B. The school nurse, as appropriate, develops a medication administration plan, which contains only those elements necessary to ensure safe, self-administration of prescription medication.

C. The client's health status and abilities have been evaluated by the school nurse, who then deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of the medication.

D. The school nurse is reasonably assured that the client is able to identify the appropriate medication, knows the frequency and time of day for which the prescription medication is ordered.

E. There is written authorization from the client's parent/guardian that the client may self-medicate, unless the client has consented to treatment under M.G.L.c. 112F or other authority permitting the client to consent to medical treatment without parental/guardian permission.

F. If requested by the school nurse, the licensed prescriber provides a written order for self-administration.

G. The client follows a procedure for documentation of self-administration of medication.

H. The school nurse establishes a policy for the safe storage of self-administered medication and as necessary, consults with teachers, the client and parent/guardian, if appropriate, to determine a safe place for storing the medication for the individual client, while providing for accessibility if the client's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventative emergency medication, whenever possible, a backup supply shall be kept in the Health Services office or other accessible location.

I. The client's self-administration is monitored based on his/her abilities and health status. Monitoring may include teaching the client the correct way of taking the medication, reminding the client to take the prescription medication, visual observation to ensure compliance, recording that the medication was taken, and notifying the parent/guardian or licensed prescriber of any side effects, variations from the plan, or the client's refusal or failure to take prescription medication.

J. With parental/guardian and client permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the client is self-administering a medication.

III. Handling, Storage, and Disposal of Medications 105 CMR210.003 (4)

A. A parent, guardian, or a parent/guardian-designated responsible adult shall deliver all medications to be administered by school personnel or to be taken by self-medication clients, if required by the self-administration agreement, to the school nurse or other responsible person designated by the school nurse.
   1. The medication must be in a pharmacy-labeled or manufactured labeled container.
   2. The school nurse or other responsible person receiving the medication shall document the quantity of the medication delivered.
   3. In extenuating circumstances, as determined by the school nurse, the medication may be delivered by other persons; provided, however, that the nurse is notified in advance by the parent/guardian of the arrangement and the quantity of medication to be delivered to the school.
   4. A Medication Receiving and Tracking form will be maintained by the school nurse for all medications received for administration. The name of medication, strength, prescribing physician will be documented along with date of quantity received, quantity on hand, and total quantity (see Appendix).

B. All prescription medications shall be stored in their original pharmacy or manufacturer labeled containers and in such manner as to render them safe and effective. Expiration dates shall be checked.

C. All medications to be administered by school personnel shall be kept in a securely locked cabinet used exclusively for medications, which is kept locked except when opened to obtain the medications. The cabinet shall be substantially constructed and anchored securely to a solid surface. Prescription medications requiring refrigeration shall be stored in either a locked box in a refrigerator or in a locked refrigerator maintained at temperatures of 38 to 42 degrees Fahrenheit (see Appendix)

D. Access to stored medication shall be limited to persons authorized to administer medications and to self-medicating clients. Access to keys and knowledge of the location of keys shall be restricted to the maximum extent possible. Clients who are approved to self-medicate shall not have access to other client's medications.

E. Parents or guardians may retrieve the medications from the school at any time.

F. No more than a thirty (30) school day supply of the medication for a client shall be stored at school.

G. Where possible, all unused, discontinued or outdated medications shall be returned to the parent or guardian and the return appropriately documented. In extenuating circumstances, with parental consent when possible, such medications may be destroyed by the school nurse in accordance with any applicable policies of the New Hampshire Department of Public Health, Division of Food and Drugs. All medications should be returned at the end of the school year.

IV. Documentation and Record-Keeping 105 CMR 210.003 (2)

A. Each school, where school personnel administer prescription medications, shall maintain a prescription Medication Administration Record (see Appendix) for each client who receives prescription medication during school hours.

1. Such record at a minimum shall include a daily log and a prescription medication administration plan, including the prescription medication order and parent/guardian authorization.

2. The prescription medication administration plan shall include the information as described in Section 210.005 (E) of the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

3. The daily log (see Appendix) shall contain:
   a. The dose or amount of prescription medication administered.
   b. The date and time or administration or omission of administration, including the reason for omission.
   c. The full signature of the nurse or designated unlicensed school personnel administering the prescription medication. If the medication is given more than once by the same person, he/she may initial the record, subsequent to signing a full signature.

4. The school nurse shall document in the prescription medication administration record significant observations of the medication's effectiveness, as appropriate, and any adverse reactions or other harmful effects, as well as any action taken.

5. All documentation shall be recorded in ink and shall not be altered.

6. With the consent of the parent, guardian or client, where appropriate, the completed prescription medication administration record and records pertinent to self-administration shall be filed in the client's cumulative health record. When the parent, guardian or client, where appropriate objects, these records shall be regarded as confidential medical notes and shall be kept confidential.

B. Unity House shall comply with the Department of Public Health's reporting requirement for prescription medication administration in the schools.

C. The Department of Public Health may inspect any individual client medication record or record relating to the administration or storage of medications, without prior notice, to ensure compliance with the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

V. Reporting and Documentation of Prescription Medication Occurrence 105 CMR 210.003(5)

A. A medication occurrence includes any failure to administer medication as prescribed for a particular client, including failure to administer the medication:
   1. correct time
   2. correct dosage

3. correct route
4. correct client
5. correct medication

B. In the event of a medication occurrence, the school nurse shall notify the parent or a guardian immediately. (The school nurse shall document the effort to reach the parent or guardian.) If there is a question of potential harm to the client, every effort should be made to reach the client's licensed prescriber.

C. The school nurse shall document medication errors on the client accident/incident report form. These reports shall be retained in the principal's office and the client health record. A copy will be submitted to the Director of Nursing. They shall be made available to the Department of Public Health upon request. All prescription medication errors resulting in serious illness requiring medical care shall be reported to the Department of Public Health, Bureau of Family and Community Health. All suspected diversion or tampering of drugs should be reported to the Department of Public Health, Division of Food and Drugs. (*MDPH School Health Medication Error Report Form* – see Appendix)

D. The school nurse shall review report of medication occurrences and take necessary steps to ensure appropriate prescription medication administration in the future.

B. Practice Guideline for the Prescription and Administration of Psychotropic Medications

Psychotropic medications are those medications that are prescribed with the intent to facilitate any number of the following:

- to promote the stability and improvement in an individual's mood and affect;
- to promote an individual's skill development with regard to impulsivity and self-control;
- to promote an individual's ability to function free from psychotic thought processes and experiences;
- to assist individuals in alleviating distressing affective states that may lead to self-destructive, aggressive or dysfunctional behavior patterns;
- to maintain a patient in a state of symptom resolution or reduction and to prevent recurrence of severe psychiatric symptoms.

Rationale and guidelines for psychotropic medication interventions

- Treatment and service is provided to client and families in cooperation with a multidisciplinary team and through development of a comprehensive treatment plan. In many cases, the administration of psychotropic medication is an additive and important component of the comprehensive treatment plan. The medication treatment is intended as an integrated component with other non-somatic interventions in the comprehensive treatment plan. The prescription of psychotropic medications is considered a major intervention.
- In this regard, the prescription of medications is approached with caution and thoughtfulness. Antipsychotic medication prescribed by a licensed physician at HLW will only be prescribed after careful review of a client's medical record and actual observation of the client. In each case, the prescribing physician will attempt to minimize the number of agents prescribed, the duration of treatment and the treatment dosage while taking steps to maximize the potential benefit from the psychotropic medications. In addition, the prescribing physician will closely monitor and attempt to minimize adverse effects of medications. Psychotropic medications are prescribed to address specific target symptoms. The prescribing physician will work with their colleagues on the treatment team, the parent or guardian and the patient to identify and develop specific criteria to monitor the efficacy of medication interventions. Prescribing physicians at HLW maintain current knowledge with regard to prescribing practices of psychotropic medications. Prescribing physicians at HLW maintain a consultative network to facilitate case-based consultation whenever necessary.

The physician shall include in their patient progress notes and discuss at MDT why the medication being prescribed is necessary, potential adverse effects that may or may not require medical attention, the times and dates that the physician will be meeting with the client, and staff monitoring requirements.

The School Nurse will educate staff providing care to a client receiving antipsychotic medication about the nature of the medication, potential side effects that may or may not require medical attention and requiring monitoring or special precautions, if any.

Informed consent for medication administration
The process of informed consent at HLW is described in detail in HLW Policy: "Informed Consent for Psychotropic Treatment." In brief, obtaining informed consent for treatment from the parent/guardian of a minor and assent for treatment from the minor are central components of the treatment process. Informed consent and assent include education about potential benefits of treatment, possible outcomes with and without treatment, potential adverse effects of recommended medication and the projected duration of treatment.

If a client is in parental custody, informed written consent is obtained and the consent for anti-psychotic medication can be revoked at anytime. If the client is in another situation regarding custody, a judicial approval may be required. If a client is in the custody of DCF, a Rogers order must be obtained before the medication is administered to the patient.

The physician prescribing the medication will notify all clients on antipsychotic medication who are twelve years or older, consistent with the clients capacity to understand about the treatment's risk and potential side effects. The program has a refusal process in place for clients who refuse medication.

Prescription and administration of psychotropic medications
The processes of prescribing and administering psychotropic medications in the programs of HLW are described in detail in the HLW Practice Guidelines: "Practice Guidelines for the Administration of Medications." In brief, all patients who are prescribed medications are evaluated regularly by the prescribing physician.

Emergency administration of antipsychotic medication
In an emergency situation an antipsychotic medication may be administered to a client without parental consent or judicial approval for treatment purposes if an unforeseen combination of circumstances or the resulting state calls for immediate action in the best interest of the client to avoid injury or harm and there is no less intrusive alternative to the medication. The treating physician must determine that the medication is necessary to prevent the immediate substantial and irreversible deterioration of a serious mental illness. If the medication continues, proper consent must be obtained as required by law.

C. Procedure for Medication Administration Off-Grounds and During Field Trips

The classroom teacher shall notify the school nurse in advance of a field trip or short-term school sponsored special event. A Medication Delegation for Field Trips Form (see Appendix), if approved DPH program, will be sent to the person responsible for administering the prescription medication during the field trip. All clients requiring medications on school field trips will have an Individual Medication Administration Plan on record in the school Health Office.

The school nurse will provide the responsible designated adult with the client's medication in a pharmacy labeled container. The school nurse will review the information on the container with that adult including: client name, medication, dose, time of administration, any special instructions or cautions.

The classroom teacher or other designated responsible adult will have responsibility for the safe keeping of the medication and for administering the medication. The designated adult will have the responsibility of returning the pharmacy labeled container to the school nurse at end of the field trip or school sponsored short-term special event.

In certain circumstances or in programs not approved by DPH, efforts will be made to have a licensed nurse accompany the client on a field trip.

D. Administering Over-the-Counter Medications and Preparations

Medication administration in New Hampshire schools must be according to protocols written by an authorized prescriber (Physician, Nurse Practitioner, and Dentist) and meet the Board of Registration in Nursing Policy Governing the Administration of Over-the-Counter Medications

Nurses may administer over-the-counter medications to clients in New Hampshire schools based on protocols which have been developed in collaboration with the school department's physician, dentist or nurse practitioner, provided that the appropriate school administrative authority allows the use of such protocols.

Written orders by licensed prescriber include:
Drug Name, Dose, Dosage Interval/Directions
Indications and Contraindications
Potential Adverse Effects
Cautions

Nursing Action/Assessment which must include:

1. Current medications the client is taking
2. Client's History of allergies

Parental/guardian consent for use of a drug according to the protocol must be on file and available to the nurse, as must information about the client's known allergies (see Appendix).

Documentation of over-the-counter medication administered according to such protocols must conform to the school department's regulations for documentation of medication administered to client (see Appendix).

The list of medications approved for administration, as well as the protocols, should be made available in each school's health office (see Appendix). A stock supply for emergency treatment, as approved and consented to by physician and parent/guardian, of epinephrine auto-injector and nasal naloxone is available for nurse administration as per approved written protocol. Sun block and insect repellant are considered medications. It is a current best practice to apply these in the morning before school.

Every effort will be made to contact parents of clients, before a medication is given.

Parent requests for their client to receive over-the-counter medication during the school day that is not included in the current list of over-the-counter medication protocols presently given by a Unity House's nurse will require a signed Parental Medication Consent form and a signed Physician Medication Consent form. This is to protect against drug interactions and to provide for the health and safety of the client. A supply of the clearly labeled over-the-counter medication needs to be provided to the nurse with the client's name along with the signed consent forms.

VIII. Nutrition and Physical Well-being Policy

Unity House recognizes the relationship between client well-being and client achievement as well as the importance of a comprehensive district wellness program. Therefore, Unity House provides developmentally appropriate and sequential nutrition and physical education as well as opportunities for physical activity. The wellness program will be implemented in a multidisciplinary fashion and will be evidence based.

Wellness Committee

Unity House shall establish a Wellness Committee that consists of at least one (1): parent, client, nurse, school nutrition representative, School Committee member, school administrator, teacher, member of the public, and other community members as appropriate. If available, a qualified, credentialed nutrition professional will be a member of the Wellness Committee. Goals will be established on an annual basis. The committee will be co-chaired by the Nurse and the Wellness Project Manager. The Wellness Project Manager, in consultation with the Wellness Committee, will complete an evaluation of the goals each year.

Nutrition Guidelines

It is the policy of the Unity House that school meals offered under the National School Lunch and School Breakfast Programs are consistent with the Healthy, Hunger-Free Kids Act of 2010. Guidelines for reimbursable school meals will not be less restrictive than regulations and guidance issued by the Secretary of Agriculture pursuant to law.

In addition to the School Breakfast and School Lunch programs, competitive foods and beverages sold or provided to clients during the school day must comply with the New Hampshire School Nutrition Standards for Competitive Foods and Beverage Act (52:125) signed into law in New Hampshire on July 30, 2010 and the Smart Snacks in School nutrition standards 7 CFR 210.31(c)(3)(iii). School day is defined as the midnight before through 30 minutes after the end of the school day. Foods and beverages offered to clients in vending machines must comply with the standards at all times.

Unity House Wellness Committee will incorporate procedures that address all foods available to clients throughout the school day in the following areas:

- guidelines for maximizing nutritional value by decreasing fat and added sugars, increasing nutrition density and moderating portion size of each individual food or beverage offered within the school environment based on the "Act Relative to School Nutrition" (July 2010);
- including foods and beverages in the following categories:
  - ✓ foods and beverages included in a la carte sales in the school nutrition program on school campus
  - ✓ foods and beverages offered in school stores
  - ✓ foods and beverages offered as part of school-sponsored fundraising activities
  - ✓ refreshments served at celebrations and meetings during the extended school day (30 minutes before and 30 minutes following the regular school day)

- ✓ any other foods or beverages included in extended school day activities
- ✓ encourage the sale of non-food items or activity drive events as part of the fundraising activities
- ✓ prohibit the use of food and beverage items as a reward or punishment

Nutrition and Physical Education

Unity House will provide nutrition education aligned with state standards. The school district will provide physical education training aligned with the standards established by the Department of Elementary and Secondary Education. The Wellness Committee will collaborate with Unity House to develop procedures that address nutrition and physical education and other school-based activities that promote wellness.

Nutrition Education Goals

- Clients participate in nutrition education that teaches the skills they need to adopt and maintain healthy eating behaviors.
- Parents and community members will receive nutrition information to support clients' healthy behaviors.
- Nutrition information is offered in the school cafeteria and on the School Nutrition website as well as in the classroom, with coordination between the school nutrition staff and other school personnel, including teachers.
- Clients receive consistent nutrition messages from all aspects of the school program.
- Parents will be informed about the policy and the procedures.
- Health education curriculum standards and procedures address both nutrition and physical education.
- Nutrition awareness is integrated into the health education or core curricula (e.g., math, science, language arts), as appropriate.
- Staff who provide nutrition education have nutrition training.

Physical Education Goals

- Clients are given opportunities for physical activity during the school day through physical education (PE) classes, daily recess periods, physical activity breaks, and the integration of physical activity into the academic curriculum where appropriate.
- PE will be taught by certified physical education teachers.
- Clients are also given opportunities for physical activity through a range of before- and/or after-school programs including, but not limited to, intramurals and interscholastic athletics, working toward the goal of sixty (60) minutes of physical activity per day.
- Additional opportunities for physical activity are encouraged, whether within the school, or through private or public facilities and/or organizations.
- Schools, in collaboration with the community, encourage parents and guardians to support their children's participation in physical activity, to be physically active role models, and to include physical activity in family events.
- Schools provide training to enable staff to promote enjoyable, lifelong physical activity among clients.
- Schools will limit exclusion of physical activity as a form of disciplinary action.

Other School-Based Goals

- An adequate amount of time is allowed for clients to eat meals in adequate lunchroom facilities.
- All children who participate in subsidized food programs are able to obtain food in a non-stigmatizing manner.
- Environmentally-friendly practices such as the use of locally grown and seasonal foods, school gardens, compostable and non-disposable tableware have been considered and implemented where appropriate.
- Physical activities and/or nutrition services or programs designed to benefit staff and clients' health have been considered and, to the extent practical, implemented.

Evaluation

The Wellness Committee will assess all education curricula and materials pertaining to wellness for accuracy, completeness, balance and consistency with the federal, state and district's educational goals and standards. The Wellness Project manager shall be responsible for devising a plan for implementation and evaluation of the district wellness policy and is charged with operational responsibility for ensuring that schools work toward achieving the goals of the district wellness policy.

IX. Working with Parents/Guardians as Partners

Client's on-going health promotion and access to the health care systems depends primarily on parents/guardians. Health Service staff work towards collaboration among the client, their families/guardians and the community, including primary care providers, with common goals of improving the client's health and experience of feeling well.

Key features of collaboration include:

- ✓ Involving the client and family in accessing needs, identifying strengths and resources, participating in the development of individual health treatment plans and the development of group programs to meet the needs and build on strengths
- ✓ Communicating the goals, intent and content of the health education program that client take part in at the program and inviting parents to be partners in this education
- ✓ Supporting the invitation by providing parallel opportunities for parents to learn about issues client are learning about in school and about strategies for being effective mentors in promoting their client's health knowledge and skills
- ✓ Helping to facilitate, but not manage family/primary care provider interaction
- ✓ Providing parents with opportunities to discuss the medications their client are taking, express their concerns, ask questions and get answers
- ✓ Work with families on strategies for safe administration and monitoring of medications at home
- ✓ Limited use of medical jargon
- ✓ Respect needs, i.e., language, child-care, transportation
- ✓ Maintain appropriate boundaries
- ✓ Work toward recognition, understanding and respect for the differences of home and program
- ✓ Communicate all health concerns to parents and develop strategies together to address the concern

X. Discharge

The clinician will inform the nurse of a pending discharge as soon as possible. The program nurse will alert the physician/health care provider of the need for the discharge prescription for the parent/guardian for all medications that will be continued after discharge. The nurse will prepare an envelope containing the Health Discharge Summary, MA health or other insurance cards, immunization record and the medication prescription, if it has not been given to the parent/guardian directly from the physician. The envelope will also contain any unopened medication that the client will continue to take following discharge. The nurse will prepare a written statement of any current medical issues or concerns, including the times of upcoming routine screenings.

If possible, the nurse will meet with the client, parent/guardian at the time of discharge to review health and medication issues, answer any questions that may arise, and/or refer questions to the client's psychiatrist for further clarification.

VIII. Appendix

Section I: Admission Forms

Client Information

Client Name (Last, First, Middle)	Birth Date:	Date of Exam:
	Gender (at birth): □Male □Female Gender Identity: □Male □Female	Pronouns: □They/theirs □His/him □Hers/her
Address (Street, Town, ZIP Code)		
Parent/Guardian Name (Last, First, Middle)	Emergency Contact Info:	
School/Grade:	Primary Care Provider	
Health Insurance Company/Number* or MassHealth:		

Health Information

PHYSICAL EXAM:
Height: ___in/____%ile Weight ____lbs/___%ile BMI:_____/___%ile Pulse____ Blood Pressure ____/____

System	*Normal*	*Describe Abnormal*	*System*	*Normal*	*Describe Abnormal*
Neurologic			Neck		
HEENT			Shoulders		
Lymphatic			Ortho		
Heart			Arms/Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/Ankles		
Gross Dental			Postural	□ No spinal abnormality	*Spine abnormality:* □ Mild □ Moderate □ Marked □ Referral made

SCREENINGS:

Vision Screening:
Date performed: / /
Method: □ Snellen □ Tumbling E
□ Other

Type:	Right	Left
With glasses:	20/	20/
Without glasses:	20/	20/

□ Referral made

Does the client wear:
□ Glasses
□ Contact lenses □ Both

Auditory Screening
Date performed: / /
Method: □ Audiometry □ OAE □Other

Type:	Right	Left
	□ Pass	□ Pass
	□ Fail	□ Fail

Does child wear a hearing aide? □ Y □N

Was child referred for further evaluation? □Y □N

	Date
History of Lead level >5ug/dL □ No □Yes	
HCT/HGB:	
Speech (school entry only)	
Other:	

TB: High-risk group? □No □Yes PPD date read: Results: Treatment:

IMMUNIZATIONS:

□ Up to Date or □ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

CHRONIC DISEASE ASSESSMENT:

Asthma	□ No □Yes	□ Intermittent □ Mild Persistent □ Moderate Persistent □Severe Persistent □ Exercise Induced *If yes, please provide a copy of the Asthma Action Plan to school*
Anaphylaxis	□ No □Yes	□ Food □Insects □Latex □Unknown source *If yes, please provide a copy of the Emergency Allergy Plan to school*
Allergies	□ No □Yes	If yes, specific allergen(s): Epi pen required □No □ Yes
Diabetes	□ No □Yes	If yes: □ Type I □Type II
Seizures	□ No □Yes	If yes, type:

SPECIAL NEEDS:

Chronic medical conditions/related surgeries?	□ No □Yes □ *Special care plan attached**	*List special needs/considerations and medications below (other than special care plans attached).*
Medications or treatments?	□ No □Yes □ *Special care plan attached**	
Allergies/sensitivities?	□ No □Yes □ *Special care plan attached**	
Behavioral issues/mental health diagnoses?	□ No □Yes □ *Special care plan attached**	
Limitations to physical activity?	□ No □Yes □ *Special care plan attached**	
Special equipment needs?	□ No □Yes □ *Special care plan attached**	
Special dietary requirements?	□ No □Yes □ *Special care plan attached**	

Signature of Intake Clinician/Licensed Nurse Date signed

Narrative Notes

Name			
Date	Time	Narrative *Include observations, HCP visits, medication changes, changes from the familiar, reportable events, etc.*	Staff Signature

EPINEPHRINE ACTION PLAN

All staff working with supported individuals who require assistance with Epinephrine shall receive formal training provided, by approved DPH programs. Training must be renewed annually.

Primary Care Provider Authorization: Epinephrine Auto-Injector

Name: _____ Date of Birth: _____
Program: _____

Allergy to: _____

Asthma: _____ Yes _____No

Signs of an allergic reaction include:

Mouth itching and swelling of the lips, tongue, or mouth
Throat * itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin hives, itchy rash, and/or swelling about the face or extremities
Stomach nausea, abdominal cramps, vomiting, and/or diarrhea
Lung* shortness of breath, repetitive coughing, and/or wheezing
Heart * "thread" pulse, "passing out"
Other individual specific symptoms: _____
_____

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

Epinephrine auto-injector should be: kept with in the immediate vicinity of the individual unless otherwise noted.

Emergency action for an allergic reaction:
1.Administer emergency medication--- epinephrine auto-injector 0.3mg
2.Call EMS (911)
3.Contact the following people:

Emergency Contact	Telephone #	Relationship

****Do not hesitate to administer medication or call for emergency assistance (EMS)**

Individual specific Instructions: (if applicable) _____
_____

_____ _____
Printed Name of ordering MD Telephone # of MD

_____ _____
MD Signature Date

Competency Evaluation Tool for Epinephrine Administration via Auto-Injector Device

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	General Knowledge
1.			Knows that only licensed personnel (nurses) and MAP Certified staff, who have successfully completed specialized training in medication administration of epinephrine via pre-filled auto-injector device training, may administer the epinephrine medication.
2.			Knows that another competency evaluation including a return demonstration with 100% accuracy must be completed annually.
3.			Knows that all MAP regulations must be followed when administering epinephrine via pre-filled auto-injector device.
4.			Knows what an auto-injector device is and knows why this individual has a Health Care Provider order for one.
5.			Knows to compare the Health Care Provider order with the label and the medication sheet at the beginning of the shift.
6.			Knows to check the epinephrine pre-filled auto-injector device expiration date at the beginning of the shift.
7.			Knows the epinephrine solution should be clear and colorless.
8.			Knows if the epinephrine solution is brown it is not to be used and another device obtained.
9.			Knows what an anaphylactic reaction is.
10.			Knows the symptoms of an anaphylactic reaction.
11.			Knows what effect epinephrine has on the body.
12.			Knows the most common effects of epinephrine felt by the individual after the injection.
13.			Knows why 911 is immediately called following epinephrine administration and the importance of informing emergency personnel that epinephrine was administered.
14.			Knows that epinephrine wears off in about 10 to 20 minutes after it is administered.
15.			Knows the Health Care Provider must be notified.
16.			States other emergency procedure guidelines per agency policy.
17.			States what s/he would do if there were an accidental administration of epinephrine via pre-filled auto-injector.
18.			Knows storage requirements of the pre-filled epinephrine via auto-injector device; that it is locked, and kept at room temperature away from heat and sunlight.
19.			Knows disposal requirements specific to the used auto-injector device(s).

	Pass (P), Fail (F), N/A	Comments	Procedure for Return Demonstration of Administration of Epinephrine via Auto-Injector Device:
1.			Follows all procedures for preparation of medications for administration according to MAP regulations and policies.
2.			Informs individual what is being done.
3.			Forms a fist around the pre-filled auto-injector with the tip [usually it is an orange tip] facing down and pulls off the safety cap. (Knows to NEVER put fingers over the tip)
4.			Places the pre-filled auto-injector device at a 90-degree angle on the outer thigh. (Knows it is not necessary to remove clothing since the auto-injector device is designed to work through clothing.).
5.			With a quick motion, pushes the pre-filled auto-injector firmly against the outer thigh. (Holds in place and slowly counts to 10 before removing needle.)
6.			Knows even though a small amount of liquid remains inside the auto-injector after use, the device cannot be used again.
7.			Calls 911 immediately for transportation to emergency room.
8.			After ER personnel arrive and individual is cared for, notifies HCP, and follows all emergency procedures per the provider's policy.
9.			Properly disposes of the used auto-injector.
10.			Documents administration according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I, as Trainer, have determined that the Certified Staff Person named below is competent to administer epinephrine via auto-injector device to the Individual named below.

Staff Person's Printed Name _____ Individual's Printed Name _____

Staff Person's Signature _____ Date _____

Trainer's Printed Name _____ Trainer's Phone Number _____

Trainer's Signature _____ Date _____

Unity House
Diabetes Action Plan

Client's Name: _____ DOB: _____ Grade: _____
Client's Address: _____

Client's Blood Sugar Goal Range: _____

Low Blood Glucose Level (Hypoglycemia)
Blood Glucose Level Less Than: _____

Symptoms

- ☐ Feeling weak or tired
- ☐ Shakiness
- ☐ Pale complexion
- ☐ Hunger
- ☐ Blurred vision
- ☐ Fast heartbeat
- ☐ Sweating
- ☐ Headache
- ☐ Stomachache
- ☐ Irritability or anxiety
- ☐ Dizziness or confusion
- ☐ More quiet than usual

Client specific symptoms include: _____
_____
_____

Actions: _____
_____
_____

Note: symptoms of hypoglycemia may change over time. The symptoms that the client reports today may be different in the future.

Low Blood Glucose Emergency
(Unconscious or Having a Seizure)

Actions:

- **NEVER** attempt to put food or drink into the client's mouth if they are unconscious or having a seizure
- **CALL 911**
- **Call** parent/guardian

Unity House
Diabetes Action Plan (cont'd.)

Client's Name: _____ DOB: _____ Grade: _____

High Blood Glucose Level (Hyperglycemia)
Blood Glucose Level Greater Than: _____

Symptoms

- ☐ Deep and rapid breathing
- ☐ Fast heartbeat
- ☐ Drinking more than usual
- ☐ Urinating more than usual
- ☐ Nausea and vomiting
- ☐ Hunger
- ☐ Stomachache
- ☐ Feeling tired or sleepy
- ☐ Blurry vision
- ☐ Dry skin or lips
- ☐ Irritability

Client specific symptoms include: _____
_____
_____

Actions: _____
_____
_____

Contacts:

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Nurse Signature: _____ Date: _____

Protocol, Procedures, and Standing Medical Orders for the Administration of Naloxone

Purpose:

- Naloxone is an opioid antagonist that is used to reverse the effects of opioids.
- Current research has determined that naloxone administration has been found to prevent death from opioid overdose, as well as reduce disability and injury from opioid overdoses.
- The rapid administration of naloxone may be life-saving in patients with an overdose due to opioid use. (Doe-Simpkins, Walley, Epstein, & Moyer, 2009)

***Drug*:** Naloxone (Narcan)

***Dose*:** 2mg initial dose for individuals > 20kg or > 5years of age naloxone HCl 1mg/ml, in pre-filled 2ml Luer-Lock needless syringe via intranasal automizer

***Route*:** Intranasal only

***Indication*:** Registered nurses may administer naloxone to a person in the event of respiratory depression, unresponsiveness, or respiratory or cardiac arrest when an overdose from opioid is suspected of a client, staff member, or visitor. Person is unresponsive, very low respiratory rate or not breathing, low blood pressure, and there is no response to sternal rub.

***Contraindications*:** diabetic ketoacidosis, electrolyte imbalance, hypothermia, meningitis, apnea, stroke, subdural hematoma, poisoning, toxicity from other drug, allergy to any ingredient in naloxone

***Precautions*:** pregnancy or those who are planning to become pregnant, breast feeding mothers, non-prescription medications, herbal remedies, diet supplements, history of heart disease or substance abuse

Emergency Procedure:

1. **Activate EMS: Call 911**. Nurse or designee will call 911 to activate emergency medical service response
2. Assessment: ABC's: Airway, Breathing, Circulation.
    a. For pulseless individuals, initiate CPR per BCLS guidelines
    b. For apnea with pulse: establish airway and begin rescue breathing
    c. Check for: foreign body in airway, *level of consciousness** or unresponsiveness, very low respiratory rate or not breathing, no response to sternal rub, *respiratory status** gasping for air while asleep or odd snoring pattern, pale or bluish skin, slow heart-rate, low blood pressure, no response to sternal rub. Pin point pupils and track marks may be present, although absence of these findings does not exclude opioid overdose.
    d. *Level of consciousness
        i. The nurse determines that the person presents with a decrease in level of consciousness as evidenced by;
            1. difficult to arouse (responds to physical stimuli but does not communicate or follow commands, may move spontaneously)
            2. unable to arouse (minimal or no response to noxious stimuli, does not communicate or follow commands)
    e. *Respiratory status
        i. The nurse determines that the person presents with a depression of respiratory status as evidenced by;
            1. decrease in respiration rate
            2. if available, interpretation of pulse oximetry measurement

f. Nurse determines need for naloxone administration

3. Administration: Intranasal administration of naloxone
    a. Assess person for contraindications or precautions to naloxone, per available information
    b. Exclusion criteria also includes: nasal trauma or epistaxis
        i. Assemble naloxone vial and intranasal atomizer:
            1. Pop off two yellow caps from the delivery syringe and one red cap from the naloxone vial
            2. Screw the naloxone vial gently into the delivery syringe
            3. Screw the mucosal atomizer device onto the top of the syringe
        ii. Spray half (1mg) of the naloxone in one nostril and the other half (1mg) in the other nostril for a total of 2 mg
        iii. Continue rescue breathing or BCLS as needed
        iv. If no response, an additional second dose/vial may be administered after 3- 5 minutes
        v. Naloxone duration of action is 30-90 minutes
        vi. Transport to nearest hospital via EMS

Storage: Store at 59° to 86° F, away from direct sunlight

Possible Side Effects: Acute withdrawal symptoms, change in mood, increased sweating, nervousness, agitation, restlessness, tremor, hyperventilation, nausea, vomiting, diarrhea, abdominal cramping, muscle or bone pain, tearing of eyes, rhinorrhea, craving of opioid, rash hives, itching, swelling of face, lips, or tongue, dizziness, fast heartbeat, headache, flushing, sudden chest pain

Nursing Considerations: Withdrawal can be unpleasant; person may just breathe but not have full arousal or person may need continued rescue breathing and support

Documentation: Record encounter in client's school health record and on incident report for client, employee, or visitor, as applicable. Documentation must include patient presentation, route (intranasal), and dose that was administered as well as the patient's response to the naloxone administration.

School Physician's signature: _____ Date _____

Effective date: xxxxx

Reference Doe-Simkins, M., Walley, A., Epstein, A. & Moyer, Peter. (2009). Saved by the nose: Bystander administered intranasal naloxone hydrochloride for opioid overdose. American Journal of Public Health, 99 (5), 788-791.

Practice Guidelines for Client Returning to Work and School

Infectious Disease or Symptom	Signs and Symptoms	Exclusion	Conditions for Return
Infectious diarrhea with vomiting and fever	Vomiting, fever, diarrhea	Yes	May return when diarrhea and fever are absent for at least 24 hours, and the client is able to tolerate eating and drinking.
Gastroenteritis, viral	Nausea and diarrhea. Fever does not usually occur.	Yes	Diarrhea free and afebrile.
Mononucleosis infection (Epstien Barr Virus)	Variable, infants and young children are generally asymptomatic. Symptoms may include fever, fatigue, swollen lymph nodes, and sore throat.	Yes	Physician approval and fever free for 24 hours.
Fever	A temperature of 100°F (37.8°C) or higher. Measure temperature when no fever suppressing medications have been given.	Yes	May return when afebrile (fever free)

Common Cold	Runny nose, watery eyes, fatigue, coughing, sneezing	No, unless febrile	May return when afebrile (fever free)
Otitis media (ear infection/ear ache)	Fever, ear pain	No, unless febrile or extremely ill	May return when afebrile (fever free)
Giardia, Salmonella, and Campylobacter	Diarrhea, abdominal pain, fever, nausea, vomiting	Yes	May return after one state tested negative stool sample and is without diarrhea and fever.
Shigella	Fever, vomiting, diarrhea, which may be bloody	Yes	May return after two state tested negative tool samples and is without symptoms.
Hepatitis A*	Client may have no symptoms; some have flu-like symptoms or diarrhea. Adults can have fever, fatigue, nausea and vomiting, anorexia and abdominal pain. Jaundice, dark urine, or diarrhea may be present.	Yes	Infected person may return one week after the illness began, fever must be absent, and the person has started treatment. Persons who have been exposed to someone ill with Hepatitis A may need to receive a preventative shot of immune globulin.

Norovirus	Acute onset of combination of nausea, vomiting, watery non-bloody diarrhea, abdominal cramps, discomfort,	Yes	After 48 hours after symptoms subside, norovirus may be contagious up to 10 days after resolution of symptoms
Influenza	Rapid onset of fever, headache, sore throat, dry cough, chill, lack of energy, and muscle aches. Client may have nausea, vomiting, and/or diarrhea.	Yes	May return when feeling well, and is without symptoms of nausea, vomiting, diarrhea, cough, muscle aches, headaches and or general weakness.
Chicken Pox (Varicella) and Shingles *	Fluid filled blisters which scab over in 7-10 days	Yes	May return when all blisters are crusted over and dried up, or after 5 days
Meningitis, bacterial *	Sudden onset of **high fever** and **headache**, may have stiff neck, photophobia, and/or vomiting	Yes	May return after treatment is begun and are feeling well with written permission from physician. People exposed to infected person should get preventative treatment as well and may return to work.

Meningitis, viral *	Sudden onset of **fever** and **headache**, may have **stiff neck**, **photophobia**, and/or **vomiting**	Yes	Afebrile (fever free) with written permission from a physician.
HIB, meningitis or epiglottitis	Subacute or sudden fever, lethargy, neck stiffness, photophobia, **drooling**, **heavy breathing, upper respiratory infection symptoms**	Yes	May return after at least 4 days of appropriate antibiotic treatment
Strep throat	Fever, sore throat, lymph node enlargement	Yes	May return 24 hours after treatment with medication is initiated, with absence of fever.
Active TB, pulmonary*	Gradual onset of fatigue, anorexia, fever, failure to gain weight, and cough	Yes	May return after treatment is completed and with a note from his/her doctor stating that they are no longer contagious.
Impetigo	Blisters on skin which open and become covered with a honey-colored or yellow crust. Fever is not usually present.	Yes	May return 24 hours after initiation of medication, sores must be lightly covered up.

Ringworm	Slowly spreading flat, scaly, ring-shaped lesion on skin. Margins may be reddish and slightly raised. May cause bald patches.	Yes	May return after treatment has started. There is no need to exclude once they are being treated.
Conjunctivitis, bacterial or viral	Red eyes, usually with some gluey discharge or crusting around the eye. May be worse in the morning.	Yes	May return after treatment has begun. If medication is not required, a note from the physician is required before return.
Scabies	Small, raised red bumps or blisters on skin with severe itching, often on thighs, arms, and webs of fingers.	Yes	May return 1 day after treatment has begun.
Head lice	Itching and scratching of scalp Presence of live lice or pinpoint sized white eggs (nits) that will not flick off the hair shaft.	Yes	May return after treatment with Permetherin or other prescription lice medication. Decision may be made for the client to stay out longer based on individual family needs and situation. Client should be checked daily for 10 days after therapy has concluded.
Herpes simplex (cold sore)	Blisters on or near lips that open and become covered with a dark crust. Recurrences are common.	No, unless severe	May return when blisters are crusted over (usually 4-5 days later)

Measles*	Fever, followed by runny nose, watery eyes, and dry cough. A blotchy red rash, which usually begins on the face, and appears between the 3rd and 7th day.	Yes	Must be isolated from public places for 4 days after appearance of rash, then may return when feeling well and are not presenting with any of the following symptoms: Rash, diarrhea, ear infection, and / or pneumonia.
Mumps*	Low grade fever which may last 3 to 4 days, myalgia, anorexia, malaise, and headache, may be followed by classic symptom of parotitis (i.e. acute onset of unilateral or bilateral, self-limited swelling of the parotid or other salivary glands) lasting two days, may last longer than 10 days.	Yes	May return 9 days after parotid glands began to swell, and with absence of symptoms which include low-grade fever, stiff neck, loss of appetite, and/or swelling of the parotid glands has subsided in the jaw area. If exposed to person with confirmed mumps infection and non-specific respiratory symptoms develop, should be excluded for incubation period of mumps (12-25 days) even with absence of parotitis.

Rubella (German Measles)*	Mild illness, symptoms may include low-grade fever, sore throat, and rash which starts on the face and spreads to the rest of the body.	Yes	May return on the 8th day after the rash began, with absence of symptoms.
Polio*	Sore throat, fever, tiredness, headache, stomach pain, paralysis	Yes	May return 6 weeks from onset of disease, with absence of symptoms, and with note from physician that the person is no longer contagious.
Diphtheria*	Weakness, sore throat, fever, swollen glands in the neck	Yes	Infected person should be isolated until 2 successive pairs of nose and throat cultures, obtained at least 24 hours apart and at least 24 hours after completion of antimicrobial therapy, are negative. If there was no antimicrobial therapy, 2 sequential pairs of cultures may be taken after symptoms resolve and more than 2 weeks after their onset.

Lyme disease	Vary and occur in stages, may include “Bulls-eye’ rash around tick bite (erythema migraines), usually not itchy or painful, rash on other parts of the body, flu-like symptoms, joint pain, joint swelling. A small red bump that lasts for a few days at the site of a tick bite usually does not indicate Lyme disease.	No, unless per HCP order	Not contagious, may attend school/work unless extremely sick with note from HCP.
Pertussis*	Minimal fever, similar to the common cold but with nonspecific cough, bursts of rapid coughing, person may turn blue during coughing fits. May hear inspiratory “whoop” during coughing fits. Coughing may be so severe it can cause vomiting.	Yes	Symptomatic persons should be excluded for the first 5 days of a full course of antimicrobial treatment. Symptomatic persons who do not take antimicrobial treatment should be excluded from child care or school for 21 days from onset of cough. Asymptomatic contacts who elect not to take antibiotics or are not up to date with their pertussis immunizations may be considered for exclusion from work or school for 21 days after their last exposure.

Unity House

Telephone Order Form

Date of Order:_____ Time:_____

Name of Client:_____ DOB: _____

Allergies:_____

Discontinue: _____

Medication Name:_____

Dose:_____ Frequency:_____ Route:_____

Reason for Medication/Change:_____

_____

_____

Special Instructions/Precautions (include instructions for common side effects, labs, include parameters if vital signs need to be taken):_____

_____

_____

Discontinue Date (if applicable):_____

HCP's Name:_____

Nurse Signature/Title:_____

Signature of HCP:_____ Date:_____

UNITY HOUSE

MEDICATION RECEIVING AND TRACKING

Date: _____

Name: _____ Allergies: _____ DOB: _____

Date	Medication	Strength	Prescribing HCP	Quantity on Hand	Quantity Received	Total Quantity	Received by Signature

Medication Refrigerator Temperature Log

Refrigerator containing medication is required to be at +38° to 42° F. +40° F is the ideal temperature. * Notify pharmacy if temperature out of range.

Record Temperatures & Initial each business day. Temperatures are recorded in Fahrenheit.

Month/Year_____

Date	Temp	Initial	Date	Temp	Initial
1	F		16	F	
2	F		17	F	
3	F		18	F	
4	F		19	F	
5	F		20	F	
6	F		21	F	
7	F		22	F	
8	F		23	F	
9	F		24	F	
10	F		25	F	
11	F		26	F	
12	F		27	F	
13	F		28	F	
14	F		29	F	
15	F		30	F	
			31	F	

Month/Year_____

Date	Temp	Initial	Date	Temp	Initial
1	F		16	F	
2	F		17	F	
3	F		18	F	
4	F		19	F	
5	F		20	F	
6	F		21	F	
7	F		22	F	
8	F		23	F	
9	F		24	F	
10	F		25	F	
11	F		26	F	
12	F		27	F	
13	F		28	F	
14	F		29	F	
15	F		30	F	
			31	F	

UNITY HOUSE

Medication Occurrence Report

A medication error is defined as: "failure to administer the prescribed medication within the time frame, in the correct dosage, in accordance with accepted practice, to the correct client".

Date of Report _____ School _____

Prepared by_____
Name of Client _____DOB _____Sex _____ Grade ____
Home Address _____Phone # _____
(Street)
_____
(City/Town) (Zip code)

Date Error Occurred _____ Time Noted _____
Person Administering Medication _____
Name Title Licensed Prescriber_____
(Name) (Address)
Reason Medication was Prescribed _____
Date of Order _____
Instructions for Administration _____
Medication _____Dose _____ Route ___ Scheduled time _____
Describe the error and how it occurred (use reverse side if necessary): _____
_____
_____

Action Taken:
Licensed Prescriber Notified: Yes ____ No _____ Date _____ Time _____
Parent/Guardian Notified: Yes ____ No _____ Date _____ Time _____
Other Persons Notified: _____
Outcome: _____

Name _____ Signature _____
Title _____ Date _____

Health Services Signature/Date_____
Copies to Principle __ Program Director__
rev____

The Home for Little Wanderers'

Preparing for an Emergency

Revised October 2020
(Manual)

Scope: All employees, interns, volunteers, foster parents, Board members, and third party vendors		
Effective Date: January 1, 2014	Revised: April 2020	Next Review: 2022

Preparing for an Emergency

1. Purpose

(A) ACTIONS

2. Threat Command procedures
3. Evacuation/Shelter in Place
    a. Temporary off-site locations
4. Internal Notifications

(B) BEFORE an emergency: Planning and Preparing

5. Training
6. Preparedness
    a. Equipment/vans
    b. Mobility challenges
    c. Supplies and storage capacity
    d. Disaster supply kits/go bags
7. Collaboration with Governing Authorities
8. Communications of the Plan

(C) COMMUNICATION: Notifications and Aftermath Management

9. Media Communications
    a. Media communications
    b. Confidential information
10. Aftermath Management
    a. Disaster recovery team
    b. Debrief and assessment of emergency response
    c. Documentation and record-keeping

Additional Resources:

A. Evacuation guidelines
B. Shelter in place guidelines
C. Executive on call procedures
D. Media response team
E. Bomb threat procedures
F. Bomb threat checklist
G. Hurricane checklist

PURPOSE:

The Home for Little Wanderers maintains a response system that provides a shared manner of practices and procedures to guide personnel and programs through emergency and/or disaster events. Essentially, the manual is designed to provide a common approach to safely manage the unpredictable circumstances that can occur in the course of an emergency and/or disaster. The manual is not designed to address the specifics of every conceivable emergency.

The Home's emergency preparedness plan is a living document, meaning that it is reviewed regularly and updated as necessary.

All questions and inquiries regarding the agency's emergency preparedness plan should be directed to Heidi Ferreira, Vice President of Risk Management, Evaluation, and Outcomes or The Home's members of the Core Safety Team.

Important to note: One area of the plan is not considered to be more important than another area, nor is there a specific chronology of what to know. All of the areas must work well together in order to properly manage an emergency.

(A) ACTIONS during an Emergency Event

THREAT COMMAND PROCEDURES:

The following is a set of **Command Protocols** all staff must be familiar with:

A. LOCK DOWN:

When: Fugitive in the immediate area, gun shots in the neighborhood, unsafe external circumstances and one option under ALICE when violent intruder is close by

- Command is made to LOCK DOWN

-Move all staff and clients to a room or area that can be locked—DO NOT HUDDLE OR CONGREGATE IN ONE AREA

-Be Quiet

-Lock all doors and windows

-Shut off light

-Barricade the doors with furniture, belts, ropes, etc.

- Cover windows, if possible

- Stay away from windows

-If possible, hide in cabinets, closets, under desks with backing

-Ignore FIRE ALARM (Lock Down anticipates a threat inside the building whereby an intruder could deliberately activate the alarm.)

-Wait for further instructions. Prepare for the possibility of the need for an **emergency exit from the building.**

-Await further instructions and only come out when the authorities say it is safe to do so.

B. DROP COVER AND HOLD:

When: High Winds, Nearby Explosion, Earthquake

-DROP & COVER command is given.

-Take cover, preferably under a desk, table, or strong doorway

-Cover eyes with arm

-Hold onto furniture

-Remain in “Drop” position until further instructions are given

C. SHELTER IN PLACE:

When: Toxic Air Quality, High Winds, Dangerous External Environment

-SHELTER Command is given.

-Bring as many clients and staff into the building as possible

-Call 911 if the program or location **has not already been** advised of the imminent danger

-Close and lock all windows and doors

-Turn off HVAC systems

-If the event is related to high winds, move to lowest level of the building.

-If threat is environmental, for example toxic air, attempt to tape all windows and doors.

-Attempt to assess duration of emergency

-Wait for further instruction from the authorities.

D. EMERGENCY EVACUATION/ESCAPE:

When: Nearby disaster or explosion, order of local authorities, building systems failure, Option under ALICE to escape or danger in the building or area

-Emergency Evacuation Command is given to evacuate the premises:

-Circumstances permitting, instructions will be given to leave the building and or site or identify specific exit routes. In an emergency evacuation staff should plan to meet at a designated rally point no less than 500 yards from the building.

-Use all means of transportation available.

-Use Fire Drill procedures to exit ***even though the Fire Alarm system may not be in use.***

- Provide assistance to injured clients or staff.

-Contact authorities for further instructions.

EVACUATION/SHELTER IN PLACE:

Longer Evacuation Plans

During extenuating circumstances, it may be decided internally or through local officials that the hazards are serious and reach the level that requires mandatory evacuations. Evacuations may be advised to avoid situations that have the potential to become more dangerous. When evacuations are necessary in a community, local officials will provide information to the public through the media or reverse 911 calls. Other warnings, such as sirens, text alerts, e-mails, or telephone calls are used.

In cases of a weather alert, such as a hurricane, there may be a day or two to make plans for an evacuation. Plans to evacuate shall be decided by program leadership, the Senior Director, Vice President of Program Operations, and the Director of Facilities. If it is determined that an evacuation is the safest option, the program director or designee is required to notify the clients' guardians, Department of Early Education and Care, Department of Mental Health, Department of Children and Families, or other collaterals within 24 hours of the evacuation.

Other emergencies may not allow time for people to gather necessities prior to evacuation. Planning for an evacuation beforehand is essential. Therefore, it is important that all sites and site personnel are familiar with their pre-determined destinations (listed below) in case an evacuation must take place. Site personnel must have access to the information specific to the evacuation routes to get their destinations.

If time allows:

- ✓ The site's on-site Safety Officer or designee shall secure the site by closing and locking doors and windows
- ✓ The Safety Officer or designee shall unplug electrical equipment such as radios, television, and small appliances. Refrigerators and freezers can remain plugged in unless there is risk of flooding.
- ✓ In addition to making proper notifications by phone, text, e-mail, etc.; or when external communications fail, the Safety Officer may leave a note at the site, notifying employees, parents, and others where clients and staff members are being evacuated to.

Each site/program shall have a check-in system in place to assure that clients and staff members are accounted for once they have exited the building during an evacuation.

Temporary Evacuation Re- Location Sites *

The following sites are pre-determined destinations for an evacuation:

Program/Site to be evacuated:	Pre-determined destination for evacuation:
10 Guest Street, Brighton (when necessary to activate mobile unit)	1) CFCC (portable office) in Roslindale 2) Walpole Campus
Redfield Street-IFC/Adoption; CSA Park Street; SAH Boston	1) Employees instructed to work from home 2) 10 Guest Street, Brighton
Roslindale-Clinic; CSA Hyde Park; POP; TASP	1) Employees instructed to work from home 2) 10 Guest Street, Brighton
Children's Community Support Collaborative	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
Harrington House	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
The Home in Walpole	1) Southeast Campus in Plymouth 2) CFCC in Roslindale 3) Local evacuation sites in town
Roxbury House & Roxbury Village	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
SAH Somerville	1) Employees are instructed to work from home

	2) 10 Guest Street, Brighton
Southeast Campus	1) Walpole Campus 2) Local evacuation sites in town 3) CFCC in Roslindale
Waltham House	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
FRC	1) Employees are instructed to work from home
Sommerville Village	2) Walpole Campus 3) Southeast Campus in Plymouth 4) CFCC in Roslindale

If local authorities direct staff members and clients to stay in the vicinity, they will be required to stay in the local/town or city designated evacuation sites rather than travel to The Home's alternative evacuation site.

CFCC in Roslindale will be the 3rd option for all sites unless indicated otherwise.

Please note: Family Networks is not included in the table. Because the program is located at the DCF Park Street location, Family Networks follows DCF protocol for evacuation.

*approved by EMT and Senior Leadership on 8/28/2014

Shelter in Place

Shelter-in-Place means to seek immediate shelter and remain at the location rather than evacuate during the emergency. A Shelter-in-Place command is typically called when an evacuation is not safe. Once a decision is made to shelter-in-place, the site's/agency's Incident Commander notifies all other staff members using all means of communication available.

INTERNAL NOTIFICATIONS

1. **If the emergency requires that 911 be called immediately, 911 is the first contact.**

2. Every staff member shall know their program's on-call structure, which includes the program's rotation for the Administrator-on-Call (AOC); and the agency's executive on-call procedure. Once emergency responders are notified of the emergency, the program's AOC is the first contact once it is safe to do so. The program's AOC must be notified of all emergencies.

3. The AOC, if not the Program Director, is responsible for notifying the Program Director.

4. The Program Director shall contact the Senior Director, Vice President or Executive on Call. (See Appendix B for additional details)

5. In some instances, a phone system will be enacted, which allows automated contact to Facilities personnel, Executive Management Team members, and other appropriate personnel. Each contact shall be contacted on their cell phone, office phone, and home phone through the automated system.
    a. The initial message in the automated system shall announce the nature of the incident, instructions to personnel about what actions to take, or shall tell personnel to wait for further instructions.

6. When it is safe to do so, and in accordance to our ICT System, the assigned liaison officer in the program is responsible for notifying the DCF hotline, the parents and guardians of the clients, and state agencies, including Department of Children and Families (DCF) and Department of Early Education and Care (EEC), when applicable.

(B) BEFORE an Emergency: Planning and Preparing

Employee training and safety meetings

1) All new employees shall be trained in the emergency preparedness plan as part of their initial new hire orientation. The orientation will include a general overview of contents in the emergency plan, threat command procedures, and evacuation procedures.

2) All Programs and Departments will review components of the emergency preparedness plan with all staff. Additionally, managers and supervisors shall be required to participate in regular discussions with a focus on their roles during an emergency.

3) Each site shall have assigned Safety Officers available to review the emergency plan with their colleagues, provide input to the emergency plan when modifications are made, and to serve as the liaison between the sites and the Core Safety Team. Safety Officers and the Core Safety Team shall meet twice a year to review elements of the emergency plan.

4) Members of the agency's Core Safety Team shall check in with programs and sites periodically to ensure that employees have an understanding of the emergency plan.

5) Significant changes to the emergency plan will be communicated to all staff in a timely manner.

6) General safety shall be discussed at least twice annually in the town hall meetings scheduled for all employees to attend.

Practice Drills and Training

Aside from the state required fire drills, programs/sites are required to complete one drill annually using the threat command procedures, , and/or other relevant components of the emergency preparedness plan.

The program/site's designated Safety Officer shall complete documentation to provide information about the practice drill such as: date, time, participants, successes, issues, and corrective action steps to address any issues noted. The documentation shall be maintained at the site and at The Home's Administrative offices.

PREPAREDNESS:

Work areas are examined frequently to establish that the work environment is safe for all clients, employees, and others. Aside from emergencies listed in the plan's purpose section, programs may encounter their own set of risks and dangers such as an explosion at a power plant or a chemical truck overturned on a local highway. Programs/sites should conduct an individual assessment to proactively address other potential risks and develop a plan to address any of these factors that could potentially impact the program/site's safety.

a. Equipment/Vans

During events that require an emergency response such as evacuation/escape and when warranted, programs shall implement a transportation plan that supports the evacuation. If agency vehicles are not an adequate resource, the plan may require staff to use their own vehicles in addition to the program's vehicles. At some locations, town resources will coordinate transportation in accordance to their own emergency planning.

Agency vehicles shall be properly maintained and determined to be in a safe operating condition by appropriate staff of The Home. Programs are required to regularly schedule appointment for routine program vehicle maintenance. A standard first aid kit must be present in all agency-owned vehicles.

Suggested items for personal vehicles include:

- Whistle
- Flashlight
- Seatbelt cutter/glass breaker
- Program contact list
- Wet wipes

b. Mobility Challenges

It is imperative that programs and sites are prepared to safely transport and manage clients, visitors, and employees with mobility challenges when an emergency occurs. To avoid confusion, employees should be assigned prior to any emergency as the individuals responsible to assist in moving or transferring people with mobility challenges.

Every site shall have a wheelchair in a designated area that is easily accessible to staff members.

All employees in congregate care programs and selected employees at the remaining sites shall be trained in proper carrying techniques in regularly scheduled CPR/First Aid training or as a separate training.

c. Supplies and Storage Capacity

Most sites that accommodate clients have designated areas to maintain emergency supplies such as water, canned food, and emergency equipment. The areas must be easily accessible and in a dry and secure location at the site.

Emergency supplies in the designated storage areas may include the following:

1. Bottled water (one week supply)
2. Purification tablets (for water)
3. Can opener
4. Sealed instructions as to where master keys are located
5. First aid kit (serves 15 people) and first aid manual
6. Hygiene/sanitation supplies-wet wipes, purel/hand sanitizer, bleach
7. Latex gloves
8. Portable or hand cranked radio
9. Flashlights, and extra batteries
10. Shovel and other useful tools-hammer, scissors, whistle, tarp, crow bar
11. Matches in a waterproof container
12. Duct tape
13. Face masks
14. Safety glasses
15. Blankets, space blankets and extra clothing
16. Small child's needs (if applicable)
17. Agency forms and documents: agency contact/on-call list, emergency phone numbers, staff emergency contact list (e.g. staff phone numbers), emergency manual; client face sheets with list of current medications (where applicable); emergency medical care releases for clients (where applicable); emergency contact information for all staff members and clients; emergency numbers for town or city

Storage Tips

- Keep food in the dry and cool areas at the site.
- Keep food sealed at all times.
- Empty opened packages of sugar, dried fruits and nuts into screw-top jars or air-tight cans to protect them from pests.
- Inspect all food containers for signs of spoilage before use.

d. Disaster Supply Kits/ Go Bags

Programs/sites must be ready at a moment's notice to leave the premises when employees and clients are instructed to immediately leave the facility or an emergency has occurred at the program/site. Each site shall maintains a disaster supply kit or "go bag", which must be readily accessible for easy exit.

Each site's assigned Safety Officer is responsible for regular checks to ensure that the "go bags" are intact and up to date. The check shall be noted on the Facility Safety Checklist.

COLLABORATION WITH GOVERNING AUTHORITIES:

Programs/sites must be proactive and know the local town/city's protocols relative to emergency preparedness, response, mitigation and management.

1. Programs/sites shall determine if the town/city where they are located has an Emergency Management Agency (EMA) or Office of Emergency Management (OEM). Most EMA/OEM's have established Emergency Preparedness/Response Plans and are directly affiliated with the Massachusetts Emergency Management Agency (MEMA).
2. The Program Director and/or site liaison schedules a meeting with the EMA/OEM either at the program or the EMA/OEM office and provides the following information:

    - Program profile information, who, what, where, assets/resources, etc.
    - Services provided (clinical, behavioral, CBAT, respite, residential, etc.)
    - Population served, such as latency age, adolescents, DMH, Court ordered, etc.
    - Licensing information, such as EEC, DPH, DMH, etc. (as applicable)
    - Program type, i.e., congregate care, day school, group home, etc.

3. The Program Director and/or site liaison establishes annual review/evaluation meetings with local EMA/OEM to ensure the program continues to meet the standards established by the EMA/OEM and apprise them of changes at the program level.

4. The program/site's Safety Officer contacts the program's local law enforcement agency to register the program as a service organization providing human services to a youth population.

5. The program/site's Safety Officer contacts the local hospitals and schools to establish what protocols/resources are available for the program, and the population served, in case of manmade or natural disaster. Many first responders prioritize youth and elderly for initial response in emergency situations.

6. Depending on the County the program resides in, there may be a County Technical Rescue Team. The County Technical Rescue Team assists towns within their respective

county and surrounding counties with extra emergency personnel and equipment that may be needed, at any given time, to protect the public. This includes events such as dive rescues, structural collapses, natural or manmade crisises.

The Home's private special education day schools should expect to receive a higher level of prioritization for response due to the EMA/OEM's obligation to MEMA and the Department of Elementary & Secondary Education.

7. Programs can register to connect with the Emergency Broadcast System (EBS) in program/site's area and make sure the program is registered to receive notifications in the event of an emergency. For example, in Plymouth County, the Plymouth County Sheriff's Department has contracted to license the Emergency Communications Network's (ECN) CodeRED high-speed notification system. The CodeRED system provides Plymouth County and Bristol County officials the ability to quickly deliver messages to targeted areas throughout these two counties.

It's anticipated that the local authorities will give the programs and sites further instructions regarding emergency management.

Communications of the Plan

In preparing the document, The Home shall share the manual for preparing for an emergency with relevant licensing agencies and funders such as the Department of Early Education and Care, the Department of Children and Families, Department for Mental Health, the Department of Early and Secondary Education and Department of Public Health. The Home shall further determine if the external agencies provide resources to assist in emergency preparedness, response, mitigation and management.

(C) COMMUNICATION: Notification and Aftermath Management

MEDIA & EXTERNAL COMMUNICATIONS:

The Vice President for Development & Communications and the Public Relations Manager, working closely with the CEO, is responsible for communicating with the media. The VP for Development & Communications will also work closely with The Home's outside public relations firm to plan, coordinate and execute the media response to a crisis.

A. Media Communications

The Media Response Team (MRT) is responsible for handling all media aspects of an emergency or crisis situation outside of the immediate emergency, and will automatically be activated. (This is not to be confused with the ICT system.) This includes developing and implementing a strategy to get the situation under control and communicating with the public, media, government officials and agencies, personnel, and the Board. Once a crisis situation has been identified and the President & CEO or Executive Vice President & CFO is notified, all communication with external audiences and within any of The Home's various programs should be coordinated by the Media Response Team. (Please see Appendix for the Media Response Team)

During off hours, the Home's switchboard will direct personnel and the media to the Vice President of Communications and Development, or designee.

The CEO or VP for Development & Communications will be the **chief spokesperson** in communicating The Home's position regarding the crisis and the actions taken to resolve it. The VP for Development & Communications will determine the need to contact the agency's crisis communications consulting agency.

All other staff members involved in the emergency or crisis situation shall refer any inquires from the media to the VP of Development and Communications. Unless directed to do so, staff members shall have minimal contact with the media in an emergency or crisis situation. The Liaison Officer assigned on the ICT is responsible for fielding media inquires.

B. Confidential Information

A crisis at a program or site run by The Home will be of interest to the media. The public and concerned parties (clients' families, employees' families, etc.) have a right to be informed and it is important to ensure that they get the facts in a timely fashion. In most cases they will hear the latest information through the media. The expectation is that all personnel are as cooperative as possible in providing information without jeopardizing the emergency response efforts or exposing The Home or individuals involved in the crisis to potential liability.

Operators, front desk staff, and other employees that are likely to field calls should be notified as soon as possible, and instructed not to give out any information and refer all media calls to the VP for Development & Communications and all other calls to the CEO or Executive Vice President & CFO. A member of the Communications Team will send at least one communication, which will inform and update all staff with the status of the crisis.

Confidential information may include:

- Personal information about clients
- Personal information about employees
- Estimates of damage as a result of the accident
- Extent of injury to clients, personnel, or visitors
- Whether or not such incidents have occurred in the past
- Individual or group of individuals responsible for incident
- Home phone numbers of key personnel or victims
- Salaries or other information regarding executive staff or Board
- Names of contractors who worked on a building (if there is a building failure)

AFTERMATH MANAGEMENT:

A. Disaster Recovery Team

Effective disaster management requires that the proper action steps are taken in the immediate emergency but it also includes planning to ensure required resources are available and coordination of those resources are available in disaster recovery. The first step after the emergency is creating a disaster recovery team involving key functional managers from all of The Home's departments and effected programs. The Disaster Recovery Team is responsible for assessing and implementing resources necessary to support the impacted site or sites in order to resume routine operations. The resources can include crisis counseling, staffing resources, repairs, temporary relocation of a site, etc. Officials from local fire, police and emergency-management offices as well as city, county or state officials may also be important members of the team.

B. Debriefing and Assessment of Emergency Response

Following any emergency, the agency is responsible for maintaining the continuity of operations and conducting an assessment of the response in areas such as communication internally; communication with families, providers, and youth; management of staff; information systems, management of facilities, and collaboration with partners and local authorities. An assessment may include the following questions:

How was the ICT instituted? Were there gaps?

What could the ICT have done differently or more effectively?

What agency/program responsibilities work effectively during the emergency?

Was the ICT and agency personnel able to stay connected to clients, families, and other providers?

Was the ICT and agency personnel able to effectively communicate with staff regularly to provide information, updates, and instructions?

How did the agency help clients, families, and staff members deal with stress of the emergency?

Was the agency able to contact all staff members quickly?

Did technology work effectively to communicate to clients, families, and staff members?

Did sites have the proper supplies and equipment for the emergency? If not, how come?

Were clients and staff members able to properly follow threat commands and additional instructions?

C. Documentation and Record Keeping

When possible, everyone involved in the response should document relevant information throughout the crisis, with specific information regarding who called whom, who stated what, response activities, and the date and time of all major events. This record will be especially important later, if managers need to reconstruct events for the media, insurance, or liability claims.

Accurately recording requests from the public, media, donors, regulatory agencies, etc. will be a critical factor in the overall response effort as well. In all staff functions, documentation will be crucial in later claims and litigation (if they occur) and may also be required by government regulators.