# INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A

**5. CURRENT ORGANIZATION**

(Fill in additional positions as appropriate)

- INCIDENT COMMANDER
  - LIAISON/PUBLIC INFORMATION OFFICER
  - SAFETY OFFICER
  - MEDICAL DIRECTOR/SPECIALIST
  - OPERATIONS SECTION CHIEF
    - RESIDENT SERVICES BRANCH DIRECTOR
    - INFRASTRUCTURE BRANCH DIRECTOR
  - PLANNING SECTION CHIEF
  - LOGISTICS SECTION CHIEF
  - FINANCE/ ADMINISTRATION SECTION CHIEF

# NHICS 201 | INCIDENT BRIEFING

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. SITUATION SUMMARY** (for briefings or transfer of command)

**4. HEALTH AND SAFETY BRIEFING** Identify potential incident health and safety hazards and implement necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. (Summary of NHICS 215a)

1.

2.

3.

4.

**5. MAP/ SKETCH** (Attach sketch showing the total area of operations, the incident site/area/ impacted and threatened areas, and/or other graphics depicting situational status and resource assignment, as needed.)

☐ See Attached

**PURPOSE:** BASIC INFORMATION REGARDING THE INCIDENT SITUATION AND RESOURCES ALLOCATED
**ORIGINATION:** INCIDENT COMMANDER OR DESIGNEE
**COPIES TO:** ALL IMT STAFF

# NHICS 202 | INCIDENT OBJECTIVES

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | | |
|---|---|---|---|---|
| | | DATE: | FROM: | TO: |
| | | TIME: | FROM: | TO: |

**3. INCIDENT OBJECTIVES**

**4. FACTORS TO CONSIDER** Considerations in relationship to the objectives and priorities, including weather and situational awareness.

**5. NHICS 215A – INCIDENT ACTION PLAN (IAP) SAFETY ANALYSIS and/ or SITE SAFETY PLAN?** ☐ YES ☐ NO

Approved Site Safety Plan Locations:

| | | | | |
|---|---|---|---|---|
| **6. PREPARED BY** | **PRINT NAME:** | ______ | **SIGNATURE:** | ______ |
| | **DATE/TIME:** | ______ | **FACILITY:** | ______ |
| **7. APPROVED BY** | **PRINT NAME:** | ______ | **SIGNATURE:** | ______ |
| | **DATE/TIME:** | ______ | **FACILITY:** | ______ |

**PURPOSE:** DESCRIBES BASIC INCIDENT OBJECTIVES AND SAFETY CONSIDERATIONS
**ORIGINATION:** PLANNING SECTION CHIEF
**COPIES TO:** ALL IMT STAFF

# NHICS 214 | ACTIVITY LOG

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | | |
|---|---|---|---|---|
| | | DATE: | FROM: | TO: |
| | | TIME: | FROM: | TO: |

| 3. NAME | | 4. IMT POSITION | |
|---|---|---|---|

| 5. ACTIVITY LOG | |
|---|---|
| DATE/TIME | MAJOR EVENTS, DECISIONS MADE AND NOTIFICATIONS |
| | |
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| 6. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: DOCUMENT INCIDENT ISSUES, DECISIONS MADE, AND NOTIFICATIONS.
**ORIGINATION**: ALL IMT STAFF
**COPIES TO**: PLANNING SECTION CHIEF

# NHICS 214 | ACTIVITY LOG

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |
| 3. NAME | | 4. IMT POSITION | |

| 5. ACTIVITY LOG | |
|---|---|
| DATE/TIME | MAJOR EVENTS, DECISIONS MADE AND NOTIFICATIONS |
| | |
| | |
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| | |

| 6. PREPARED BY | | |
|---|---|---|
| | PRINT NAME: ______ | SIGNATURE: ______ |
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: DOCUMENT INCIDENT ISSUES, DECISIONS MADE, AND NOTIFICATIONS.
**ORIGINATION**: ALL IMT STAFF
**COPIES TO**: PLANNING SECTION CHIEF

# NHICS 205 | COMMUNICATIONS LIST

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD |
|---|---|---|
| | | DATE: FROM: / / 2018 TO: |
| | | TIME: FROM: TO: |

**3. INTERNAL CONTACTS**

| NAME | NHICS ASSIGNMENT | PHONE (PRIMARY & ALTERNATE) | FAX | E-MAIL | ALTERNATE COMMUNICATION DEVICE | COMMENTS |
|---|---|---|---|---|---|---|
| UNION PLAZA | | 7186700700 | 7186700726 | unionplazacares@gmail.com | 3477329758 | Seperate Hardline phone @ front desk (white phone) |
| | | | | | 9179921302 | Emergency Cellphone Nursing REDBOX |
| | | | | | inmarsat Sat Phone | SATELLITE PHONE Assist Admin Office |
| | | | | | | behind door |
| | | | | | PORTABLE WIFI JETPACK | WIFI 1 Asst. Admin Office behind Door REDBOX |
| | | | | | PORTABLE WIFI JETPACK | WIFI 2 Asst. DNS Office Top Right Desk Drawer |
| | Incident Commander | | | | | |
| | Operations Section Chief | | | | | |

**PURPOSE**: PROVIDES INFORMATION ON ALL COMMUNICATION DEVICES ASSIGNED
**ORIGINATION**: LOGISTICS SECTION CHIEF
**COPIES TO**: ALL IMT STAFF
**NOTE**: CAN BE PREFILLED BEFORE INCIDENT AND UPDATED AS NEEDED

# NHICS 252 | SECTION PERSONNEL TIME SHEET

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. TIME RECORD**

| # | EMPLOYEE (E)/ VOLUNTEER (V) NAME ( PRINT) | E/V | EMPLOYEE NUMBER | NHICS ASSIGNMENT | DATE/TIME IN | DATE/TIME OUT | TOTAL HOURS | SIGNATURE (TO VERIFY TIMES) |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |

* MAY BE USUAL NURSING HOME VOLUNTEERS OR APPROVED VOLUNTEERS FROM COMMUNITY

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY
**ORIGINATION**: INCIDENT MANAGEMENT TEAM PERSONNEL AS DIRECTED BY THE INCIDENT COMMANDER
**ORIGINAL TO:** FINANCE/ADMINISTRATION SECTION CHIEF
**COPIES TO:** PLANNING SECTION CHIEF

# NHICS 252 | SECTION PERSONNEL TIME SHEET

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. TIME RECORD**

| # | EMPLOYEE (E)/ VOLUNTEER (V) NAME ( PRINT) | E/V | EMPLOYEE NUMBER | NHICS ASSIGNMENT | DATE/TIME IN | DATE/TIME OUT | TOTAL HOURS | SIGNATURE (TO VERIFY TIMES) |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |

* MAY BE USUAL NURSING HOME VOLUNTEERS OR APPROVED VOLUNTEERS FROM COMMUNITY

| 4. PREPARED BY | PRINT NAME: ______ SIGNATURE: ______<br>DATE/TIME: ______ FACILITY: ______ |
|---|---|

**PURPOSE:** RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY
**ORIGINATION:** INCIDENT MANAGEMENT TEAM PERSONNEL AS DIRECTED BY THE INCIDENT COMMANDER
**ORIGINAL TO:** FINANCE/ADMINISTRATION SECTION CHIEF
**COPIES TO:** PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

**INSTRUCTIONS**

**PURPOSE:** Records the disposition of residents during a facility evacuation.

**ORIGINATION:** Resident Services Branch Director

**COPIES TO:** Operations Section Chief and Planning Section Chief

**NOTES:** Completed with information taken from each NHICS 260 - Resident Evacuation Tracking form. If additional pages are needed, use a blank NHICS 255 and repaginate as needed

| NUMBER | TITLE | INSTRUCTIONS |
|---|---|---|
| 1 | **Incident Name** | Enter the name assigned to the incident. |
| 2 | **Operational Period** | Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies. |
| 3 | **Resident Evacuation Information** | |
| | **Resident Name** | Enter the full name of the resident. |
| | **Medical Record #** | Enter medical record number. |
| | **Medical Record Sent** | Indicate yes or no. |
| | **Disposition** | Indicate the resident's disposition. |
| | **Mode of Transport** | Indicate the mode of transport (CCT, ALS, BLS, Van, Bus, Car) |
| | **Accepting Facility Name and Contact Info** | Enter accepting (receiving) facility name and contact information |
| | **Time Facility contacted & report given** | Enter time prepared (24-hour clock). |
| | **Transfer Initiated (Time/ Transport Co.)** | Enter time, vehicle company, and identification number. |
| | **Medication Sent** | Indicate yes or no. |
| | **MD/Family Notified** | Indicate yes or no. |
| | **Arrival Confirmed** | Indicate yes or no. |
| 4 | **Prepared by** | Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility. |

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: | | SIGNATURE: | |
|---|---|---|---|---|
| | DATE/TIME: | | FACILITY: | |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
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| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| . INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**. RESIDENT EVACUATION INFORMATION**

| ESIDENT NAME | | MEDICAL RECORD # | | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| ISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| ESIDENT NAME | | MEDICAL RECORD # | | | MED RECORD SENT | ☐ YES ☐ NO |
| ISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| ESIDENT NAME | | MEDICAL RECORD # | | | MED RECORD SENT | ☐ YES ☐ NO |
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| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| . PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

RPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
IGINATION: RESIDENT SERVICES BRANCH DIRECTOR
PIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
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| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | | |
|---|---|---|---|---|
| | | DATE: | FROM: | TO: |
| | | TIME: | FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ____________ | SIGNATURE: ____________ |
|---|---|---|
| | DATE/TIME: ____________ | FACILITY: ____________ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | | |
|---|---|---|
| | PRINT NAME: ______ | SIGNATURE: ______ |
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Executive Summary - Emergency Preparedness | |
| **Policy Date:** | **Policy Revision:** Revision Date 1/31/18, 7/24/24 |

This Emergency Management Plan has been developed for use by and is hereby approved for implementation and intended to supersede all previous versions. This Emergency Management Plan was established to promote a system to: save lives; protect the health and ensure the safety of all persons in facility; alleviate damage and hardship; and reduce future vulnerability to hazards that may disrupt normal activities within the facility and resident care areas. Furthermore, this document indicates the commitment to annual planning, training, and exercise activities in order to ensure the level of preparedness necessary to respond to internal or external emergencies or incidents that affect the nursing home.

**Purpose**

The purpose of the Emergency Management Plan is to improve the capacity to detect, respond to, recover from, and mitigate the negative outcomes of threats and emergencies. The plan establishes a basic emergency plan to provide timely, integrated, and coordinated response to the wide range of natural and manmade events, which can occur both inside and outside the facility, that may disrupt ***normal operations and require pre-planned response.***

The objectives of our Emergency Management Plan include:

- Providing maximum safety and protection from injury to residents, visitors, and staff
- Attending promptly and efficiently to all individuals requiring medical attention in an emergency situation
- Providing a logical and flexible chain of command to enable the maximum use of resources
- Utilizing all community-based services
- Maintaining and restoring essential services as quickly as possible following an incident.
- Protecting facility property and equipment
- Satisfying all applicable regulatory and accreditation requirements
- Keeping Official Authorities informed of any emergency that directly impacts this facility
- Identification of all business functions essential to the facility's operations that should be continued during an emergency;
- Identification of all risks or emergencies that the facility may reasonably expect to confront;
- Identification of all contingencies for which the facility should plan;
- Consideration of the facility's location;
- Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and,
- Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

**Scope:**

Within the context of this plan, an incident is any emergency event which overwhelms or threatens to overwhelm the routine capabilities of the facility. This all-hazards Emergency Management Plan designed to respond to natural and manmade incidents, including natural disasters as well as technological, hazardous material, and terrorist events. The plan describes the policies and procedures the facility will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.

Union Plaza Care Center has conducted a review of the Kaiser HVA system and a review of the county hazard plan. This plan has been developed by committee in conjunction with the local OEM to ensure a comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. Union Plaza Care Center has entered into arrangements with facilities and maintains MOU for the safe transfer of residents to facilities in the event of required evacuation. Contact information with community Hospitals and nursing homes shall be maintained in this plan and reviewed annually. The coordination of facility requirements will have been updated via the HYS HCS system along the HERDS system.

Deborah Luongo 7/24/24

Deborah Luongo
Administrator

Date

| NAME | CONTACT PERSON | TELEPHONE # | FAX # |
|---|---|---|---|
| ALL SERVICE DAY & NIGHT | JENINE 347 -- 886 - 5356 | 516 – 378 - 1176 | |
| ABALINE | HERSHAL | 732 – 582 - 0200 | 732 – 596 - 1308 |
| ABOTT " ROSS " | SUSAN | 203 – 536 - 9154 | |
| BERTRAM | INDRA | 908 – 862 - 8200 ext. 2 | 815 – 377 - 3860 |
| BETTER PLASTIC | | 718 – 875 - 5555 | 718 – 875 - 5702 |
| DRISCOL | ROSA | 973 – 672 - 9400 ext. 119 | |
| GOLDEN FLOW | ACCT # 5041 | 718 – 488 - 0700 ext. 6 | 718 – 488 - 0795 |
| HERSEY'S ICE CREAM | BRANCH # 631 – 410-7250 ext. 105 | 631 – 462 - 0259 | 631 – 462 - 0753 |
| H. SCHRIER & CO | STEVE MAIORANO sale director | 718 – 258 - 7500 | 718 – 258 - 9586 |
| ISLAND WHOLESALE | DAN JR. | 631 – 434 - 2700 | 631 – 434 - 27777 |
| KIM CHI | SONGS | 347 – 728 - 2222 | |
| MIRON PRODUCE | | 718 – 378 - 5983 | 347 – 823 - 2937 |
| ND LABS | MIKE | 516 – 612 - 4900 | 516 – 504 - 0289 |
| PECHTERS | ANTHONY 718 – 749-8280 | 718 – 439 - 9600 | 718 – 439 - 9601 / 9109 |
| PETER'S WHOLESALE MEAT | | 718 – 659 - 6328 | 718 – 738 - 2986 |
| POMERANTZ SUPPLY | JASHUA POMERANTZ<br>WAREHOUSE | 718 – 207 - 5451<br>201 – 246 - 8800 | 201 – 246 - 8801 |
| RONBAR | | 718 – 937 - 6755 | 718 – 786 - 1109 |
| TRI STATE | GRACE ext. 846 | 718 – 624 - 7980 | |
| U. S. FOODS | 800 – 222-1278 option 2 | 516 – 766 - 1802 ELLIOT | 516 – 766 - 1872 |
| UNITEX | ACCT # 7688 | 718 – 324 - 5900 | |
| YORKVILLE | LARRY 917 – 539-7741 | 718 – 768 - 4848 | 718 – 768 - 0539 |

JENINE. 347 886 5356 All Service

**Building Service Providers**

| Company Name | Service Provided | Phone Number |
|---|---|---|
| Fire Suppression Services | Fire Pump & Sprinklers | 516-608-8366 |
| All Service | Kitchen Equipment Repair | 718-528-7777 |
| Action | Garbage Removal | 201-376-5032 |
| eCopier Solutions | Copies | 212-300-3582 |
| Reliatech/Hocs Consultants | Computers/IT Support | 718-377-0922 |
| Spectrum Business | Internet | 877-227-8711 |
| Parkway | Pest Control | 800-220-7275 |
| Tristate | Tube Feeding equipment | 718-624-7980 x229 |
| Day & Nite | Refrigerator Repair COLD Equip | 516-378-1176 |
| All Service | Repairs (Kitchen HOT Equip) | 516378-1176 |
| Windstream (Broadview) | Phone Carrier | 516-348-2561 |
| SaveComtel | Phone/Voicemail Hardware Repair | 212-444-1005 |
| Airtech | Air Conditioning Repairs | 718-786-6200 |
| ISPI Integrated Systems | Fire Alarm System | 201-305-6728 |
| Matt Haberlack | Landscape & Gardening | 516-395-8320 |
| Alboro Security | Security Services | 929-280-9888 |
| Paragon Inc. | Boiler/Heating Systems | 914-804-7578 |
| Power House | Generator | 877-322-0678 |
| Star Satellites | Satellite TV | 718-496-4552 |
| TKElevator | Elevator Service | 212-947-8800 |
| APS, Inc. | Carendo & Marisa Lifts | 516-444-5439 |
| Sentry | Cameras | 866-573-6879 |
| Tyco | Fire Alarm | 800-289-2647 |
| Johnson Controls | Fire Alarm Panel/System | 844-628-2529 |
| Filta Clean | Range/Hood Cleaning Repair | 718-495-4747 |

## SUPPLIES AND EQUIPMENT VENDORS

| Company Name | Service provided | Phone Number |
| --- | --- | --- |
| Advanced Care | Home Equipment | 516-295-2092 |
| Abaline | Paper Eat/Drink | 732-582-0200 |
| Unitex, Inc. | Laundry & Linen | 732-442-3099 |
| Ronbar | Housekeeping | 718-937-6755 |
| DELT | Hardware Supplies | 888-645-6257 |
| Grainger | Engineering Supplies | 800-706-5501 x233 |
| Twin Med | Nursing/Resident | 877-894-6633 |
| Pechters | Breads/Baked | 718-749-8280 |
| Bertram | Food | 908-862-8200 x 101 |
| US Foods | Food | 516-766-1802 |
| Hershey's | Ice Cream/Deserts | 631-462-0259 |
| Med part | Medical Equipment | 718-436-5100 |
| Peter Meats | Meat/Food | 718-659-6328 |
| Island Meats | Meat/ Food | 631-434-2700 |
| Meyer's Emergency Water Inc. | Potable Water | 833-636-4030 |
| SMD, Inc. | Bracelet Wanderguard | 800-899-7264 |
| Direct Supply | Engineering/Housekeeping | **888-367-3690** |
| Triple AHA Supplies | Salt | 845-566-4200 |
| USA Wholesale | Electrical Supplies | **855-872-8444** |
| Valmar Surgical | Home Equipment | **888-596-3070** |

| ID | Full Name | Div | Home Phone | Cellular Phone |
|---|---|---|---|---|
| 10827 | BADIA, DIANA | ADMIN | | (917) 559 - 5511 |
| 442 | KERNEY, MARGARET A. | ADMIN | (516) 724-1312 | |
| 10732 | LUONGO, ANGELO | ADMIN | 3472877153 | |
| 10718 | LUONGO, DEBORAH | ADMIN | 9179099709 | |
| 2 | Pelman, Jonathan | ADMIN | | (917)923-0954 |
| 10823 | PURCELL, ERYKA | ADMIN | | (917) 608-9334 |
| 10764 | CHUNG, CHAOCHI JENNY | ADMSN | | (516)808-0073 |
| 10695 | KOCHNER, KAREN | ADMSN | (917)838-3169 | |
| 10742 | LEONG (Chris), WAI HON | ADMSN | 7187018808 | 9179220768 |
| 10850 | LIM, SUNG JOON (CORY) | ADMSN | | (443)851-7755 |
| 10722 | AHN, ELIZABETH | BKPNG | | 3478078764 |
| 10497 | HUNG, KA YI (DORA) | BKPNG | | 9175837770 |
| 10014 | RAMSUNDAR, SITA | BKPNG | 5166325474 | (516)317-4224 |
| 10820 | REYNOLDS, ERIN | BKPNG | | (516) 314-4703 |
| 10759 | SABZON, ESTHER | BKPNG | | 347-761-2335 |
| 10012 | LIPSCHUTZ, MOISHE | COMTR | 7184363562 | |
| 10834 | SALGUERO, MARVIN | CTRLSP | | (917) 558-4651 |
| 10211 | BENAVIDES, JOSE | DIETRY | (347)743-8085 | |
| 10849 | BORJA, ESNEYDER | DIETRY | | (929) 599-0728 |
| 10215 | BROWN, CHEDDI | DIETRY | (718)659-1996 | (718)772-6140 |
| 10594 | CHANG, YU-LIN | DIETRY | (917)912-3167 | (646)251-4212 |
| 10504 | COLON, BEATRIZ | DIETRY | | (646) 340-7374 |
| 10443 | COLON, JOSE | DIETRY | (718)380-8736 | (347)726-1676 |
| 10654 | FERNANDO, DANIEL J. | DIETRY | (516)833-6665 | (718)607-3424 |
| 10223 | FLORES, JAVIER | DIETRY | (718)813-1557 | |
| 10655 | FRAZER, SHAVAUGHN | DIETRY | (347)988-0120 | (347)221-4913 |
| 7166 | HERNANDEZ-MONTILBA, RUBER | DIETRY | | (516) 920-9258 |
| 10453 | HUNTER, PETER | DIETRY | (718)735-1198 | (347)495-0351 |
| 10838 | HYMAN, EVOL V | DIETRY | | (516)234-1522 |
| 10782 | JONES, MARCUS SAMUEL | DIETRY | | (929) 412-8709 |
| 10489 | LEE, YU-JU CHUANG | DIETRY | (917)603-4800 | |
| 10418 | MAGNAYON, CHRISTIAN | DIETRY | (718)465-2640 | (646)352-2177 |
| 10672 | MAGNAYON, YUBERKYS D. | DIETRY | (718)465-2640 | (347)679-0355 |
| 10671 | NAM, JUHA | DIETRY | | (646)379-4659 |
| 10226 | NAVARRO, MARGARITA | DIETRY | (917)885-4236 | (347)476-2642 |
| 10452 | NEWMAN, CHUI | DIETRY | (718)789-6707 | (917)474-1319 |
| 10656 | NUUANU, KIARA | DIETRY | (347)707-0045 | |
| 10506 | RAMCHAND, VASANT | DIETRY | (646)460-5274 | |
| 10771 | RASUL, ZEYAD | DIETRY | | (347) 257-6016 |
| 10439 | RESTREPO, HECTOR | DIETRY | (718)461-1311 | |
| 10729 | REYNOLDS, MICHAEL | DIETRY | | (929) 231-2593 |
| 10812 | ROGERS, JOSHUA EYON | DIETRY | (347)445-1189 | (929)688-1686 |
| 10845 | ROSADO, BRANDON | DIETRY | (917) 543-7849 | (929) 923-2996 |
| 10516 | ROSARIO, SANDRA | DIETRY | (646)512-1241 | |
| 10230 | SALGUERO, FABRICIO | DIETRY | (917)650-8128 | |
| 10505 | SANCHEZ, NORRIS | DIETRY | (917)498-0955 | (347)615-8366 |

| | | | | |
|---|---|---|---|---|
| 10833 | SINGH, RAJKUMAR | DIETRY | | (718) 807-5483 |
| 10232 | SMITH, DEVON | DIETRY | (718)276-6908 | (917)496-9190 |
| 10234 | STEWART, GARY | DIETRY | (718)493-3877 | (917)586-6479 |
| 10412 | WALKER, TRUDY | DIETRY | | (516)870-8444 |
| 10788 | WANG, GE | DIETRY | | (347) 988-9797 |
| 10761 | WANG, YU-HSIN | DIETRY | | (216)716-9964 |
| 10277 | WHITE, LENNOX | DIETRY | (516)285-5468 | (646)526-3752 |
| 7160 | WILSON, RASHAWN O | DIETRY | | (929)434-4861 |
| 10513 | ZELAYA, VICTOR | DIETRY | (917)420-1751 | |
| 10244 | BABAEV, SOLOMON | HSKPNG | (718)544-0476 | |
| 10253 | DURHAM(LATIMORE), JAQUELYNE | HSKPNG | (347)553-2477 | 3478168910 |
| 10371 | EDWARDS, ANDREW | HSKPNG | (718)219-2509 | |
| 10257 | FERREIRA(NIVAR), ROSAURA | HSKPNG | (718)404-1782 | |
| 10391 | FRANCO, JOSE | HSKPNG | (718)672-5389 | |
| 10247 | FRANCO-SEVERINO, ANTONIA | HSKPNG | (718)672-5389 | (347)536-4697 |
| 10250 | HOUSTON, ANTHONY | HSKPNG | (718)861-5498 | (347)860-1203 |
| 10763 | HUERTA, MAYRA | HSKPNG | | (929) 240 - 9241 |
| 10317 | HUNTER, HERVEL | HSKPNG | (718)735-1198 | |
| 7161 | JEROME, ENROCK | HSKPNG | | (347) 932-6047 |
| 7164 | LARROY, NICOLE M | HSKPNG | | (929)253-9287 |
| 10254 | LEATHERS, DERRICK | HSKPNG | (347)807-5740 | |
| 10841 | LOUIS, PIWOLSKY RAYMOND | HSKPNG | | (516) 665-4401 |
| 10768 | MARTINEZ, ERIC A | HSKPNG | | (917) 846-6213 |
| 10842 | MCCLAIN, FRED | HSKPNG | | (347)463-2655 |
| 10256 | NARAIN, HARESH | HSKPNG | 6465122300 | 9177415585 |
| 10794 | PAULINO, REINALDO | HSKPNG | | 7185141796 |
| 10258 | RAMCHAND, SUNIL | HSKPNG | (347)455-4778 | (347)455-4478 |
| 10726 | RODRIGUEZ, AURA | HSKPNG | | (347)792-5187 |
| 10259 | ROSARIO, LUZ | HSKPNG | (718)380-0968 | |
| 10260 | ROSARIO, MARIA | HSKPNG | 7184069060 | |
| 10665 | SANCHEZ, ALMA DELIA | HSKPNG | (347)221-9212 | |
| 10241 | SEDA, DAVID | HSKPNG | (718)908-2783 | (347)698-3530 |
| 10313 | SENATENGIL, JUNIOR | HSKPNG | (917)509-6756 | |
| 10263 | VALME, WISNEL | HSKPNG | (631)277-6206 | (917)685-1463 |
| 10552 | VASQUEZ, PATRIA | HSKPNG | (347)398-0802 | |
| 10749 | CHICAIZA, JOSE | MAINT | | (347) 397-2069 |
| 10819 | GERICKE, DENNIS | MAINT | | (917) 566 - 8747 |
| 7149 | MEDRANO, CARLOS | MAINT | | (347) 506-9574 |
| 10572 | SAQUICARAY, LUIS | MAINT | | (646)236-4113 |
| 10750 | VALDEZ, JAMES ROMEO | MAINT | | |
| 10030 | NISANOV, OLGA | MDREC | (718)969-1855 | (516)250-9652 |
| 10807 | ABDELRAHMAN, NOURHAN M | NURSE | | (347)209-0670 |
| 10469 | ACEVEDO, MARIA | NURSE | | (646)712-1308 |
| 10163 | ALVARADO, SONIA | NURSE | (718)208-0389 | (929)217-9191 |
| 10712 | AN, BYOUNGUK | NURSE | | (347)752-8801 |
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| 7546 | ANIAWONWA, IJEOMA PROMISE | NURSE | | (631) 640-5857 |

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| 10440 | AURELUS, CHANTAL | NURSE | (718)209-3631 | (347)232-0496 |
| 10498 | AZI, JUDITH | NURSE | (347)209-6724 | (347)977-8355 |
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| 3619 | BALAN, NATALIE | NURSE | | (646) 806-4386 |
| 7529 | BALDE, AMANATOU | NURSE | | (917)995-3248 |
| 10652 | BAPTISTE, FLORENCE | NURSE | | (646)696-5003 |
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| 10570 | BENJAMIN, THEDOSIA | NURSE | | (917)292-4159 |
| 10683 | BLAY, LIEZEL MARIE | NURSE | (646)479-6155 | |
| 7581 | BLIDGEN, BRITANNI NORIA | NURSE | | |
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| 7139 | CHEN, SAIE CHEN | NURSE | | (917) 886 - 5225 |
| 10341 | CHEONG, HYANJA | NURSE | | (917)916-0988 |
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| 7515 | CHEVALIER, STEPHANIE | NURSE | | (917) 684-2664 |
| 10825 | CHO, EUNJI | NURSE | | (347) 585 - 0154 |
| 10438 | CHUN, CHOON HEE | NURSE | (718)380-1243 | (646)441-0800 |
| 7585 | CROSBOURNE, MARIO VAUGHN | NURSE | | (929) 601 - 6359 |
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| 10640 | DUVIELLARD, MARTYSE | NURSE | | (917)365-9381 |
| 10639 | EDWARDS, DYDRE | NURSE | (718)723-3312 | (646)573-8533 |
| 90304 | EDWARDS, DYDRE | NURSE | 7187233312 | |
| 3615 | ELLERBY, NONA JEAN | NURSE | | (203)916-2947 |
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| 7520 | ETAFO, FOLASADE FLORENCE | NURSE | | (646)374-7678 |
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| 10095 | FAUBLAS(APOLON), MARIE | NURSE | (718)525-5374 | (516)444-7809 |
| 7165 | FENG, QINGSHAN | NURSE | | 9917) 578-0679 |
| 10134 | FILS-AIME, GABRIELLE | NURSE | (718)527-1682 | (347)581-9369 |
| 518 | FLORES, EUNMI | NURSE | | (917)670-4640 |
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| 10384 | FREID, GOLDA | NURSE | (718)575-3351 | (917)575-8553 |
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| 10713 | GHATAK, SANDHYA | NURSE | (718)446-0348 | (347)421-9654 |
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| 10445 | GRANADA, NATHALIA | NURSE | (917)299-1983 | |
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| 10199 | IGWE, ROSELINE | NURSE | (718)776-2520 | (646)600-1652 |
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| 7548 | JEAN-CHARLES, MACDA | NURSE | (516)254-1784 | (347)795-5753 |
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| 10745 | LAWAL, RASHEEDAT | NURSE | 9174859837 | |
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| 10848 | LUDIZACA, NUBE J | NURSE | | (347) 684-2551 |
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| 10508 | MAIGNAN, CLAIRE | NURSE | (718)525-9863 | (516)271-8481 |
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| 10139 | MARAJ, MARILYN | NURSE | (718)641-8477 | (347)449-4002 |
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| 10290 | MCCLENDON, MONIQUE | NURSE | 7185250556 | (917)853-8058 |
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| 7120 | MEDY, VANINA | NURSE | | (917) 742 - 9431 |
| 10174 | MEUS, ELVIE | NURSE | (718)888-0857 | (929)496-7278 |
| 10128 | MOMPOINT, NICOLE | NURSE | (718)527-4960 | (917)939-2876 |
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| 10839 | MORA C, ROSA ELVIVA | NURSE | | (347)459-7226 |
| 10114 | MOXAM, SILVYLYN | NURSE | (718)457-8971 | (718)683-7083 |
| 90334 | MUNIZ, KIMBERRY JULIA | NURSE | | (347)213-7779 |
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| 10066 | NI, YING(STELLA) | NURSE | 7183800219 | (646)421-9883 |
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| 7577 | OKUBALU, TOCHUKUOY FRANCE | NURSE | | (929)335-0941 |
| 10604 | OLIVIER, MICHELE | NURSE | (718)969-0759 | (917)373-0556 |
| 7538 | OWARE, RUTH | NURSE | | (401) 500-9816 |
| 10806 | PALAGUACHI PALA, ROSA | NURSE | | (646) 353-8786 |
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| 10176 | PAUL, JULIET | NURSE | (718)451-2452 | (917)402-7368 |

| 10385 | PERSAUD, CHARAINE | NURSE | (347)320-7315 | (646)804-0421 |
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| 10622 | RHULE, MONICA | NURSE | (718)525-1248 | (917)783-0033 |
| 10597 | ROBINSON, CLOVER | NURSE | | (347)673-4994 |
| 10121 | ROBINSON, EDITH | NURSE | (347)627-4716 | (347)933-0333 |
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| 10813 | LIM, CHRISTINE | RECR | | (646) 673-1922 |
| 10630 | LO, WAI MING | RECR | 6465783518 | |
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| 90318 | RIVERA, PENELOPE | RECR | | (347) 692-9037 |
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| 2120 | CARRE, MARIE | REHAB | | (516)426-0987 |
| 2100 | CAYAHYAB, MARTIN | REHAB | 9175288764 | |
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| 10022 | HUNG, PETER | REHAB | 9174532228 | |
| 2117 | JIN, EILEEN | REHAB | | (347)393-8992 |
| 10636 | KIM, HYE YOUNG | REHAB | 6466788471 | |
| 10670 | KIM, JEONG HAE | REHAB | 3474268238 | |
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| 2114 | LANZUELA, JOANNE JOAQUIN | REHAB | | 9178227612 |
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| CODES | EMERGENCY CODE DEFINITIONS | |
|---|---|---|
| DR RED | FIRE | Communicate and mobilize a response to protect residents, families, visitors, staff, physicians, and property the event of smoke and/or fire. |
| STAT | Medical Emergency | Facilitate the arrival of equipment and specialized personnel to the location of a medical emergency. Provide life support and emergency care. |
| CODE D | Bomb Threat | Activate response to a bomb threat or the discovery of a suspicious package. |
| DR FIND | Missing Person | Activate response to locate a missing resident. |
| CODE SILVER | Person with Weapon | Activate facility and staff response to event in which staff members are confronted by: persons brandishing a weapon or who have taken hostages in the facility. |
| CODE YELLOW | Hazardous Material Spill | Identify unsafe exposure conditions, safely evacuate an area and protect others from exposure due to hazardous materials spill release. Perform procedures to be taken to a minor major spill. |

# EXTERNAL DISASTERS

## 1. Severe Weather

The facility has developed a Pre-Storm Mitigation Plan to be implemented in the event of severe weather such as hurricane, tornado, high wind advisory, winter storm, flood advisory. As soon as the facility is made aware of impeding severe weather, all department heads will be notified and the Pre-Storm Mitigation Plan will be implemented. For unexpected events, the most senior charge person in the facility at the time will immediately notify the Administrator, DNS and Director of Environmental Services.

## 2. Transit Strike

**Overview**
If notice is given of impending strike by the New York City Transit Authority, the following plan will be implemented.

**Notification Procedure**
All department heads and staff will be immediately notified of impending transit strike.

**Response Procedure**
The facility has available a list of all employees address and emergency contact information.
All Department Heads will compile a list specifying each employee's means of transportation.
When possible, employees who commute by automobiles will be asked to carpool with other employees who live in the same area.
Staffing schedules will be adjusted to accommodate carpooling arrangements and other transportation arrangements.
In the case of key employees who are unable to get to work, the facility will set up specific pick-up/ drop-off locations and transport employees to and from facility.
The facility will contact its transportation provider and make arrangements for employees' transportation to and from the facility to specific pick-up/ drop-off locations.

**Restoration of Service**
Upon restoration of NYC Transit services, the facility will implement its usual staffing schedule.

# B. INTERNAL DISASTERS

## 1. Fire Safety Plan

### Overview

This facility shall be equipped, maintained and operated by personnel trained to effectively prevent, extinguish and confine fire/ products of combustion, safeguarding all persons by methods outlined in the facility Fire Safety Policy and Procedure Manual.
This facility shall comply with all applicable federal, state and local codes, rules and regulations regarding fire safety/ emergencies.

### Notification Process:

The announcement of "Dr. RED" will be paged on the overhead speaker system.
Fire Alarm System
The fire alarm system is a reliable and automatic device for transmitting an alarm from any fire alarm pull box station automatically through the facility to the Fire Department. This firm alarm system has been installed for a quick and automatic fire alert to a central station (TYCO) that is manned 24 hours 7 days a week, who will transmit the alarm to the Fire Department.

There are three basic parts to the fire alarm system:

1. **PULL STATION**: Pull handle down all the way and release. This is a mechanical lever device (no glass) which must be pulled down to the lowest position and released to activate the alarm.
2. **ALARM**: Visual and auditory alarm stations are located throughout the building. When the fire alarm box is pulled and/or automatic detector activated, an alarm will automatically be transmitted throughout the entire nursing home and the Fire Department through TYCO.
3. **FIRE DETECTORS**: These devices consisting of smoke, heat and sprinkler heads will automatically detect and transmit an alarm condition upon activation.

When a person discovers the fire and pulls the alarm, they should notify the operator (Dial "0") stating the exact location of the fire. If operator is not available, overhead page (Dial *2) and announce "Dr. Red" and give the exact location of the fire, three times.

### Response Procedures

Fire Safety training is a mandatory in-service education that must be completed during orientation for new employees and mandated annually thereafter.
Fire and evacuation drills will be conducted at least once per shift per quarter.

### I. Responsibilities of Staff When Discovering Fire, Smoke, Excessive Heat, Sprinkler Activation (A.R.C.E.)

**ALARM** - Upon discovery of a fire, the discoverer will cause the nearest alarm box to be transmitted or Dial "*2" on a facility phone and announce "Dr. Red "three times over the paging system. If you are directly involved in the fire announce the code phrase "Dr. Red". Any staff member hearing this phrase shall pull the nearest fire alarm and then go to the aid of that person.

**RESCUE** – Rescue any person in immediate danger if you can safely do so, and remove them to a safe place on the other side of the corridor barrier doors towards the nearest safe exit. Remove any compressed gasses and shut off any fans. All doors must be closed in the immediate hazardous area.

**EXTINGUISH & CONFINE** – Fight fire with proper extinguisher if possible. Close doors and windows in the hazardous area.

## II. STAFF RESPONSE to ALARMS

When ALARM sounds LISTEN to the alarm and COUNT the number of bells or listen for the operator's announcement for the location of the fire.

In the event a 10-1 alarm sequence has been sounded, **ALL STAFF** must conduct a search on the floor they are located on to determine the location of the activated sprinkler. Once the area has been located, notify the operator to announce the location overhead or you can DIAL " * 2 " and make the announcement three times. Staff discovering hazardous situation, should follow staff discoverer responsibilities.

Staff should report to fire scene or pooling area according to departmental assignments. All employees are either part of the Response Team or the Personnel Pool. However, **ANY STAFF** discovering a hazardous condition should take immediate action in accordance to the discoverer's responsibilities as indicated above, whether you are part of the Personnel Pool or not.

**Response Team**

The purpose of the facility response team, made up of designated employees (see below), is to provide to the emergency scene sufficient personnel to fight fire and safeguard residents, visitors and others.

Response Team Members:

- All maintenance department personnel
- All housekeeping department personnel
- Nursing staff – at least 1 CNA per non-affected floor not engaged in direct care or supervision at the time

Assigned Response Team members should immediately report to the fire scene with using appropriate stairways only. Use no elevators.

Response Team Personnel Pool (includes all other staff not part of the response team):

- All administrative office staff
- Dietary personnel except for manager and persons necessary for safety
- All Rehab, Recreation, Social Work, and all auxiliary staff.
- Any personnel pool staff involved with a resident(s) care, supervision or treatment must remain with the resident(s).

Personnel in the response team pool will report to the Incident Command Center in the LOBBY with sheets, blankets and fire extinguishers found nearby or enroute by using stairways only.

**General fire response instructions:**

The following guidelines must be strictly adhered to in all fire emergency situations:

- Close all doors and windows, except in the room of 'origin' where windows may be left open if impossible to safely access them
- Attempt to extinguish the fire with extinguisher or materials at hand if possible.
- DO NOT use elevators unless authorized by Incident Commander or the Senior fire department official on the scene.
- DO NOT move beds into the corridor unless authorized by Incident Commander or Senior fire department official on the scene OR if other methods are not viable.

- Residents and visitors are to remain isolated in rooms, NOT in corridors and passageways. Movement of infirm or bed-ridden residents to other areas or to the exterior is not required unless endangered.
- In the search and evacuation of rooms, do not assume a room is vacated by viewing from the doorway. You must look in corners, under beds and in bathrooms. After completion of searching a resident's room, close the door and slide the room marker to "yellow" on the doorframe.
- All equipment (not necessary to the fire effort) must be removed from passageways, exits, doors and stairs.
- Move quickly and quietly along the RIGHT side of corridors and stairways.
- DO NOT use facility telephones or paging devices except for emergency reporting and announcements.
- Turn ALL lights ON at the fire scene.
- Reassure and comfort residents and visitors.

Department Specific Responsibilities and instructions are located in the Fire Safety Manual available in each department and nursing unit.

**Fire Evacuation Procedures**
Whatever direction the fire, smoke or fumes are coming from, you will evacuate to the opposite direction from the fire, smoke or fumes.

**Methods of Evacuation:**
PARTIAL: Transferring all occupants from one smoke compartment or floor to another.
HORIZONTAL: Transferring residents from one smoke compartment to another on the same floor.
VERTICAL: Transferring residents from one level/floor to another.
COMPLETE: Transferring all occupants completely out of the building. Occupants must be led to a place of shelter and out of the way of the Fire Department operations.

**Evacuation Equipment**

| **GENERAL EVACUATION EQUIPMENT** | | |
|---|---|---|
| ***EQUIPMENT*** | ***QUANTITY*** | ***STORAGE LOCATION** (FOR 24 HOUR ACCESS)* |
| Wheelchairs | 10 | Basement Central Supply & Rehab storage room |
| | | 2 wheelchairs -1st FL, 1 wheelchair FL 2-8 |
| Resident Chart/ Medication Bags | 280 | Storage Carts in Nurses Lounge to be used for chart transport– (40 bags – 1 per resident floor) |
| **VERTICAL EVACUATION EQUIPMENT** | | |
| Evacuation Sleds | | |
| Stair Carry Chairs | 2 | 1 North & 1 South Stairwell 9th floor Wall |
| Portable Stretchers | 3 | Holding Room |
| **BARIATRIC EVACUATION EQUIPMENT** | | |
| Wheelchairs | 1 | Basement Rehab storage room |
| Evacuation Sleds | | |
| **EQUIPMENT STAGING LOCATION** | | |
| **PRIMARY** | | **ALTERNATE** |
| 1st Floor Recreation Room | | 9th Floor Staff Development Room |

**Resident Evacuation Prioritization**

Determine evacuation prioritization for all units / departments with feedback from and in consultation with:

- Safety and/or Security
- Command Center Personnel (Section Chiefs)
- Emergency Services (Fire, EMS, etc.)

Evacuation of residents will be done by mobility status and acuity level as follows:

General Resident Population

1. Ambulatory
2. Non-ambulatory, low acuity
3. Non-ambulatory bariatric (consider transferring non-ambulatory bariatric residents directly to EMS stretchers to avoid multiple transfers)

Union Plaza Care Center will hold higher acuity units for later evacuation since this gives a chance to assemble an evacuation.

Fire Evacuation General Instructions:

1. Obtain evacuation emergency equipment from the lobby emergency closet.
2. Any occupant requiring a wheelchair or a stretcher will be moved by a blanket carry, if necessary or by using the emergency equipment.
3. Those nearest to danger should be moved first.
4. Supervisors will lead their sections out in a group. If necessary, form a chain by holding hands.
5. Before a person in charge of a section leaves, make certain no one is left behind.
6. Conduct a headcount of all residents and staff on the unit and assure all are accounted for.
7. Staff members away from their normal work areas will leave via the most direct exit or nearest alternate exit.
8. Everyone should be cautioned against attempting to retrieve personal belongings before leaving.
9. Every precaution should be taken to prevent re-entry of building by occupants.
10. If trapped in room, close door; try connecting doors. If exit is not possible, remain at windows and attract attention.

**Restoration of Service**

The Incident Commander with the approval of the Fire Department Officer-in-Charge will notify the Security Officer when the emergency is over.
The Security Officer will then announce over the public address system three (3) times: "ALL CLEAR"

## UNION PLAZA CARE CENTER

## FIRE ALARM BELL & PULL STATION CODE CHART

**(IN CASE OF FIRE, PULL LEVER DOWN AND LET GO)**

| FLOOR | STATION # | LOCATION | ALARM CODE | STATION # | LOCATION | ALARM CODE |
|---|---|---|---|---|---|---|
| Roof | 42 | ROOF BOILER ROOM | 10-1-2 | 39 | 9th FL MULTI-PURPOSE RM | 9-1-3 |
| 9TH Floor | 41 | 9TH FL PATIO BULKHEAD | 10-1-1 | 38 | 9TH FL MULTI-PURPOSE RM | 9-1-1 |
| | 40 | 9th FL NORTH DOOR | 9-1-2 | | | |
| 8TH Floor | 37 | 8TH FL NORTH CORRIDOR | 8-1-3 | 36 | 8TH FL MIDDLE CORRIDOR | 8-1-2 |
| | 35 | 8TH FL SOUTH | 8-1-1 | | | |
| 7TH Floor | 34 | 7TH FL NORTH CORRIDOR | 7-1-3 | 33 | 7TH FL MIDDLE CORRIDOR | 7-1-2 |
| | 32 | 7TH FL SOUTH | 7-1-1 | | | |
| 6TH Floor | 31 | 6TH FL NORTH CORRIDOR | 6-1-3 | 30 | 6TH FL MIDDLE CORRIDOR | 6-1-2 |
| | 29 | 6TH FL SOUTH | 6-1-1 | | | |
| 5th Floor | 28 | 5TH FL NORTH CORRIDOR | 5-1-2 | 27 | 5TH FL MIDDLE CORRIDOR | 5-1-3 |
| | 26 | 5TH FL SOUTH | 5-1-1 | | | |
| 4th Floor | 25 | 4TH FL NORTH CORRIDOR | 4-1-3 | 24 | 4TH FL MIDDLE CORRIDOR | 4-1-2 |
| | 23 | 4TH FL SOUTH | 4-1-1 | | | |
| 3rd Floor | 22 | 3RD FL NORTH CORRIDOR | 3-1-3 | 21 | 3RD FL MIDDLE CORRIDOR | 3-1-2 |
| | 20 | 3RD FL SOUTH | 3-1-1 | | | |
| 2nd Floor | 19 | 2ND FL NORTH CORRIDOR | 2-1-2 | 18 | 2ND FL MIDDLE CORRIDOR | 2-1-3 |
| | 17 | 2ND FL SOUTH | 2-1-1 | | | |
| 1ST FL GARAGE | 16 | 1ST FL GARAGE NORTH | 1-1-2 | 15 | 1ST FL GARAGE REAR | 1-1-3 |
| | 14 | 1ST FL GARAGE SOUTH | 1-1-1 | 13 | 1st FL GARAGE MID | 1-1-4 |
| Lobby | 12 | LOBBY SERVICE HALL B-03 | 1-2-4 | 11 | LOBBY NORTH ACCESS PARK B-39 | 1-2-5 |
| | 10 | LOBBY MID ACCESS PARK B-39 | 1-2-6 | 9 | LOBBY SOUTH ACCESS PARKB-39 | 1-2-7 |
| | 8 | LOBBY SOUTH RECREATION RM B-6 | 1-2-1 | 7 | LOBBY NORTH RECREATION RM B-6 | 1-2-2 |
| | 6 | LOBBY B-6 | 1-2-3 | | | |
| LOWER LEVEL | 5 | LOWER LEVEL NORTH SERVICE CORRDIOR | 1-3-1 | 4 | LOWER LEVEL MID SERVICE CORRDIOR | 1-3-2 |
| | 3 | LOWER LEVEL ELEVATOR LOBBY | 1-3-3 | 2 | LOWER LEVEL CORRIDOR C-39 | 1-3-4 |
| | 1 | LOWER LEVEL CORRIDOR C-40 | 1-3-5 | | | |
| SMOKE, HEAT & DUCT DETECTORS | | | 10-2 | WATERFLOWS | | 10-1 |

**Any persons tampering with this system or transmitting false alarms will be subject to arrest and/or fines - By order of the NYC Fire Department.**

## 2. Interruption of Utility Services

### A. Loss of Main Electrical Power

**Overview:**

The facility is currently serviced by the local utility company, Con Edison, which provides the primary electrical power service, sized to service the total demand of the nursing home.

The facility has an autonomous emergency power source which is made up of one emergency stand-by generator which totals 250 KVA of available powers. For information and generator service, the Maintenance Supervisor/ Environmental Services Director will the servicing company.

Essential services include all systems, equipment and items necessary to provide services for the health and safety of all occupants.

**Notification Process:**

The Administrator/ Incident Commander will be notified immediately and appropriate action will be taken. Once the severity of the outage is determined, the Incident Commander will coordinate all necessary actions. The Administrator/ Incident Commander will notify the DOH if applicable.

**Response Procedures:**

1. Emergency stand-by generator starts automatically.
2. Administration/Maintenance shall perform the following:
   - Check each generator to ensure that it is running smoothly.
   - Check each automatic transfer switch to ensure that it transferred and closed.
   - Call Power Company to obtain power outage information.
     Con Edison 1-800-752-6633
   - Page and telephone: request reduction in loading by all departments
   - While waiting for assistance, record the following:
     - Generator voltages
     - Generator currents
     - Fuel levels
     - Continue to monitor and record each generator's characteristics as indicated on the instrument panels.

**Restoration of Service:**

- Call Con Edison to confirm status (1-800-752-6633)
- Check manual transfer switch for Radiology.
- Check all generators to termination on cool-down cycle.
- Check all areas to ensure normal operation.
- Check all motor control centers.
- Check all miscellaneous pump and motor controls.
- Check fuel tank for adequate capacity.

## B. Loss of Phone Communications

**Overview**

In order to maintain communications during a telephone system failure, the facility's telecommunications system is connected to the emergency generator. In case of system failure, the facility will contact the phone carrier company (Appendix 21).

The facility has the following means available for communications to be utilized in the event of total or partial loss of phone communications, as appropriate:

- Standard pay phones
- Runners
- Portable radios – will be provided by the Environmental Services Director or Maintenance supervisor and are available at the Front Desk in the lobby.
- Email – access available on all staff computers
- See back up Communication Sheet

**Notification Process**

- The Environmental Services Director/ Maintenance Supervisor will inform the Administrator/ Incident Commander of loss of communications services, and will communicate to determine the nature and potential duration of the communications outage.
- Environmental Services Director/ Maintenance Supervisor will contact the telecommunications and data systems provider - Empire to request repair and restoration services.
- All staff will be notified of communications outage.
- Facility staff will notify all residents currently in the facility of loss of communications services.

**Response Procedures**

- In the event of a total phone communications failure, the back-up communications system will be initiated by the Incident Commander, Environmental Services Director or Maintenance Supervisor.
- Facility staff will limit telephone communications to critical operational and/or resident care issues only.
- Staff will use standard pay phones and/ email to communicate with service providers outside of the facility.
- The Environmental Services Director/ Maintenance supervisor will provide walkie-talkie radios to staff for internal communication.

**Restoration of service**

Upon restoration of the telephone services, all residents currently in the facility will be notified immediately.

## C. Failure of Water System, Potable Water Supply

**Overview**

A failure of the facility's water system/ potable water supply can imply total loss of or contamination of the facility's water supply, or partial loss/ contamination of water to a specific area/ floor/ unit.
The facility's emergency water supplier is Nestle Waters North America (914-460-2303). The Food Services Department is responsible for storage and distribution of potable water.

**Notification Process**

The individual who discovered water system failure will immediately notify his/ her respective supervisor specifying the location and problem identified and affected area. The supervisor will then notify the Administrator/ Incident Commander, Environmental Services Director/ Maintenance Supervisor.

**Response Process**

- Administrator/ Incident Commander and Environmental Services Director and Food Services Director will determine the extent and type of problem and the anticipated duration.
- The Environmental Services Director/ Maintenance Supervisor will check the main water supply, boiler water make up, hot water supply and sprinkler system and will proceed to repairs as necessary, or will contact a services provider for assistance if needed.
- The Environmental Services Director will contact the Fire Department for emergency procedures to be followed in order to maintain the proper operation of the sprinkler system.
- Food Services Director will contact the designated water provider, Nestle Waters North America to request emergency water delivery. Water deliveries will be made daily in tank trucks and 5/6 gallon containers.
- Emergency water rationing procedures will be implemented for the entire duration of the emergency.

For drinking purposes, the following purification procedures will be followed;

  - Water will be poured into small containers
  - Water which is to be used for drinking or cooking, and does not come from an authorized source, (i.e. fire hydrant) shall be boiled and only used upon the direction of the Medical Director and the N.Y.S. Department of Health.

- The Fire Department will be contacted for emergency procedures to be followed in order to maintain the proper operation of the sprinkler system.
- If the utility failure involves the entire facility, the Incident Command System will be activated. The Incident Commander/ Administrator and Environmental Services Director will determine the length and extent of the water system failure and the facility's ability to provide services to residents.
- In the event when the facility can no longer provide care services to its residents, the Incident Commander will activate the Evacuation Plan.

### Restoration of Service

- Upon restoration of water system/ potable water supply services, the facility will resume services as prior to the incident.
- The Food Services Director will restock the emergency water supply.
- The Environmental Services Director/ Maintenance Supervisor will ensure that the water system/ potable water supply is fully operational.

## D. Sewage System Failure

**Overview**

The emergency response to the problem of the facility's sewage system failure will depend on the type and condition of the problem. This could be total loss of utility to the nursing home, a partial loss of only one (1) portion (floor or unit) of the nursing home. Nursing Home Administration/Maintenance will advise all departments with responsibilities whether the loss is minor and limited to a specific area or is very extensive, possibly involving the entire Facility.

**Notification Process**

Personnel discovering failure in the utility system should immediately contact the Maintenance Supervisor and provide the following information: name, location and telephone extension, location and problem identified.

The Maintenance Supervisor will notify the Director of Environmental Services and Administrator/ Designee.

**Response Procedures**

The Administrator/ Designee and Environmental Services Director will determine the extent and type of problem with the utility system failure and the anticipated duration.

The Environmental Services Director/ Maintenance Supervisor will undertake repairs as necessary, and/or will contact outside service providers to assist with repairs as needed.

If the problem involves the entire nursing home or is very extensive, the Incident Command System will be activated. The Administrator/ Incident Commander, Environmental Services Director and DNS will determine the facility's ability to provide care and services to residents.

In case of interruption of service, the Evacuation Plan will be activated and implemented.

**Restoration of Service**

The Environmental Services Director/ Maintenance Supervisor and Administrator will ensure utility system is fully operational prior to reinstating services.

In case of partial failure of sewage system, heat, ventilation and air conditioning, the Incident Commander and Environmental Services will inform determine reinstatement of services.

In the event of evacuation due to total loss of utility, the facility will follow procedures for Recovery and Repatriation as specified in the Evacuation Plan.

## E. Heat System Failure

**Overview**

The cold weather emergency response procedures will be implemented in the event of failure of the heating system during while outside temperature drops below 25 degrees Fahrenheit.

These procedures will be implemented in addition to the utilities system failure.

The Cold Weather Emergency will be divided into two phases: Plan "A," which will be the initial action, and Plan "B," which will be extensive action.

The Administrator/ Incident Commander will activate the plan and will determine appropriate response procedures based on the extent and estimated duration of the heat system failure.

**Notification Procedure**
The following individuals must be notified immediately:
Administrator/ Designee, Environmental Services Director, Director of Nursing Services, Nursing Staff on affected units, Housekeeping Supervisor
Notification to the appropriate authorities and DOH

**Response Procedures-** **<u>PLAN "A"</u>**
Housekeeping will supply extra blankets to the nursing stations and check all windows for drafts. Curtains or drapes will be drawn to minimize drafts and air flow. Sealing of air leaks will be called to the attention of the Maintenance Department. The Maintenance Department staff will check all heating elements for maximum productivity. On notification of air leaks in or around windows or doors, sealant will be used by the maintenance department to effectuate stoppage.

All nursing staff will monitor patient room areas and patients on an ongoing basis. Patients will be checked for hypothermia signs and symptoms, room temperature will be checked on a one-hour basis. Patients that demonstrate any kind of discomfort will be called to the supervisor's attention and the physician's attention following vital signs being checked by the supervisor.

The Food Services Department will provide additional warm or hot fluids to be served to all patients. Cold fluids will not be used. All meals will be hot meals. Therapeutic Recreation Department will run activities according to schedule. Efforts should be made by the activities staff to motivate the patients to engage in activities that stimulate circulation. Social Service staff will assist in the monitoring of patients for complaints and/or concerns.

IF ROOM TEMPERATURE DROPS BELOW 60 DEGREES F, THEN PLAN B WILL BE IMPLEMENTED.

**<u>PLAN "B"</u>**
Maintenance department will check room to determine if anything can be done to increase temperature.
Residents will be transferred to other rooms when partial heat loss.
In the event of total failure of heating system, the Incident Commander will determine the facility's ability to continue to provide services to residents or the need for transfer to other facilities or hospitals. In this case, the Evacuation Plan will be implemented as stated in this manual.

**Restoration of Service**
The Environmental Services Director and Administrator/ Incident Commander will determine when affected area is safe for residents' return. Resident/s will return to their respective room when temperature is above 60 degree Fahrenheit.

## F. Air conditioning System Failure

**Overview**
A spell of "high temperature weather", especially with high humidity is defined as a single day in-which ambient temperatures as recorded on thermometers at Nursing Stations are 85 degrees F or over, Humidity can be determined by radio reports and is to be considered high if over 50%. Temperatures at Nursing Stations will be recorded at noon daily and entered in the patient temperature book.

**Notification Process**
The Administrator/ Designee, DNS, Environmental Services Director and Maintenance Director must be notified immediately of hot weather advisory/ emergency or failure of air conditioning system.

Staff on units will be notified in order to monitor residents' well-being as well as temperature on unit.

**Response Procedures**
Additional fans and cooling devices will be installed in day rooms and by nurses' stations if needed.

Patients, as far as possible, should be dressed in light, loose and comfortable clothing.

Staff members working in direct patient contact must be aware of the signs and symptoms of heat exhaustion and take every precaution to prevent the initial stages from progressing, both in the patients/residents and in themselves.

Rooms should be kept as cool as possible by lowering shades, maintaining air circulation and keeping windows closed. Hall lights should be turned off and used only as needed to maintain safe visual passage.

Frequent offering of water or other types of fluids should be made with supervision of intake and output on all patients.

Physicians will be notified immediately of any patients are not taking sufficient fluids by mouth to maintain hydration status (1500cc. minimally in a 24 hour period) and obtain orders for intravenous hydration.

**Restoration of Service**
The facility will resume activities as normal as soon as the hot weather advisory expires.

## G. Elevator Service Failure

**Overview**
Failure in elevator service can cause disruption in resident care/ services. The facility has precise procedures to be followed in case of elevator service failure. The facility has two (2) operational staff/ resident elevator and a service elevator.

Category 1 tests are conducted annually to ensure safe operation of elevators. Maintenance/ Environmental Services Department conducts daily recall tests to ensure functionality.

The facility's elevators are connected to the generator as source of electrical power, to ensure continuous operation. If loss of elevator service is due to loss of electrical power, please refer to response procedures to be implemented in case of loss of electrical power if applicable.

If loss of elevator service is due to malfunction, the following procedures are to be implemented.

**Notification Process**
The individual who discovered elevator service failure will immediately notify the Maintenance Supervisor/ Environmental Services Director.

The Environmental Services Director/ Maintenance Supervisor will notify the Administrator/ Incident Commander and front desk security officer.

The Environmental Services Director/ Maintenance Supervisor will post a visible sign on respective broken elevator.

The Administrator/ Environmental Services Director will determine the length of elevator service failure. If estimate time exceeds 72 hours, the Administrator will notify DOH.

**Response Procedures**
The Environmental Services Director/ Maintenance Supervisor will contact elevator services company to request immediate repair services.

If service elevator is broken, staff will be redirected to temporarily use one of the functioning elevators.

If service is lost to one of the resident/ public elevators, the security guard will operate the service elevator and permit residents and other building occupants to access to upper floors.

Staff will be asked to use stairs for access to various floors and reduce elevator use to a minimum.

**Restoration of Service**
The Environmental Services Director/ Maintenance Supervisor will ensure elevator is fully operational prior to reinstating for public use.

All building occupants will be informed upon restoration of elevator services.

## 3. Elopement of a Resident

### Overview

Elopement occurs when a resident successfully leaves the facility undetected and unsupervised, and enters into harm's way.

The facility has developed an Elopement Prevention Policy and Procedure in order to provide a safe and secure environment for its residents. This program is implemented to reduce the risk of unsafe wondering behaviors and adverse outcomes that can result from such behaviors.

The facility will assess all residents on admission, readmission and for any significant change to their health or mental status to determine if elopement risks are present, utilizing the Elopement Risk Assessment Tool. Residents determined to be at risk (see Risk Assessment tool), for unsafe wandering/elopement will immediately have a secure care bracelet applied and an individualized care plan developed.

The facility has set in place the following environmental protective warning systems:

1. Secure Care system with alarms at exit doors.
2. Security Guard/ Receptionist monitoring the front entrance and cameras 24hrs/day
3. Screening of visitors using sign-in book.
4. Names and pictures of residents identified at risk for wandering/elopement at the front desk.
5. Audible alarms on all stairwells and exit doors that are tied into a main panel at the front desk.
6. Security surveillance cameras are positioned to monitor exit doors and basement corridors. Cameras and tapes are monitored by the security/reception desk and are also periodically monitored by the Director of Environmental Services and Administration.
7. During the warmer weather months, trained Porch Sitters, under the Recreation Department, will be assigned to monitor the residents that go outside to the patio.

### Notification Process

Determination that a resident is missing will be made after the Nursing Supervisor has completed and re-checked a full head count, paged the resident on the overhead system and checked that the resident didn't leave the facility with a family member.

The announcement of "Dr. FIND" will be paged on the overhead speaker system. The resident's name may be paged every 15 minutes for the next hour, if necessary.

Key notifications to be made immediately:

1. The Administrator and DNS must be notified immediately. The NYC Police Department will be called by the Incident Commander (109th Precinct Police at 718-321-2250)
2. The resident's designated representative or family member will also be notified immediately by the team leader or Director of Social Work.
3. The Attending Physician will be called as soon as it has been established that the resident is missing.
4. The Administrator/ DNS will immediately notify the DOH.

### Response Procedures

Upon hearing the Code "Dr. Find", all department heads will report to the reception desk for instructions from the Incident Commander who will be the Director of Environmental Services or Designee.

A full house search will be conducted as specified for each shift: (7-3, 3-11, 11-7)

Resident room check on each floor by nursing personnel assigned to that floor. The search will be made room to room starting at the far end of the corridor and concludes at the nursing station. Every bathroom, utility room/closet, storage closet, office, dayroom and pantry will be searched and secured. CNAs will report to RNS when search is finished, RNS will report to the team leader for further instructions.

In general, on the day shift, the following guidelines will be in effect:

- The outside grounds and roof will be immediately searched by the Maintenance and Housekeeping staff, including all stairwells.
- The recreation and office staff will search the main floor offices, storage areas and dining room.
- All other staff will assist in the search as directed by the team leader.

The Incident Commander/ Designee will initiate an incident report and time line with the following information gathered:

- Approximate time the resident was last seen
- Description of the resident's clothing
- Information on the resident's general condition and diagnosis
- Obtain a picture of the resident from the MAR or, if possible, the admissions office.
- Gather information on resident's previous address or customary habits.

**Resolution**

If the resident is located:

1. The Incident Commander will announce "Cancel Dr. Find"
2. Notification of essential personnel will proceed as listed above the "Notifications" section, at the discretion of the Incident Commander, DNS and Administrator.
3. An investigation of occurrence will be immediately conducted with a breakdown of communication thoroughly assessed evaluated and corrected, where necessary.
4. The RNS will immediately clinically assess the resident for signs/symptoms of injury and/or any physical/mental findings and notify the Attending Physician.
   The resident will be examined by a physician within 72hrs.
5. The RNS will review current plan of care, under the guidance of the DNS/Designee, until the CCP team meets.
6. An emergency CCP will be conducted within 72hrs. to review and revise interventions in the plan of care. The resident's designated representative will be notified of any revisions.

Evaluation of Effectiveness of Response

1. An adhoc Q/A review of the Code Dr. Find response will be conducted within 72hrs post event, with a root cause analysis of the incident.
2. The critical areas of effective organizational responses to the elopement will be reviewed: leadership, policies, procedures and staff training. The QA team will make the necessary operational revisions.
3. All policies and procedures will be reviewed and revised if needed. All staff will be re-educated as needed.
4. Missing Resident Drills will be conducted on an annual basis, by the designated department.

## 4. Robbery

**Overview**
In the event robbery occurs, the main objective is to reduce the risk of injury to employees and residents and get the robber out of the building as soon as possible.

**Notification Process**
If any witnesses, they should notify the Security Officer, Administrator, Safety Officer and call 911.
The individual affected must notify the Administrator/ Incident Commander and Safety Officer/ Environmental Services Director as soon as safe to do so.

The individual should call 911 if possible without endangering self or others.

The Administrator/ Incident Commander will notify:

Call " 911"
109th Precinct Police at 718-321-2250
Safety Officer/ Environmental Services Director

**Response Procedures**
The individual affected should:

- Be calm and courteous
- Do not make sudden moves
- Listen attentively
- Give up money/ valuables or objects requested by the robber
- Remain alert and try to remember details of the robber's appearance, clothing, speech etc.
- If possible, watch the robber's method and direction of escape.
- Begin documenting time line immediately
- If any witnesses, ask them to write detailed statements of events
- Contact the Administrator/ designee to inform them of the event and for further direction as needed.

**Resolution**
The Administrator/ Environmental Services Director will assess safety of all facility occupants.
The Administrator/ Designee will assess well-being of the individual(s) involved.
The facility will assess any physical damages and losses.
The Administrator/ Environmental Services Director/ Security Officer will assess the facility's safety and security system and evaluate their efficiency.

## 5. Bomb Threat

### Overview

This procedure provides guidelines for prompt and responsible action when a bomb threat is received. Generally, a bomb threat procedure is comprised of seven important phases: the threat, the search, the evacuation, the bomb or suspected object, traffic control, all clear, and filing the report.

### Notification Process

The announcement of "CODE D" will be paged on the overhead speaker system.
The individual receiving the call must immediately notify the Administrator/ Incident Commander and Safety Officer/ Environmental Services Director.
The Administrator/ Incident Commander will notify:

1. Fire Department – 911
2. 109th Precinct Police at 718-321-2250
3. NYS Department of Health Queens 1-800-462-6785; NYS After Hours Hotline (Monday-Friday 4pm to 8pm and Saturday & Sunday 10am to 6pm) 1-800-872-2777
4. Safety Officer/ Environmental Services Director

### Response Procedures

The actions to be taken in response to a bomb threat are described in terms of these phases.
1. The Threat:
The operator or individual receiving the threat must remember the following:

- Be calm and courteous.
- Listen attentively.
- Begin documenting timeline.
- Do not interrupt the caller.
- Use the attached check list to obtain as much information as possible.

After receiving the threat, the individual receiving the call must immediately notify:

1. Administrator ext. 721 or Assistant Administrator ext. 722
2. 109th Precinct Police at 718-321-2250 and Fire Department – 911
3. Incident Commander
4. Department of Health
5. Safety Officer/ Environmental Services Director ext. 777

2. The Search:
The Incident Commander or designee, after interviewing the individual who received the call, will immediately organize a search. Staff will be assigned specific areas to be searched.

A security officer will be assigned to meet the 109th Precinct Fire and Police Departments and direct them to the Incident Commander. On arrival, the Police should be told all available information. The Incident Commander will remain with the Police until an "All Clear" is given so that the Police can be immediately escorted to inspect any suspicious device which may be discovered.

The Incident Commander will be responsible for establishing a search plan for all areas and for designating a call list of personnel responsible for that search.

Search Technique

- Do not touch, handle, or move any suspicious objects!

- Pending the arrival of the fire/police, an area search will be conducted for suspicious packages, boxes, and objects. Give particular attention to elevators, hallways, rest rooms, waste baskets, false ceilings, and every other conceivable location where an explosive or incendiary device might be concealed.
- Search thoroughly, systematically, and discreetly.
- Anything of a strange or suspicious nature which is found will be reported to the Incident Commander/ designee and reported to the fire/police upon their arrival.
- The danger zone and surrounding area of approximately 300 feet should be blocked off or barricaded until the threat is removed.
- Sometimes the location given by the bomb threat caller will include an occupied area such as a floor, room, or office during the daytime. The Incident Commander/ designee may request the assistance of all facility personnel to help with the search process.
- If it is determined that a device may exist in a resident room, the Incident Commander, Administrator, Director of Nursing, Safety Officer, Supervisor or designee will be advised to proceed with the following precautionary measures:

  (a) Move residents away from windows and attempt to cover windows to prevent flying glass.

  (b) Open all doors within suspected area to allow the force of an explosion to be dissipated throughout the area.

  (c) Do not alarm residents. Act as casually as possible and try to offer a logical explanation for the conducted activities.

3. Evacuation
   - The Senior 109th Precinct Police Officer contacted or the Senior Fire Department Official contacted is authorized by law to evacuate buildings, or parts thereof. The decision to evacuate is only ordered after consultation with Incident Commander Designee. In addition, the Incident Commander/ designee is authorized to order an evacuation.
   - In deciding whether to evacuate, various factors must be taken into consideration, including:
     - The specificity of the location
     - The time involved
     - The veracity of the caller
     - The risk to those to be evacuated
   - The Incident Commander/ designee must be kept advised of all actions contemplated or taken as time and circumstance permit.
   - If evacuation proves necessary, the facility will follow the Evacuation Plan.
   - Act calmly and with care to avoid accidents and panic. Do not attempt to move the suspected bomb.

4. The Bomb or Suspicious Object
   - Remove wrist watches near the vicinity of the object. Watches may trigger certain bombs.
   - Never touch, handle, or move any suspicious object. Only the bomb squad should handle the object.
   - The bomb or suspicious object may be of any size or type and be concealed in virtually any container.
   - If a suspicious object is found, notify the bomb squad immediately. Do not use your radio in the vicinity of a suspected bomb. Radio transmissions can trigger certain bombs. Use the telephone instead.

5. Traffic Control

   Security is responsible for traffic control and provides the following services:

   1) Escorts the police to the area where the device has been located.

2) Ensures that the escort is in possession of keys necessary to allow police access to the area if secured.
3) Provides internal traffic control as required.

6. All Clear

The "ALL CLEAR" must be given by Incident Commander or Administrator via the Senior 109th Precinct Police or Fire Officer present. Maintenance will advise, but cannot make this decision.

7. Filling the Report

Once the "ALL CLEAR" has been given, the Incident Commander/ designee must file an Incident Report together with a completed Bomb Threat Checklist. The report must include the following information:

- include all actions taken
- identify all persons responding, including outside agencies
- identify all persons notified by the Security Department
- identify the time the "ALL CLEAR" was given
- identify who gave the "ALL CLEAR"
- include any other pertinent information.

**Union Plaza Care Center**

**Bomb Threat Checklist**

INSTRUCTIONS: Be calm. Be courteous. Listen. Do not interrupt the caller. Attempt to notify Incident Commander, Administrator, and/or Safety Officer while caller is on line. Begin documenting timeline.

Name of Operator: Time: ______ Date: ______

Caller's Identity: Sex: o Male o Female o Adult o Juvenile Appr. Age o Yrs

Origin of Call: o Local o Long Distance o Booth o Internal - from within bldg

| VOICE CHARACTERISTICS | | | | SPEECH | | | |
|---|---|---|---|---|---|---|---|
| O | Loud | O | Soft | o | Fast | o | Slow |
| O | High Pitch | O | Deep | o | Distinct | o | Distorted |
| O | Raspy | O | Pleasant | o | Stutter | o | Nasal |
| O | Intoxicated | O | Other ________ | o | Slurred | o | Limp |

| LANGUAGE | | | | ACCENT | | | |
|---|---|---|---|---|---|---|---|
| O | Excellent | O | Good | o | Local | o | Not Local |
| O | Fair | O | Poor | o | Foreign | o | Race |
| O | Foul | O | Other ________ | | | | |

| MANNER | | | | BACKGROUND NOISES | | | |
|---|---|---|---|---|---|---|---|
| O | Calm | O | Angry | o | Trains | o | Animals |
| O | Rational | O | Irrational | o | Bedlam | o | Voices |
| O | Coherent | O | Incoherent | o | Airplane | o | Mixed |
| O | Deliberate | O | Emotional | o | Quiet | o | Street Traffic |
| O | Righteous | O | Laughing | o | Party | o | Office |
| | | | | o | Atmosphere | o | Machines |
| | | | | o | Factory | o | Music |

**BOMB FACTS**

Pretend difficulty with hearing. Keep caller talking. If caller seems agreeable to further conversation, ask questions like:

When will it go off? Certain Hour Time Remaining
Where is it located? Building Area
What kind of Bomb? Where are you now?
How do you know so much about the bomb?
What is your name and address?

Inform caller that detonation could cause injury or death. Did caller appear familiar with the facility by his/her description of the bomb location? Write out the message in its entirety and other comments.

**Immediately after the call**: Notify Administrator, Incident Commander, Safety Officer/ Environmental Services Director.

## 6. Bio-Terrorism – Mail

**Overview**
The facility has developed procedures to follow for safe handling of mail in order to protect the safety of employees and residents.

**Notification Process**
The Administrator/ Designee and Director of Environmental Services will be immediately notified.
In the event of real threat, the Administrator/ Designee will call 911.

**Response Procedure**
All mail is inspected upon receipt for foreign bodies and/or powder.
Letters and packages should be opened using a letter opener, with a minimum of movement in order to avoid spilling of any potential content.

Suspicious Mail criteria:

- Any letters or packages with suspicious or threatening messages written on them
- Envelopes/ packages that are lopsided, rigid, bulky, discolored, with strange odor
- Envelopes/ packages with no return address or no postage
- Unexpected envelopes/ packages from foreign countries

Suspicious Mail Handling Protocol

- DO NOT OPEN envelope or package if suspicious
- Evacuate the room and keep others from entering area/ room
- Notify Administrator/ Designee and Director of Environmental Services
- If letter/ package was opened, proceed with caution.
- If possible, close down the building heating/ air conditioning/ ventilation system
- Keep a list of all individuals who had actual contact with the suspicious substance
- Contain the area to prevent visitors, residents and staff traffic
- The Administrator/ Incident Commander will consider the need for partial or total evacuation as directed by appropriate authorities.

**Restoration of Services**
The Administrator/ Incident Commander will determine the safety of area and return to normal activities.

## 7. Chemical Spill/ Exposure

**Overview**

In the event of chemical spill resulting in a fire, pull fire alarm and follow Fire Safety Procedures. Chemical spills are classified as low, medium, or high hazard incidents and are generally defined below. Response depends on incident classification.

Low Hazard Spill:

- Small volume of one gallon or less and incidental to ordinary use.
- Material identified and hazard characteristics do not require specialized response.

Medium Hazard Spill:

- Moderate Volume - possibly up to several gallons.
- Beyond capability for safe in-house response and/or presents possibilities for spread to on-site or off-site areas with hazards to public health, safety, or the environment.
- Incident localized to immediate area of release - no hazard to public health, safety, or environment.
- High hazard spills shall be handled by commercial emergency service providers with the required notifications to public authorities as described herein.

HIGH Hazard:

- Involves volumes larger than several gallons or severe or non-defined hazards
- Beyond capability for safe in-house response and/or presents possibilities for spread to on-site or off-site areas with hazards to public health, safety, or the environment.

  High hazard spills shall be handled by commercial emergency service providers with the required notifications to public authorities as described herein.

**Notification Process**

The announcement of "CODE YELLOW" will be paged on the overhead speaker system.
Notify appropriate personnel in adjacent areas.

Report chemical spills to the Incident Commander. Give your name, location, phone number, and a brief description of the incident.

**Response Procedure**

I. RESPONSE FOR LOW HAZARD SPILL
- Address low hazard spills directly, as they occur.
- Neutralize or otherwise treat, if necessary.
- Absorb with paper towel, spill-pillow, sponge, or other material as appropriate (CHEMICAL SPILL KIT).
- Contain spill materials; seal and label container.
- Dispose of as hazardous chemical waste.

II. RESPONSE FOR MEDIUM and high HAZARD SPILLS
- Attend to injured personnel. Avoid injuring or contaminating oneself in the process.

- Prevent further injury.
- Render first aid.
- Help victims locate and operate emergency eyewashes, showers, etc.
- Obtain emergency medical assistance.
- Evacuate the area as necessary.
- Close doors to the area of incident.
- Restrict access to essential functions only.
- Limit the spread of the spill, if possible, and secure the area.
- Extinguish open flames and other sources of ignition.
- Stop spillage and leakage. Whenever possible and with appropriate precautions, tip leaking containers to stop flow, place catch basins under leaks, or secure valves.
- Wipe spills with an absorbent towel from spill kit
- Monitor the situation until help arrives.
- Control traffic into and through the area of incident.
- Post signs if needed to help prevent entry.
- Assess the extent of the spill. Consider volumes, chemical characteristics, and other pertinent data. Proceed as appropriate, and notify the 109th Precinct, Fire Department if the incident involves a flammable liquid.
- Confirm potential hazards to public health, safety, or the environment. Hazards shall include both direct and indirect effects of fire, explosion, corrosively, toxicity, and reactivity and any hazardous surface run-off from water or chemical agents used to control fire or heat-induced explosions.
- Contact one of the chemical emergency response service companies available 24 hours a day seven days a week
- Notify local, state and federal agencies as required if the incident presents a public hazard as described

## LOCAL AND GOVERNMENT AGENCIES

| | |
|---|---|
| Fire Department | 911 |
| 109th Precinct Police Department | 911 |
| Local Health Department | 212-417-4999 |
| NYSDOH | 518-408-5300 |
| Emergency Management Local Office | 718-422-4800 |

## 8. EMPLOYEE STRIKE

**Overview**

In the event that an employee strike/ labor action is anticipated, the facility has developed a detailed strike plan in order to provide for the ongoing quality care and treatment of residents, and to ensure that all residents' needs are met in accordance with the goals and objectives of his/ her individual plan of care.

Should an employee strike occur, the following Strike Plan will be activated and managed under the ICS.

**STRIKE PLAN**

**LABOR ACTION NOTIFICATION:**

- On ____________, Union Plaza Care Center (Union Plaza Care Center or the facility), received notification that all its employees covered under the 1199 Collective Bargaining Agreement will engage in a strike, picketing and other concerted refusal to work beginning at 6:00am on ____________ and ending at 6:00am on ________________.

- A management meeting was held ______________________, to review the implementation of the facility strike plan.

**DEPARTMENTS AFFECTED BY THIS LABOR ACTION:**

- Nursing (CNAs, some LPNs)
- Housekeeping/Laundry employees
- Recreation
- Dietary (Aides, Cooks)

**No Department Heads or Supervisors will be affected by the strike. Dieticians and Food Services Managers, Rehab personnel, Social Workers and Security are unaffected.**

**CENSUS**

Census: Our bed capacity is 280, with 7 seven 40 bed units.
Current census is 263 occupied beds.
Union Plaza Care Center is a skilled nursing facility catering to long and short term care residents. We provide Wound care, IV therapy, Rehab Services including OT, PT, and ST.

## SERVICES PROVIDED BY INDEPENDENT CONTRACTORS WILL NOT BE AFFECTED BY THIS LABOR ACTION

**All vendors will be notified for continuity of service**

**See Facility Assessment for a complete list of independent contractors and vendors**

- **Building Services Providers**
- **Staffing Agencies**
- **Medical Services**
- **Supplies and Equipment Vendors**

**The following plan will be implemented on __________ 6am to ________ 6am to provide appropriate staff coverage and services to our residents**

***STRIKE PLAN: Administration***

**OBJECTIVE:**

To provide for the ongoing, uninterrupted quality care and treatment of residents during an employee strike/ labor action. To ensure that all residents' needs are met in accordance with the goals and objectives of his or her individual plan of care. To ensure that all personnel are appropriately trained to maintain an environment of care that is clean and comfortable, and preserves the rights and dignity of the resident population.

**PROCEDURES:**

"Administration" refers to the Administrator, The Operations Director and all of the facility's Department Heads. Administration will provide the Facility all their telephone contact numbers and vehicle identification information. All administrative, management and care personnel must wear their ID badges at all times including upon entering and leaving the facility during any union work action.

**Period of Strike**

The strike plan will be activated as of 4am on _______________ and will continue throughout the Labor Action.

The Administrator, Dr. Adinah Pelman is the facility's Strike Coordinator.

The Director of Nursing and the Assistant Director of Nurses will then follow as designated alternates.

The Command Post will the Administrators Office, unless otherwise directed, which is located on the first floor. The Telephone number for the office is 718.430.0003. The conference room may be designated as an alternate Command Post and the telephone number is 718.430.0003.

The facility's main number is 718.670.0700 which is covered by a Receptionist and Security 24 hours a day 7 days a week.

In the event the switchboard is compromised, the following is available Cellular Phones, Pay Phones and Fax Machine Phones.

**Public Pay Phones**

Lobby 646-448-2985
2nd floor 646-448-2986
3rd floor 646-448-2987
4th floor 646-448-2988
5th floor 646-448-2989
6th floor 646-448-2990
7th floor 646-448-2991
8th floor 646-448-2992

**Department Fax Numbers**

Administration 718-670-0726

| | |
|---|---|
| Admissions | 718-670-0701 |
| Bookkeeping | 718-670-0740 |
| Dietary | 718-670-0757 |
| Nursing | 718-670-0738 |
| Rehab | 718-670-0784 |
| Social Services | 718-670-0767 |

Security Desk phone number 718.670.0700 and paging is done through the facility's phone system by dialing "* 2", and announcing the Page.

All facility phones are manned 24 hours a day, as all lines are direct line to various areas, such as offices and each of the 7 floors.

**Role of Administration during Strike**

Continue to provide uninterrupted facility services to residents and families; maintain a safe and comfortable environment for residents, staff and visitors.
Provide residents and families with status updates re: continued delivery of care and operations of the Facility during the strike;
Provide supportive working employees/volunteers, residents, resident families to assist them in elevating any fear, anxiety, general stress generated by a work stoppage;

Provide support to residents, staff and visitors affected by the work stoppage;
Conduct informational meetings and speaking to individual staff members under the advice of Council.
Maintain log of all picket line incidents. Provide staff, visitors and residents' safe entrance/ exit to Facility.

**Administrative/Designee Duties Prior to Strike**
Review strike plan with all departments.
Distribute list of names, addresses and telephone numbers of all management, supervisory and other non-union personnel.
Obtain list of other facilities from which non-union, professional personnel may be available

Compile list of emergency Vendors for Service and suppliers, and contact each to ensure that there will be no disruption in services or delivery throughout the strike. The list of vendors shall include, but not limited to, Pharmacy, X-Ray, Laboratory, Food and Supply Vendors, Transportation (Residents/Staff), Linen and Resident Clothing, Medical Supplies, Catering services. Security services will be further enhanced through contracting with an outside Security Company.

**Strike Notice Given:**
Overall responsibility for direction to and coordination of all working personnel, volunteers, etc.
Administration will notify legal counsel: NYPD, FDNY, DOH, Family Council, Resident Council, vendors and local political representatives.

Arrange for alternate transportation in order to have "pick-up" points for staff and volunteers and rotate them daily. Handle press and community relations.

**During Strike**:
Maintain reports of picket line incidents.
Maintain communicate with legal counsel.
Maintain communication with New York State Department of Health and the Union.
Direct office personnel/staff and other non-assigned staff and or volunteers.
Place ad in newspapers for additional staff and/or volunteers, if necessary.
Initiate and ensure the carrying out of each department's procedures as outlined in this plan.
Arrange for postal service, incoming and outgoing.
Arrange for ongoing communications with families and residents through letter and phone contact utilizing Social Services, Admissions and other non-designated personnel.

**Other Exempt Personnel**

**Admissions**

The Director of Admissions is responsible to ensure that all potential admissions and readmissions are appropriately managed per facility policy. All required documentation and arrangements for receiving residents into the facility will be organized and maintained by the Director of Admissions/designee.

**Business Office**

No Business office personnel are affected by the strike. Resident Banking and Patient Funds services will not be interrupted and the regular schedule of services will remain. The staff at other times will be assigned duties as needed and assigned.

**Human Resources**

Human Resources will work directly with Administrator/designee to coordinate any and all new employees/ agency personnel and to assist in other areas as assigned as necessary. It will be the responsibility of the HR Coordinator to ensure that all temporary and replacement personnel have been properly screened in compliance with all Federal and State laws and regulations regarding Criminal History Record Checks and credentialing.
Will maintain an accurate list of all potential employees by discipline and job title for immediate hiring purposes.

**Staff Development**

The Staff Development Coordinator will work closely with HR, Nursing Administration and all other departments for orienting temporary staff, volunteers, families, etc. to basic functions including safety procedures. The Coordinator will ensure that all personnel have been fully oriented on the facility's mandatory in-services, including policies and procedures regarding abuse prevention prior to assuming job responsibilities.

**Medical Records**

The Medical Records coordinator will be responsible and assist in the replacement of personnel as well as training and orienting unassigned personnel to the basic medical record functions and requirements.

**Resident and Family Councils**

A resident council meeting was scheduled for ______________ to inform the residents of the facility's strike plan and provide reassurance that there will be no interruption of services, and to answer any questions or concerns they may have.

A letter was sent to all residents and family members informing them of the pending strike.

The Family Council was notified and a meeting will be scheduled, as needed, to discuss any issues or concerns they may have.

**Period immediately following a strike**

As soon as practicable, the Administrator/staff will resume of normal operations at conclusion of strike, and the Administrator along with the Nursing Director, Medical Director will collaborate and make an assessment of the Facility and address any and all issues for a resumption of normal operations throughout the Facility.

Arrange for expression of gratitude to non-striking participants and volunteer groups.

**Hospital List According to Proximity**

Flushing Hospital Medical Center (1.7 Miles)
4500 Parsons Blvd
Flushing, NY 11355
718-670-5000

New York Presbyterian Queens (2.7 Miles)
56-45 Main Street
Flushing, NY 11355
(718) 670-2000

Long Island Jewish Forest Hills (4.4 Miles)
102-01 66th Road
Forest Hills, NY 11375
(718) 830-4000

Elmhurst Hospital (4.2 Miles from UPCC)
79-01 Broadway
Elmhurst, NY 11373
718-334-4000

Mount Sinai Queens (6.1 Miles from UPCC)
25-10 30th Road
Long Island City, NY 11102
718-932-1000

***STRIKE PLAN: Nursing Services***

**OBJECTIVE:**

To provide ongoing daily nursing care, assessment, and management during a period of strike, without significant compromise of care.

A strike is likely to lead to increased stress generally and resultant increased tension among staff, even immediately after the event. Senior staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES**

"Nursing Staff" refers to nursing administration including the Director of Nursing, Assistant Director of nursing, Nurse Supervisors, RNs, LPNs, CNAs, resident assessors, and the risk manager.

All non-nursing personnel have been requested to provide all their telephone contact numbers and vehicle identification information. This information will be available to Administration, Nursing Office, and Security.

All management staff must wear their ID badges at all times including upon entering and leaving the facility during any union work action.

**Period of a Strike**

At all times, there must be readily accessible telephone contact between Nursing Staff and all other departments. The overhead paging system will be used to communicate within the building. The Director of Nursing and Assistant Director of Nursing will be available by cell phone at all times.

**Nursing Management Coverage**

Nursing Management will work 7-12 hour shifts (as needed) covering both days and nights at the commencement of a strike and will continue to provide this coverage until the unit operations and coverage are resembling normal day-to-day operations. Once normal operations have been achieved, nursing management will return to an 8-hour a day work schedule.

The Director of Nursing/ designee will be responsible for the overall operations of the day shift for the nursing department and will be the contact with the NYS Department of Health. The Assistant Director of Nursing/ designee will be responsible for the overall operations of the night shift for the nursing department and will be the contact with the NYS Department of Health at that time during the interval of 12 hour shifts.

Should a Physician/NP/PA arrive at the Facility, the Director of Nursing/Nurse Supervisor or designee will request that particular Physician/NP/PA to attend to any urgent medical problems that cannot be deferred. The Physician/NP/PA will also be asked to sign any new prescriptions for restricted medications, but should not be asked to sign any routine orders or undertake routine or non-urgent medical evaluations. If a resident expires and no physician is able to come to the facility, the Director of Nursing/Nurse Supervisor or designee will endeavor to have the copies of the pertinent parts of the deceased resident's chart/information required for the Physician on call.

**Nursing Unit Coverage**

The nursing staffing scheduler will work with a number of staffing agencies to ensure that there are adequate numbers of licensed and unlicensed staff to care for the residents. The staffing patterns will be determined using our usual staffing patterns and then modifying the needs based on the unit census, acuity, and the skill levels required for the care of the residents on the unit.

Each unit will be covered by a specific, assigned agency to maintain continuity of care and efficiency in the assignment agency personnel.

There will be a comprehensive list of staffing agencies with phone numbers and addresses available in the nursing office. The contracts for each agency will also be available in the master strike plan policy manual in the administrator's office.

Each contract agency will be given a packet of the facility orientation and will be responsible for orienting the staff assigned to cover the facility at the agency. This will be done upon the facility receiving the 10-day strike notice so employees will be oriented prior to being needed.
The facility will then provide an onsite orientation to agency workers prior to the commencement of the strike to review special procedures including the fire alarm system, security systems, disaster codes, elopement policies and procedures, paging system, medication pass for nurses (etc.) Each agency will also be responsible for working with the human resource department to ensure that each agency employee has the necessary information (PPD testing, fingerprinting, etc.) prior to starting a facility work assignment.

Agency staff will be assigned to the same work assignment as much as possible to provide consistency to the worker as well as the residents and families. The nursing scheduler will be responsible for maintaining the daily staffing roster. The Assistant Director of Nursing will be responsible for reviewing the staffing to ensure that there are adequate numbers of staff or reporting shortages to the Director of Nursing and Administrator to ensure that adequate staffing can be provided.

**Period immediately following a strike**

As soon as practicable, the union members will return to the usual schedule of attendance at the Facility. The master schedule will be given to the business agent of the union upon notice that the strike is over and will be posted at the designated locations within the facility. All staff members will be instructed that everyone is to be welcomed back and there is to be no dialogue about the events that have just taken place. The Strike Plan will then be reviewed, and modified as appropriate following discussions with Nursing Staff and Facility Heads of Departments.

## ***STRIKE PLAN: MEDICAL SERVICES***

**OBJECTIVE:**
To continue to provide medical services without compromise during a period of strike.

**PROCEDURES:**
There will be no interruption in any medical service (Nurse Practitioners and Physician Assistants), including the Medical Director.

All Physicians and Mid-level Providers have provided the Facility with contact numbers and vehicle identification information. This information will be available to the Medical Director, Administration, Nursing Office, and Security.

All Physicians and Mid-level Providers have been requested to consider applying for a New York State Department of Health Physician Identification Card. The Physician Identification Card may allow for easier access when there are restrictions to travel and refueling of vehicles, and used for identification if Facility identification badges are not available.

**Period of a Strike**
At all times, there must be readily accessible telephone contact between Nursing Staff and Medical Staff. The Director of Nursing/Nurse Supervisor or designate should have a line manned at all times.

It is anticipated that during any period of a strike, implementation of medical orders within the Facility may be compromised, as there may be limitations on the availability of staff, medications, other therapies and equipment. Therefore urgent medical problems will require hospital assessment more frequently than usual.

Medical Staff will endeavor to attend the Facility as per their usual schedule. In the event that Medical Staff is unable to reach the Facility as scheduled, Park Avenue Health Care Management will provide alternate coverage.

The Medical Director or designate will arrange a schedule so that a member of the Medical Staff is always on-call by telephone. The Medical Director will notify the Director of Nursing/Nurse Supervisor or designate of this schedule, and also which Physician is on call for Death Certificates. The Director of Nursing/Nurse Supervisor or designate will ensure that all Nursing Units are informed of this schedule, so that during periods when no Medical Staff can arrive at the Facility, the Physician/NP/PA on call will be contacted by telephone for any urgent medical matters.

***Periods when an individual Physician/NP/PA cannot arrive at the Facility as scheduled***

The Physician/NP/PA will call the pre-arranged contact number of the Director of Nursing/Nurse Supervisor or designate. If there are any urgent medical problems relating to residents under the care of this particular Physician/NP/PA, then the Director of Nursing/Nurse Supervisor or designate will ascertain if there is another Physician/NP/PA in the Facility at that time. If so, then that Physician/NP/PA will be requested to assess these residents and their urgent medical problems.

If there is no Physician/NP/PA in the Facility at that time, then the
Director of Nursing/Nurse Supervisor or designate will arrange for the abovementioned problems to be discussed by telephone with the Physician/NP/PA who had called in.

***Periods when it is difficult for any Physician/NP/PA to arrive at the Facility***

The Director of Nursing/Nurse Supervisor or designate will contact the Physician/NP/PA on call for any urgent medical matters. Nursing Staff will evaluate the Resident, and then present as much information as possible about the problem to the Physician/NP/PA on call.

The Director of Nursing/Nurse Supervisor or designate will evaluate reports of investigations and consultations to determine which reports require urgent medical review. These reports will then be faxed and/or telephoned to the Physician/NP/PA on call, who will arrange appropriate further action after discussing the case with Nursing Staff.

The Director of Nursing/Nurse Supervisor or designate will notify the Physician/NP/PA on call about any urgent prescriptions (mostly restricted medications), and provide the Physician/NP/PA on call with the required information for making a telephone prescription to the pharmacy.

Should a Physician/NP/PA manage to arrive at the Facility, then the Director of Nursing/Nurse Supervisor or designate will request that particular Physician/NP/PA to attend to any urgent medical problems that cannot be deferred. The Physician/NP/PA will also be asked to sign any new prescriptions for restricted medications, but should not be asked to sign any routine orders or undertake routine or non-urgent medical evaluations.

**Period immediately following a strike**

As soon as practicable, the Medical Staff will return to the usual schedule of attendance at the Facility. The Medical Director or designate, in collaboration with the Director of Nursing/Nurse Supervisor or designate, will arrange an order of priorities for Medical Staff to complete tasks that had been deferred. Again, initially only urgent medical assessments will be performed, but routine evaluations will be resumed as soon as possible.

As soon as practicable, the Medical Director will make an assessment of the impact of the strike on the medical conditions of residents of the Facility. The Strike Plan will then be reviewed, and modified as appropriate following discussions with Medical Staff and Facility Heads of Departments.

***STRIKE PLAN: Social Services***

**OBJECTIVE:**
To provide immediate and necessary social services to residents and families as indicated; Provide residents and families will status updates re: continued delivery of care and operations of the facility, Provide supportive counseling to residents and families re: fear, anxiety, general stress generated by a work stoppage; and provide supportive counseling to staff affected by the work stoppage;

A strike is likely to lead to increased stress generally and resultant increased tension among staff, even immediately after the event. Staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES**

All Social Services staff will provide the Facility all their telephone contact numbers. This information will be available to the Social Services Director, Administration, Nursing Office, and Security.

**Period of a Strike**

At all times, there must be readily accessible telephone contact between Nursing Staff and Social Service Staff. The Director of Nursing/Nurse Supervisor or designate should have a line manned at all times.

Roles of the Social Workers during a Strike:

1. Continue to provide Social Work services to residents and families as indicated;
2. Provide residents and families will status updates re: continued delivery of care and operations of the facility during the strike;
3. Provide supportive counseling to residents and families re: fear, anxiety, general stress generated by a work stoppage;
4. Provide supportive counseling to staff affected by the work stoppage;
5. Man and answer telephones on the units and/or in the lobby;
6. Assist the Recreation Department in delivering programs and activities to residents;
7. Sort and deliver resident mail;
8. Assist the Food Services Department in delivering meal service to residents (serving trays, for example);
9. Man and supervise the Smoke Room;
10. Other duties as assigned by Administration;

The Social Service Staff will endeavor to attend the Facility as per their usual schedule. In the event that the Social Service Staff is unable to reach the Facility as scheduled, the following arrangements will be in place:

***On-Call Schedule***

The Director of Social Services or designate will arrange a schedule so that there are at least 2-3 Social Workers in the facility at any given time The other members of the Staff will be on-call by telephone. The Director of Social Services will notify the Administrator, Director of Nursing/Nurse Supervisor or designate of this schedule.

The Director of Nursing/Nurse Supervisor or designate will ensure that all Nursing Units are informed of this schedule.

***Periods when an individual Social Worker cannot arrive at the Facility as scheduled***

The Social Worker will call the pre-arranged contact number of the Director of Social Services or designate. If there are any urgent matters/ problems relating to residents the Director of Social Services will ascertain if there is another Social Worker in the Facility at that time. If so, that Social worker will be requested to assist the resident(s) with regards to their urgent matter(s).

If there is no Social Worker in the Facility at that time, then the Director of Social Services Nursing/Nurse Supervisor or designate will arrange for the above mentioned problems to be discussed by telephone with the one of the Social workers on call.

**Period immediately following a strike**

As soon as practicable, the Social Service Staff will return to the usual schedule of attendance at the Facility. The Director of Social Services, in collaboration with the Director of Nursing/Nurse Supervisor or designate, will arrange an order of priorities for the Social Service staff to complete tasks that had been deferred.

As soon as practicable, the Director of Social Services, along with the Medical Director, Director of Nurses and the Administrator will make an assessment of the impact of the strike on the psychosocial conditions of residents of the Facility. The Strike Plan will then be reviewed, and modified as appropriate following discussions with the Social Service Staff, the Administrator and the facility Heads of Departments.

## ***STRIKE PLAN: Recreation Department***

### OBJECTIVE:

To provide meaningful activities for residents at all activity levels daily. To keep residents' daily activities to remain consistent and in keeping with the posted schedule of programs, as is possible. To maintain each resident's individual daily routine, as is possible. To offer encouragement, support and TLC often to keep residents as calm and stress free as possible.

### PROCEDURES

Recreation Director will recruit as many volunteers as possible. Ensure that all volunteer are fully oriented and educated regarding responsibilities during the strike. A list of volunteers will be prepared and up dated as appropriate. The volunteer list will consist of names, addresses and what they will be capable of covering during the strike.

Roles of the Activity Leaders and volunteers during a strike:

Activities will take place on a regular basis as scheduled. Recreation Staff/ Volunteers/ – Can/will provide/assist in the following:

- Continue to provide recreational programs to residents as scheduled;
- Activity 1:1 visits for residents – will be scheduled daily upon staff/volunteer availability each day;
- Help deliver meals (serving the trays);
- Any other miscellaneous jobs that volunteer/recreation staff is assigned by Administrator

***STRIKE PLAN: Rehabilitation Department***

**OBJECTIVE:**

To provide immediate and necessary rehabilitation services to residents as indicated;
Provide residents and families with status updates as the customary and usual information regarding the resident on Program. Provide the necessary support to nursing and other departments which may be affected by work stoppage;
A strike is likely to lead to increased stress generally and resultant increased tension among staff, even immediately after the event. Staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES**

"Rehabilitation staff" refers to the Director of Rehabilitation, Physical, Occupational and Speech Therapists, Physical Therapy Assistants, Certified Occupational Therapist Assistants, Rehab Aides as well as an individual assigned to the department for specialized duties, such as transporter.

All Department Therapists will provide the facility all their telephone contact numbers and vehicle identification information. This information will be available to the Rehabilitation Therapy Director, Administration, Nursing office and Security.

**Period of a Strike**

At all times, there must be readily accessible telephone contact between Nursing Staff and Rehabilitation Therapy Staff.

All rehab personnel is not included in the Collective bargaining Unit that is covered by the union contract.

**ROLES of the Therapist and the Assistants during Strike:**

1. Continue to provide Therapeutic Rehab services to residents as indicated;
2. Provide residents and families status updates re: continued delivery of care and operations of the facility during the strike
3. Provide supportive counseling to residents and families re: fear, anxiety, general stress generated by work stoppage.
4. Provide supportive counseling to staff affected by the work stoppage;
5. Ensure that the department carries out all of the duties and services
6. Assist other Departments as needed and or directed by the Director of Rehab, the Administrator or the Director of Nursing.

The Rehab Department Staff will endeavor to attend the facility as per their usual schedule. In the event that the department is unable to reach the facility as scheduled, the following arrangements will be in place:

**On- Call Schedule**

The Director of Rehab or designate will arrange a schedule so that there are at least one Physical Therapist, Physical therapy assistant, Occupational Therapist and a Certified Occupational

Therapist and support staff in the facility at any given time. The other members of the Staff will be on-call by telephone. The Director of Rehab will notify the Administrator, Director of Nursing/ Nurse Supervisor or designate of this schedule.

**Periods when an Individual Therapist cannot arrive at the facility as scheduled.**

The Therapist will call the pre-arranged contact number of the Director of Rehab or designate. If there are any urgent matters/problems relating to residents, the Director of Rehab will ascertain if there is another Therapist in the facility at that time. If so, that Therapist will be requested to assist the resident(s) with regards to their urgent matter(s).

If there is no Therapist in the facility at that time, then the Nursing/Nurse Supervisor or designate will arrange for the above mentioned problems to be discussed by telephone with the one of the Therapist on-call.

**Period immediately following Strike**

As soon as practicable, the Rehab Staff will return to the usual schedule of attendance at the Facility. The Director of Rehab, in collaboration with the Director of Nursing/ Nurse Supervisor or designate, will arrange an order of priorities for the Rehab Staff to complete tasks that had been deferred.

As soon as practicable, the Director of Rehab along with the Medical Director, Director of Nursing, Director of Social Services and the Administrator will make an assessment of the impact of the strike on the conditions of residents of the Facility. The Strike Plan will then be reviewed, and modified as appropriate following discussions with the Rehab Staff, the Administrator and the facility Heads of Departments.

***STRIKE PLAN: Dietary Department***

**OBJECTIVE:**

To ensure that the Residents at Union Plaza Care Center Extended Care Facility continue to receive high quality and nutritious meals. To ensure provision of clinical nutrition services by the Dietitians according to regulations.

**PROCEDURES**

1. Dietary management and other non-union employees will cover all areas of kitchen sanitation, food production and food transportation.

2. A strike menu has been prepared for utilization during the strike period. This menu will cover 7 days of breakfast, lunch and dinner. Food items will be purchased in advance of the strike.

3. All orders are placed through Central Care Solutions (phone # *908-912-2777*). Central Care Solutions purchases all food items, disposables, chemicals and supplements for the food service department.

4. The Dietary Dept. will need 7 people to facilitate the tray-line. Coffee is delivered to the units in bulk with food trucks.

5. All disposable dishes, cups, flatware will be used. Regular coffee cups, adaptive equipment and trays will be used.

6. The Clinical Dietitians cover all areas of clinical nutrition care and documentation as required by the NYS health department. Additional assistance from a Consultant/ per-diem may be required. The Dietitians may be asked to assist in the kitchen as well.

7. The Food Service Director/ Supervisor will be responsible for printing daily meal tickets and nourishment labels as well as updating Geri Menu.

8. Food will also be provided to the staff. Meals will be pre-portioned into hinged plates and left in the staff dining room refrigerator.

9. Management staff will work 12 hour shifts to ensure all areas of the kitchen needs are met.

***STRIKE PLAN: Housekeeping Department***

**OBJECTIVE:**

To provide a safe, comfortable and clean environment. To ensure urgent and necessary provision of vital and non-vital equipment and services is conducted in a timely manner during a period of a strike without significant compromise to residents.

A strike is likely to lead to increased stress generally and result in increased tension among staff, even immediately after the event. Senior staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES**

The Housekeeping Department will institute their normal Sat/Sun staffing schedule for all 7 days in the week during the 1st 60 days of the strike.

7 Housekeepers for patient units: 7:30AM – 3:30PM
Sweep and mop all bathroom, resident rooms, dining room and corridors.

- Remove all trash from the unit and place in soiled utility room
- Clean all dining room tables after meals
- Replenish all supplies needed in the rooms
- Clean all sinks and toilets
- Dust all flat surfaces as needed

One (1) Housekeeper 7:30AM – 3:30PM
LL and Lobby floor

- Remove all trash from 1st and 2nd floor offices and bathroom
- Clean all bathroom
- Clean CCP room Clean day room
- Sweep, mop, and vacuum all floors on the LL and Lobby floor
- Bathroom and locker rooms
- Receive deliveries
- Deliver housekeeping products to the resident floors
- Sweep and mop all corridors
- Load and deliver all clean linen and diapers to the resident units

Two (2) Utility Porters: 6AM – 2PM

- Removes all trash from resident floors and dump in container
- 3 times during shift
- Remove all medical waste trash from all units and store in special shed outside

One (1) Evening Porters: 3:30PM – 11:30PM

- Remove trash from entire facility and dump
- Deliver evening shift linen and diapers to all the units
- Clean all dining rooms after dinner
- Collect all soiled personal clothes from resident floor
- Empty soiled linen chute

One (1) Wheel Chair Cleaner: 11PM – 7AM – Once a week

- Clean all wheelchairs and med carts as per schedule
- Clean and buff staff dining room daily

After 60 days the facility needs to return to normal weekly staffing pattern for the Housekeeping Department.

**Period of a Strike**

- Full census. If census is reduced, Housekeeping staff can be reduced accordingly
- Residents will be maintained in gowns provided by our laundry services

**SCHEDULE:**

- Order sufficient paper supplies and garbage liners for two weeks
- Call linen company to advise them of strike. If they do not cross picket line, order two (2) weeks supply of linen.
- Prepare storage area to receive emergency supplies.
- Prepare storage area to keep dirty linen

***STRIKE PLAN: Maintenance***

**OBJECTIVE:**
To ensure a safe and comfortable environment for residents. To ensure urgent and necessary repairs of vital and non-vital equipment are conducted in a timely basis during a period of a strike without significant compromise to residents.

A strike is likely to lead to increased stress generally and resultant increased tension among staff, even immediately after the event. Senior staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES**
"Maintenance Staff" refers to maintenance engineer including the, Supervisor/Designee and Director of Maintenance.

All maintenance personnel have been requested to provide all their telephone contact numbers and vehicle identification information. This information will be available to Administration and Security.

All management staff must wear their ID badges at all times including upon entering and leaving the facility during any union work action.

**Period of a Strike**
At all times, there must be readily accessible telephone contact between Maintenance Staff and all other departments. The overhead paging system will be used to communicate within the building. In addition maintenance staff will be assigned two way radio transceivers to communicate. The Director of Maintenance will be available by cell phone at all times.

It is anticipated that during any period of a strike, implementation of equipment repair within the Facility may be compromised, as there may be limitations on the availability of staff. Therefore certain urgent equipment repairs will be outsourced to known vendors in the community during this time to avoid any potential negative outcomes.

**Maintenance Director Coverage**
Maintenance Director and Supervisor will work 12 hour shifts covering both days and nights at the commencement of a strike and will continue to provide this coverage until the facilities operations and coverage resemble normal day-to-day operations. Once normal operations have been achieved, Maintenance management will return to an 8-hour a day work schedule.

The Director of Maintenance will be responsible for the overall operations of the day shift for the Maintenance department and will be in contact with the NYS Department of Health as needed. The Supervisor/ Designee will be responsible for the overall operations of the night shift for the Maintenance department and will be in contact with the Director of Maintenance and or Administrator should the need arise.

The Director of Maintenance will work with staffing agencies to make certain that there are adequate numbers of qualified staff to ensure the day to day operations of the facility. The staffing patterns will be determined using our usual staffing patterns and then modifying the schedule based on facility needs.

There will be a list of staffing agencies with phone numbers and addresses available in the maintenance office. The contracts for each agency will also be available in the master strike plan policy manual in the administrator's office.

Each contract agency will be given a packet of the facility orientation and will be responsible for orienting the staff assigned to cover the facility at the agency. This will be done upon the facility receiving the 10-day strike notice so employees will be oriented prior to being needed. The facility will then provide an onsite orientation to agency workers prior to the commencement of the strike to review special procedures including the fire alarm system, security systems, disaster codes, elopement policies and procedures, paging system (etc.). Each agency will also be responsible for working with the human resource department to ensure that each agency employee has the necessary information (PPD testing, fingerprinting, etc.) prior to starting a facility work assignment.

The Maintenance Director will be responsible for reviewing the staffing to ensure that there are adequate numbers of staff or reporting shortages to the Administrator to ensure that adequate staffing can be provided.

1. **Prior to Strike**
   a. Arrange for service companies to check vital equipment, i.e., elevators, boilers, sprinklers, etc. and advise companies of impending strike: see attachment
   b. Change locks on all vital service rooms, i.e., boiler, sprinklers, and give new key only to Administrator.
   c. Have all tanks filled.
   d. Schedule pick up of garbage with Housekeeping Department.
   e. Close and lock all 1st floor windows.

2. **During Strike**
   a. Maintain vital services and emergency repairs.
   b. Assume responsibility for private Guard Service.
   c. Monitor security of building.
   d. Work with Housekeeping and Dietary as needed.

**Period immediately following a strike**

As soon as practicable, the union members will return to the usual schedule of attendance at the Facility. The master schedule will be given to the business agent of the union upon notice that the strike is over and will be posted at the designated locations within the facility. All staff members will be instructed that everyone is to be welcomed back and there is to be no dialogue about the events that have just taken place. The Strike Plan will then be reviewed, and modified as appropriate following discussions with Administrator.

***STRIKE PLAN: Security***

**OBJECTIVE:**

To ensure a safe, secure and comfortable environment for residents. To ensure urgent and necessary repairs of vital and non-vital equipment are conducted in a timely basis during a period of a strike without significant compromise to residents. A strike is likely to lead to increased stress generally and resultant increased tension among staff, even immediately after the event. Senior staff members will try to alleviate such stress and tension as much as possible, both at the individual level and also by cooperation between Departments in the implementation of Strike Plans.

**PROCEDURES:**

- Following a review of the facility' contract with a Security Company for additional guards and develop a strike assignment to ensure security for staff, Residents and families.
- Security will be maintained 24 hours 7 days a week throughout the strike.
- Guards should be posted at the front door once strike is active.
- Guards will be trained and knowledge as to who is permitted inside the building.
- An authorized employee/volunteer list will be available and updated regularly to ensure utmost security.
- Special ID tags OR as Visitor Pass must be available to ensure proper access to the building and to ensure that off duty Employees cannot enter the building unless authorized.
- Has the authority and responsibility to ensure that, if an employee does not show or have ID and does not cooperate they cannot be permitted in the building and their name and description is reported to administration.
- Maintain communication with local police enforcement and Facility Administrator/Designee
- Maintain on-going surveillance of building and property for Security.
- Ensure safe entry and existing of staff, residents, and visitors.
- Monitor orderly conduct.
- Report any and all disruptions to Administration and/or police as necessary and/or directed.
- Provide shift to shift reports as well as daily reports to the Administrator.
- Attend informational meetings as necessary
- Conduct themselves with a customer service approach at all times.

All Security personnel will be thoroughly trained and familiar with the facility's policy and procedure with regard to the following:

- Abuse Prevention and Reporting
- Out On Pass for Residents
- Elopement prevention
- Admission process
- Transportation of Residents and Staff
- Door Alarms
- Access
- Vital Service areas
- Fire Emergency Procedures
- Bomb Threat Procedure

Security personnel are responsible to maintain full observation and monitoring of the grounds, building and individual actions and behaviors. (No loitering at end of shift, no congregating in the build or on the premises. No impediment to optimum security and surveillance

If there is safety issues a report must be made a submitted to Administration/designee and the Security Director.

**Period of Strike**

Security Guards    Alboro Security    Marcel Delatorre 646.860.5212

Vehicle Identification information - Authorized Entry

**LOCAL NYP – Precinct**

- NYPD-109th Precinct was contacted and will provide _____ metal barricades to set the demonstration perimeter. Officer ________________________ from the NYPD Community Affairs was contacted at (718) 321-2269 and indicated that their precinct will provide police officers during the labor action as previously arranged.

## ADMINISTRATIVE STRIKE COUNTDOWN CHECKLIST

### A. Prior to Negotiations:

- ☐ Review the issues anticipated in negotiations.
- ☐ The union's strike history and conduct and demands in the contemporaneous negotiations with other institutions.
- ☐ Assign accounting staff to identify the expected cost of a settlement based on settlements elsewhere.
- ☐ Assign accounting staff to evaluate financial and non-financial costs of taking a strike.
- ☐ Retain counsel expert in labor relations.
- ☐ Implement any capital improvements required to maintain security during a strike.
- ☐ Review strike plan with strike contingency plan council and department heads.
- ☐ Have members, operators or top management review and approve the strike plan and authorize expenditures associated with it.
- ☐ Develop and train potential volunteer staff to serve as temporary replacements in the event of a strike.
- ☐ Review emergency or catastrophe procedures and update.
- ☐ Review bomb threat procedure.
- ☐ Prepare emergency notification checklist.

### B. Sixty (60) Days Prior To Anticipated Strike

- ☐ Evaluate financial and non-financial cost of union demands and balance against cost of a strike.
- ☐ Consider the value of important concessions which might be made by the Union.
- ☐ Inventory existing vehicles which could be used to transport supplies or personnel over the picket line.
- ☐ Inventory all supervisory and managerial personnel having chauffeur's licenses and determine what kind of vehicles they can operate.
- ☐ Locate possible warehousing facilities away from the premises for pick-up of supplies.
- ☐ Make sure night lighting, perimeter fencing, gates, housing and other capital improvements are completed.
- ☐ Begin storing plywood or other materials which might be useful in covering glass which is near perimeters and susceptible to vandalism.
- ☐ Make an up-to-date assessment of personnel resources.
- ☐ Re-establish contact with medical pools and personnel agencies and advise them of potential needs.
- ☐ Update your bank of employment applications and begin making requests for employment references if you have not already done so.
- ☐ Develop materials for training supervisory and management personnel on how to cope with strike situation.

## C. Thirty (30) Days Prior to Anticipated Strike

- ☐ Develop expected orientation program for replacement personnel who will be brought in commencing with the day before the strike.
- ☐ Develop expedited orientation and training program for non-union personnel who will be temporarily transferred into the bargaining unit.
- ☐ Prepare a draft of the following pre-strike communications with the assistance of labor counsel
- ☐ A letter to bargaining unit employees concerning the final offer and your Right to continue operating in the event of a strike.
- ☐ A letter to non-bargaining unit personnel concerning your desire to protect their right to work and assurances of protection.
- ☐ A letter to physicians informing them of your receipt of a strike notice and requesting their support and cooperation.
- ☐ A letter to subcontractors requesting their cooperation in the event of a strike
- ☐ A letter to the patients' families assuring them of continued patient care
- ☐ Clear all communications with counsel.
- ☐ In the event of a possibility of a strike becomes a topic, meet with all managerial and supervisory personnel and give them guidance on how to legally respond to questions about the strike.
- ☐ Notify the State Health Department and inform them of your receipt of notice
- ☐ Contact strike security company and notify them of your need for coverage in 10 days.

## D. Ten (10) Days before anticipated Strike

- ☐ Set up a meeting with the security supervisor(s) within 72 hours of the anticipated strike to discuss schedules and last minute changes.
- ☐ Set up a meeting with the medical pools and personnel agencies you have selected for temporary replacement personnel.
- ☐ Define your needs for them and make sure they can deliver total coverage of bargaining unit positions. It is advisable to make arrangements with at least one backup agency.
- ☐ Contact and make reservation at local hotels in anticipation of the influx of personnel from other facilities and other out-of-town replacement personnel
- ☐ While avoiding stock piling, make sure all regularly scheduled deliveries of food and medical supplies are made in the week before the anticipate strike
- ☐ Anticipate and prepare for questions from the press concerning the anticipated Strike.
- ☐ Clear any releases with counsel in advance.
- ☐ Plug any possible security leaks that may exist in administrative offices.

## E. Eight (8) Days Before the Anticipated Strike

- ☐ Conduct meeting with supervisory personnel and give them an update on the negotiations.
- ☐ Advise them to make no comment or a limited comment concerning the negotiations.
- ☐ Do not discuss strike contingencies with supervisors at this point, but assure them that follow-up meeting will be held later, if the Strike appears to be likely. Review with supervisors what can and cannot be said about the strike.
- ☐ Obtain contracts with a bus company or lease buses and vans for transporting
- ☐ Non-striking personnel across the picket line.
- ☐ Obtain contracts with local warehousing companies, if necessary

## F. Six (6) Days Before the Strike

- ☐ Conduct meeting with Personnel Coordinator and any in-service training and work up a schedule for orienting and training staff and work up schedule for orienting and training (a) transferees from other facilities, (b) likely Transferees from non-bargaining unit positions within, ( c) medical pool and Temporary agency personnel and (d) new hires from your application bank
- ☐ Make arrangements with other facilities and personnel agencies for transportation of such replacement personnel to site of pre-strike training
- ☐ Commence calls to new hires that can be hired and oriented through normal channels prior to the strike.

## G. Three (3) Days Before the Strike

- ☐ Send out letters to bargaining unit employees, non-bargaining unit employees, physicians, subcontractors, referral agencies, families, and other constituents
- ☐ Conduct meeting at least 48 hours before anticipate strike with security Consultant.
- ☐ Arrive at consensus concerning security coverage, clearance passes Security desks or gates and other details of operations.

## H. 48-Hours Before the Strike

- ☐ Security checks of sensitive equipment and areas should be intensified.
- ☐ Arrange to have locks on security sensitive areas changed the following day.
- ☐ Contact suppliers and make sure they will deliver through a picket line. (If not pressure them to use supervisors to drive.
- ☐ Map out pick-up points for transporting non-striking personnel across the picket line.
- ☐ Make sure strike documentation notebooks; kits, etc. have been obtained
- ☐ Contact Phone Company and repair services for elevators and other equipment and get assurances that they will come in during strike. Have Telephone Company install separate private line for task force coordinator.
- ☐ Notify Mayor's Office, District and City Attorneys and County Sheriff's Department of possible strike.

## I. Day Before Anticipated Strike

- ☐ Conduct a strike orientation and training session for supervisors and other Management personnel.
- ☐ Transport security personnel to off-site location for orientation and training
- ☐ Conduct security orientation and training for security personnel, maintenance supervisors, receptionists, etc.
- ☐ Discuss security preparations, special labor relations rules of conduct, procedure in the event of government investigation, bomb threat or catastrophe and discuss priority notification.
- ☐ Conduct meeting with non-bargaining unit personnel concerning problem of transportation, change in schedules, possible overtime, etc.
- ☐ Notify them to call facility in the morning concerning pick up locations
- ☐ Conduct special orientation on bargaining unit work for non-bargaining transferees.
- ☐ Have draft of communication prepared in the event of change in progress of negotiations or cancellation of strike.
- ☐ Plain clothes guards should begin duty to prevent sabotage on the day before the strike.

- ☐ Conduct orientation and training of out-of-town personnel at hotel or elsewhere off-the-premises
- ☐ Set up security desk or gate, check positing make sure fencing is ready
- ☐ Paint yellow property lines at all entrances or areas of possible picketing.

**J. Two hours before anticipated strike**

- ☐ Uniformed guards should be on duty.

Arrange to have the appropriate number of trained receptionists ready to answer calls on the morning of the strike and answer questions appropriately

**Attachment #1**

**Available Facilities/Agencies for Administrative & Staffing Support**

Meadowbrook Care Center
320 West Merrick Road Freeport, NY 11520
Phone:(516) 377-8200 Fax: (516) 377-8233

Blue Leaf Staffing
40 W 37th, #402a, New York, NY 10018
Phone:(212) 382-2935

**Attachment #2: NURSING ADMINISTRATIVE COVERAGE**

The following Nursing Management Team is assigned to monitor the tours during the duration of the Labor Action:

| Name | Title | Telephone |
|---|---|---|
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| | | |

**Attachment #3: STRIKE NURSING SCHEDULE**

## Nursing Management

| 6am-6pm | 6pm-6am |
| --- | --- |
| | |

### 7-3 (6-3*) Staff Coverage

| 2 | 3 | 4 | 5 | 6 |
| --- | --- | --- | --- | --- |
| RN | RN | RN | RN | RN |
| LPN | LPN | CNA | CNA | LPN |
| CNA | CAN | CNA | RN | LPN |
| CNA | CAN | Adm | Adm | CNA |
| SW | SW | SW | Adm | Rehab |
| | | | | |

### 3-11 Staff Coverage

| | | | | |
| --- | --- | --- | --- | --- |
| | LPN | RN | LPN | LPN |
| RN | LPN | LPN | CNA | LPN |
| CNA | CAN | CNA | CNA | CNA |
| CNA | CAN | CNA | CNA | CNA |

### 11-7 Staff Coverage

| | | | | |
| --- | --- | --- | --- | --- |
| RN | LPN | LPN | LPN | LPN |
| RN | CNA | CNA | CNA | CNA |
| CNA | CNA | CNA | CNA | CNA |

* NOTE* Resident Care will be provided by all staff members with licensure and additional support to those members will be given by non-licensed staff members (Feeding, Transport, Entertainment, Meal Prep, etc).

**ATTACHMENT #4: NURSING STAFFING CONTRACTS**

**Staffing Agencies**

**County**
(718) 782-5306

**Towne**
(718) 998-4660

**Five Star**
(718) 534-7400

**Blue Leaf**
(212) 382-2935

The completed nursing schedule will be submitted to your office 24 hours prior to the commencing of the labor action.

On ____________ staffing will begin at 6am.
All other days of the strike the staffing shifts will be from 7am to 7pm
Then 7pm to 7am.

**Attachment #5: STRIKE MEDICAL STAFF COVERAGE**

The following medical staff will provide medical care:

| Name | Unit | Pager & Cell # |
|---|---|---|
| Dr. Michael Tadros, M.D. | 2 & 8 | 917-509-8705 |
| Assigned Doctors | 7 | 347-675-6723 |
| Jae Hong, MD | 3 | 718-838-0642 |
| Jitendra Tolia, MD | 6 | 917-683-2567 |
| Dr. Neil Jaglall | 4 | 347-803-3173 |
| Bruce Lowell, MD | 5 | 516-972-4728 |
| Dr. Shao, Liang | Psychologist | 212-365-4866 |
| Dr. Yu, Wei Zhen | Psychologist | 646-526-8162 |
| Louisa Chan, NP | Psychiatry- Chinese Speaking | 718-964-6161 x 103 |
| Margarite Soh-Choe, NP | Psychiatry – Korean Speaking | 718-964-6161 x 103 |
| Emily Stern | OPTUM | 646-734-0999 |
| Franckel Taylor, NP | OPTUM | 718-734-7492 |
| After hours<br>5pm-8am Weekday<br>5pm-8am Weekend & Holidays | OPTUM | (877) 493-1469 |

## Attachment #6: STRIKE PLAN: SOCIAL SERVICES ADMINISTRATIVE STAFFING

Social Workers will be scheduled to work from 8AM to 6PM Monday – Friday.
The Director of Social Work will provide evening and weekend coverage if necessary.

**STAFF**

Dr. Su Jeong Park, Director
718-670-0711

Jane Yeh, SW
(718) 670-0717

Clara Hahn, SW
718-670-0712

Peter Jang, SW
718-670-0715

## Attachment #7: THERAPEUTIC RECREATION SERVICES

Recreation Department Staff Plan

| Name | Title | Address | Phone | Schedule |
|---|---|---|---|---|
| Larissa Tadjiev | Director | | | For duration |
| | | | | For duration |
| | | | | For duration |
| | | | | For duration |
| | | | | For duration |

**Companion**

| | | | | |
|---|---|---|---|---|
| | | | Social Visits<br>Delivery Meal<br>(serving trays) | Mon-Fri |

**Attachment #8: FOOD SERVICES STAFFING & SCHEDULE**

The Food Service Director will be responsible to ensure that all food deliveries will be received without interruption.

Staffing, as needed, will be secured through backup on call staffing

**The following is a guideline of availability and coverage of the dietitians.**
**All consultants can be left information regarding supplies.**

| | |
|---|---|
| Chief Clinical Dietitians: | Teresa Lee x 755 Juha Nam x 753 |
| Dietitian: | Rosie Wang x 752 |
| Director of Food Services- | Lennox White x 750 |
| Asst. Director of Food Services- | Betty Colon x 751 |

**STARTER 6:30am – 8:00 pm**

| | |
|---|---|
| 6:30 – 7:00 | fill cold water containers |
| 7:00 – 8:00 | work starter position breakfast tray line |
| 8:00 – 8:45 | break down, clean and refill tray line starter station,<br>Prepare silverware |
| 8:45 – 9:00 | break |
| 9:00 – 10:30 | work dirty side of dish room; clean trucks |
| 10:30 – 11:00 | set up staff dining room (bread, milk, condiments)<br>Set up trays with placemats |
| 11:00 – 11:30 | Lunch |
| 11:30 – 12:30 | work starter position lunch tray line |
| 12:30 – 12:45 | break down tray line, wipe clean<br>Refill starter station |
| 12:45 – 1:00 | break |
| 1:00 – 2:30 | work dish room; clean trucks |
| 2:30 – 3:00 | prepare silverware |
| 3:00 – 3:30 | lunch |
| 3:30 -4:00 | cleaning |
| 4:00 – 5:00 | set up cereal;<br>Prepare starter station |
| 5:00 – 6:00 | work starter position dinner tray line |
| 6:00 – 6:15 | call backs |
| 6:15 – 8:00 | dish room |

**LOADER 6:30 – 8:00**

| | |
|---|---|
| 6:30 – 7:00 | prepare bowls applesauce for delivery to floors |
| 7:00 – 8:00 | work loader station on breakfast tray line |
| 8:00 – 8:45 | sweep and mop floor<br>Answer call backs |
| 8:45 – 9:00 | break |
| 9:00 – 10:30 | load dish machine dirty function |
| 10:30 – 11:00 | clean dish room (dish machine, floor, and drains) |
| 11:00 – 11:30 | lunch |
| 11:30 – 12:30 | work loader position for lunch tray line<br>Set up area (hot cereal, pastina) |
| 12:30 – 12:45 | clean work area |
| 12:45 – 1:00 | break |
| 12:45 – 2:30 | work dirty side dish machine<br>Clean dish room (dish machine, floor, and drains) |
| 2:30 – 3:30 | Lunch |
| 3:30 – 5:00 | put placemats on trays; set up tray covers;<br>cleaning |
| 5:00 – 6:00 | work loader position for dinner tray line (cover trays and load)<br>Set up area (hot cereal, soup) |
| 6:00 – 6:15 | break |
| 6:15 – 8:00 | bring trucks down from units<br>Wash coffee carts |

**POT WASHER 6:30 – 8:00**

| | |
|---|---|
| 6:30 – 7:00 | set up coffee cups<br>Set up pot washer area |
| 7:00 – 8:00 | transport trucks, coffee carts and juice |
| 8:00 – 8:45 | sweep and mop |
| 8:45 – 9:00 | break |
| 9:00 -10:30 | bring trucks down<br>Work clean side in dish room<br>Sort silverware |
| 10:30 – 11:00 | wash pots |
| 11:00 – 11:30 | lunch |
| 11:30 – 12:30 | bring lunch trucks upstairs |
| 12:30 – 2:15 | wash pots; cleaning |
| 2:15 – 2:30 | break |
| 2:30 – 3:00 | pot washing; cleaning |
| 3:00 – 4:00 | lunch |
| 4:00 – 6:00 | set up pot area; wash pots |
| 6:00 – 6:15 | break |
| 6:15 – 8:00 | finish pot washing; clean steam take, sweep & mop |

**COLD STATION 6:30 – 8:00**

| | |
|---|---|
| 6:30 -7:00 | set cold station for breakfast; portion out hot cereal |
| 7:00 – 8:00 | work cold station for breakfast tray line |
| 8:00 -8:15 | break |
| 8:15 – 9:00 | set up cold station |
| 9:00 – 10:30 | prepare desserts for supper, pudding, jello, applesauce, lactaid mil |

| | |
|---|---|
| 10:30 – 11:00 | set up food for staff salad bar (place in refrigerator) |
| 11:00 – 11:30 | lunch |
| 11:30 -12:30 | work cold station for lunch tray line |
| 12:30 – 1:00 | clean steam table |
| 1:00 – 2:00 | prepare desserts for lunch for next day |
| 2:00 – 3:00 | prepare silver ware |
| 3:00 – 4:00 | break |
| 4:00 – 5:00 | set cold station; make coffee |
| 5:00 – 6:00 | work cold station for dinner tray line |
| 6:00 -6:15 | break |
| 6:15 – 8:00 | clean up cold station; prepare stewed prunes, cottage cheese,<br>Sliced cheese for breakfast; make trays |

**COOKS HELPER / RUNNER 6:30 – 8:00**

| | |
|---|---|
| 6:30- 7:00 | set up serving utensils for breakfast tray line; assist in breakfast preparation |
| 7:00 -8:00 | serve breakfast tray line |
| 8:00 – 8:15 | break |
| 8:15 – 10:00 | assist cook with lunch meal |
| 10:00 -12:30 | make sandwiches for lunch and dinner |
| 12:30 – 1:00 | prepare nourishments for dinner delivery |
| 1:00 -1:30 | prepare items for salad bar for next day<br>Slice cold cuts; prepare cold salads for the next day |
| 1:30 -1:45 | break |
| 1:45 – 3:00 | prep meat, vegetables, and breakfast items for next day<br>Cleaning |
| 3:00 – 4:00 | Lunch |
| 4:00 – 5:00 | set up and deliver juice and cookies<br>Set up 7pm nourishments<br>Set up coffee carts |
| 5:00 -6:00 | deliver food carts |
| 6:00 -6:15 | break |
| 6:15 – 8:00 | bring down food trucks, coffee and water carts<br>Clean urns and carts<br>Work in dish room; clean dish room |

**Attachment #9: STRIKE PLAN: HOUSEKEEPING SCHEDULE SERVICES**

| Schedule Hours | Employee | Area of Coverage | Service to be Provided |
|---|---|---|---|
| 6AM – 6PM | 2 | 3rd – 4th Floors | 1. Pick up trash in all rooms, place in dirty utility room<br>2. Sweep all rooms & corridors<br>3. Wash dining room tables and chairs<br>4. Clean up spillages<br>5. Replenish toilet tissue, paper towels and soap<br>6. Take trash to compactor |
| 6AM – 6PM | 2 | 1st – 2nd Floors | 1. Pick up trash in all rooms, place in dirty utility room<br>2. Sweep all rooms 2nd floor including corridor & dining room<br>3. Sweep corridors 1' color & basement including staff dining room<br>4. Wash dining room tables and chairs and clean up spillages<br>5. Replenish toilet tissue, paper towels and soap<br>6. Vacuum 1st floor dining room<br>7. Take trash to compactor |
| 5AM – 5PM | 2 | Linen/Laundry | 1. Pick up soiled linen from dirty utility room on resident floors and bring to soiled linen room shed<br>2. Pick up dirty towels from resident floors and bring to laundry and launder unpack cleaned linen from commercial laundry<br>3. Pack truck with clean linen according to pars<br>4. Launder residents' personal laundry |
| 3PM – 12Mid | 1 | All Floors | 1. Pick up garbage from dining rooms and take to compactor<br>2. Pick up all soiled linen and place in shed<br>3. Pick up all bath towels and place in laundry room, clean all dining room tables and chairs including staff dining room<br>4. Damp mop spillage<br>5. Sweep 2nd, 3rd, 4th floor dining room<br>6. Vacuum 1st floor dining room |

The following services will continue to be provided:

- Marking of resident laundry
- Mop floors
- Strip and re-wax
- Dusting
- Washing of sinks
- Washing of toilets
- Changing cubicle curtains, shower curtain cleaning
- Other general cleaning
- Office cleaning
- Supply deliveries with exception of laundry
- Cleaning of wheeled equipment such as wheelchairs, stretchers, I.V. poles, etc.

**Linen & Laundry Services:**

**All linen and resident laundry services will be provided by Unitex Inc. starting _____2018 for the entire duration of the strike.**

**Unitex, Inc.**

**866-UNITEX-9**

**VENDORS:**

All linen, clothes, paper and plastic goods, housekeeping supplies will be delivered on the normal schedule. Unitex will cross picket lines as needed to make normal deliveries.

- Action Waste will continue to do their normal garbage and card board removal scheduling during the strike
- Approved Hauling will continue their normal weekly medical waste removal
- A possible strike will in no way disrupt the services provided by the above vendors, provided they are able to access the building by crossing the picket lines safely

**STRIKE PLAN**
**MORNING HOUSEKEEPING SCHEDULE 7AM – 3 PM**

| TIME | CHECK IF COMPLETED | ACTIVITY |
|---|---|---|
| 7 AM – 8 AM | | Collect garbage from resident rooms, pantry, day room, nurses station, locker room, staff toilet, shower room, tub room, utility rooms, and replace all liners |
| 8 AM – 9 AM | | Sweep, dust mop and high dust resident rooms and all corridors. Clean nurses station, utility room, water fountains, staff toilet, nurses office and locker room. |
| 9 AM – 9:30 AM | | Clean dining room tables, sweep and mop dining room. Clean pantry and day room toilet. |
| 9:30 AM – 9:45 AM | | Break |
| 9:45 AM – 10:30 AM | | Damp mop "A" wing, nurses' station, elevator landings, utility corridor, staff locker room and nurses' office. |
| 10:30 AM – 11:30 AM | | Clean resident rooms – mop resident rooms and bathrooms, high dust over bed lights and window sills, wipe over bed tables and bedside cabinets, clean sink, mirrors, toilets, walls & IV poles. |
| 11:30 AM – 12 NOON | | Lunch |
| 12 NOON – 1:30 PM | | Clean resident rooms |
| 1:30 PM – 1:45 PM | | Wipe dining room tables, sweep and mop dining room, and clean day room toilet. |
| 1:45 PM – 2 PM | | Break |
| 2 PM – 2:15 PM | | Pull garbage in all resident rooms, pantry, dining room, clean utility room and soiled utility room. |
| 2:15 PM – 2:45 PM | | Damp mop corridors, mop shower room and tub room. Check paper towel dispensers, toilet paper and soap. |
| 2:45 PM – 3 | | Inspect your work. Fill out and turn in the report to the supervisor. |

STRIKE PLAN
HOUSEKEEPING SCHEDULE
3 PM – 11 PM

| TIME | CHECK IF COMPLETED | ACTIVITY |
|---|---|---|
| 3 PM – 4 PM | | Deliver linen to all floors. Put out laundry pick up barrels per schedule. Pick up trash from all units, soil utility, pantry, and dining room; take trash out to compactor, boxes to dumpster and red bags to Biohazard room. |
| 4 PM – 5 PM | | Sweep, pick up trash in garage, garage stairway to parking lot and roadway to garage. |
| 5 PM – 5:15 PM | | Break |
| 5:15 PM – 6 PM | | Clean tables, pantry area, office and toilets on TN 7. Sweep and mop all floor surfaces on TN 7. |
| 6 PM – 6:30 PM | | Dinner break |
| 6:30 PM – 7 PM | | Clean tables, pick up trash from pantry and dining room, sweep and mop dining room floors, clean dining room toilet and clean pantry according to schedule. |
| 7 PM – 7:30 PM | | Same as above on next resident floor per schedule. |
| 7:30 PM – 8 PM | | Same as above on next resident floor per schedule. |
| 8 [illegible] – 8:30 PM | | Clean tables, sweep and mop floor and pull garbage from cafeteria. |
| :30 PM – 9:30 PM | | Sweep and mop three day room floors per schedule. Wipe down chairs in day rooms. Deliver laundry barrels to laundry. |
| :30 PM – 9:45 PM | | Break |
| :45 PM – 10:50 PM | | Pick-up garbage, red bags, and isolation linen from all floors. Put garbage in compactor, break down boxes and put in dumpster, pack red bags in containers in Biohazard room. Mop soil utility room. Clean chute, check equipment and organize chute room. |
| ):50 PM – 11 PM | | Check all doors to housekeeping areas and make sure all doors are locked. Fill out and turn in the report. Punch out |

OTES:

# APPENDICES AND FORMS


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# APPENDIX 1 – EVACUATION TASKERS

## 1.1 INCIDENT COMMANDER - TASKER

**Mission:** Give overall strategic direction for facility incident management and support activities, including emergency response and recovery. Authorize total facility evacuation.

**Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** ___________________

**Telephone #:** __________________________ **Radio Title:** __________________________

Attached Forms and Information:

- Unit / Area Evacuation Status

| Full Building Evacuation Related Actions: | √ |
|---|---|
| Activate the Full Building Evacuation Plan. | |
| Read this entire Tasker. | |
| Activate key incident command positions, if not already activated, including:<br>▪ Logistics Section Chief<br>▪ Operations Section Chief<br>▪ Planning Section Chief<br>Establish communications with all Section Chiefs. | |
| Designate a Liaison Officer to coordinate with emergency services and other healthcare facilities. | |
| Designate a Safety and Security Officer. Consider building lock down. | |
| Activate the Full Building Evacuation Plan via facility wide announcement. | |
| Ensure a Labor Pool has been established through the Logistics Section Chief. | |
| Ensure a Holding Area has been established through the Operations Section Chief. | |
| Ensure both internal and external transportation is being addressed through the Operations Section Chief and the Infrastructure Branch Director. | |
| Determine evacuation options and capacity through the Planning Section Chief and Liaison Officer. | |
| Determine evacuation priority and feasibility with input from Operations, Emergency Services, and Safety/Security. Utilize the "*Resident Care Department / Unit Evacuation Status Form" (Appendix 11)*. Make extra copies as necessary. | |
| Ensure adequate staff and initiate staff call-back as necessary through the Logistics Section. | |
| Ensure evacuation floor plans and Resident Preparation Guide (for the units) is readily available. | |
| Commence evacuation once the Holding Area is established, evacuation groups are in place, and transportation is available. | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied. | |

## 1.2 OPERATIONS SECTION CHIEF - TASKER

**Mission:** Organize, assign, and supervise Medical Care, Infrastructure, Hazardous Materials, and Business Continuity resources. Ultimately oversee the clinical aspects of vertical evacuation and triage.

**Date:** ________ **Start:** ________ **End:** ______ **Position Assigned to:** ________________
**Telephone #:** ______________________ **Radio Title:** ______________________
**Position Reports to: Incident Commander**
Attached Forms and Information:

- Holding Area Locations and Resident Pick-up Points

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Read this entire Tasker. | |
| Activate key incident command positions, if not already activated, including:<br>▪ Medical Care Branch Director<br>▪ Infrastructure Branch Director<br>Establish communications with Branch Directors. | |
| Through the Medical Care Branch Director, designate a Holding Unit Leader to set up and manage the Holding Area. | |
| Update the Incident Commander on the location of the Holding Area. Advise when the Holding Area is prepared to receive residents. | |
| Support the Holding Area by ensuring the necessary staffing and supplies through correspondence with the Logistics Section Chief. | |
| Provide input to the Liaison Officer on the number and type of transportation units needed based on in-house clinical needs. | |
| Determine clinical staffing needs. Authorize staff call back as necessary. Coordinate with the Logistics Section Chief. | |
| Assist Incident Commander in determining evacuation priority and feasibility. Utilize the "*Resident Care Department / Unit Evacuation Status Form" (Appendix 11).* | |
| Develop a plan to address the medications being packaged with residents. | |
| Monitor the status of the Holding Area throughout the evacuation. Keep Incident Commander advised when the Holding Area is full and when they can receive additional residents. | |
| Instruct the Infrastructure Branch Director to prepare a strategy for managing waste for the facility both during and post evacuation. Work with disposal vendors as necessary. | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied. | |

## 1.3 LOGISTICS SECTION CHIEF - TASKER

**Mission:** Organize and direct operations associated with the physical environment, human resources, materials, and services to support the incident activities. Oversee communication and transportation aspects of evacuation planning and activities.

**Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** __________________

**Telephone #:** ________________________ **Radio Title:**_________________________

**Reports to: Incident Commander**

Attached Forms and Information - N/A

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Read this entire Tasker. | |
| Complete the *"Facility Systems Status Report " (Appendix 3).* | |
| Activate key incident command positions, if not already activated, including:<br>▪ Transportation Unit Leader<br>▪ Labor Pool Unit Leader<br>Establish communications with these positions. | |
| Dispatch the Labor Pool Unit Leader to establish the Labor Pool as soon as possible. | |
| Inform all Incident Command staff of the location of the Labor Pool. | |
| Ensure communications is available to all Command Center staff. Additionally, ensure communication with the Holding Unit Leader. | |
| Request frequent updates from the Labor Pool Unit Leader regarding the staffing status. Monitor staffing needs with the Operations Section Chief. Initiate staff call back as necessary. | |
| Assign Housekeeping Director/ Designee to gather supplies from units and prepare for transport to receiving facility. Utilize *Staff and Equipment Tracking Form* (Appendix 16) for inventory of supplies sent to receiving facility. | |
| Provide equipment and supplies to the Labor Pool(s) as necessary. | |
| Monitor internal evacuation equipment needs via the Transportation Unit Leader. Coordinate EMS equipment through the Liaison Officer. | |
| Monitor external transportation vehicle staging and pick-up points via the Transportation Unit Leader. Coordinate efforts with Safety and Security. | |
| Ensure the food preparation and meal delivery process continues for residents and staff. Supply the Holding Areas and/or stop over point as necessary. | |
| Provide equipment and staffing to the Holding Areas as necessary. Coordinate needs through the Operations Section Chief. | |
| Assist Incident Commander in determining evacuation priority and feasibility. Utilize the "*Resident Care Department / Unit Evacuation Status Form"(Appendix 11).* | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied after completing the "*Facility Recovery and Inspection Guidelines Report " (Appendix 10).* | |
| | |

## 1.4 PLANNING SECTION CHIEF - TASKER

**Mission:** Oversee all evacuation related data gathering and analysis. Develop alternatives for operations, conduct planning meetings, and prepare action plans for each operational period. Manage resident tracking.

**Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** ________________

**Telephone #:** ______________________ **Radio Title:** _______________________

**Reports to: Incident Commander**

Attached Forms and Information:

- Evacuation Destination Form

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Read this entire Tasker. | |
| Oversee the tracking of residents as they leave the facility. | |
| Collaborate with the Holding Areas and the Operations Section Chief to determine the final destination of residents. | |
| Monitor the evacuation of staff and equipment with evacuating residents. | |
| Manage resident location data on the "*Evacuation Destination Form"(Appendix 12)*. | |
| Coordinate messages to families and/or responsible parties with the Public Information Officer. | |
| Provide updates related to resident, staff and equipment tracking to the Incident Commander as requested. | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied. | |

## 1.5 LIAISON OFFICER - TASKER

**Mission:** Function as the incident contact person in the Command Center for representatives from other agencies (including emergency services and other healthcare facilities).

**Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** __________________

**Telephone #:** ________________________ **Radio Title:**_________________________

**Reports to: Incident Commander**

Attached Forms and Information - N/A

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Read this entire Tasker. | |
| Establish communication with other healthcare facilities, local Emergency Operations Center (EOC), and/or local response agencies (e.g., public health). Report current facility status. | |
| Consider need to deploy a representative to local EOC; make recommendation to the Incident Commander. | |
| Communicate with the Operations Section Chief regarding the number and type of transportation resources required. | |
| Request transportation resources via the local EOC or EMS/Fire. | |
| Request internal vertical evacuation equipment from EMS as needed. Coordinate needs with the Logistics Section Chief. | |
| Coordinate the number and acuity of residents to be evacuated with the Operations Section Chief. | |
| Coordinate evacuation receiving sites. Inform Holding Area of receiving sites and the type of resident they can accept. | |
| Place facility Public Information Officer in contact with Public Information Officers of other agencies. | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied. | |

## 1.6 PUBLIC INFORMATION OFFICER (PIO) - TASKER

**Mission:** Serve as the conduit for information to staff, visitors, families and the news media as approved by the Incident Commander

**Date:** _________ **Start:** ________ **End:** ______ **Position Assigned to:** ___________________

**Telephone #:** __________________________ **Radio Title:**__________________________

**Reports to: Incident Commander**

Attached Forms and Information - N/A

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Read this entire Tasker. | |
| Establish a media staging and briefing area located away from the Command Center, Holding Area and resident care activity areas. Inform on-site media of the physical areas to which they have access and those which are restricted. Coordinate designation of such areas with the Safety/Security. | |
| Contact external Public Information Officers from community and governmental agencies to ascertain and collaborate public information and media messages being developed by those entities to ensure consistent and collaborative messages. | |
| If other than yourself, identify appropriate spokespersons to deliver press briefings and public information announcements. | |
| Develop public information and media messages to be reviewed and approved by the Incident Commander before release to the news media and the public. Continue this process throughout the preparation, evacuation and recovery phases. | |
| Ensure communication with receiving facilities via the Liaison Officer prior to publicly announcing sites that are receiving evacuated residents. | |
| Ensure that proactive phone calls and other communications are taking place with Resident Responsible Parties. | |
| Utilize internal communications systems (e.g., email, intranet, phone, written report postings, etc.) to disseminate current information and status update messages to staff. | |
| Monitor staff for exhaustion and psychological wellness. | |
| Move to recovery operations until reoccupied. | |

## 1.7 CHARGE NURSE / DEPARTMENT DIRECTOR - TASKER

**Mission:** Provide oversight and direction to unit/department staff during a full building evacuation.

**Date:** _________ **Start:** ________ **End:** _______ **Position Assigned to:** ___________________

**Telephone #:** ___________________________ **Radio Title:** ___________________________

**Position Reports to: Operations Section Chief**

Attached Forms and Information:

- Resident Destination – To Holding

| Full Building Evacuation Related Actions: | √ |
|---|---|
| Read this entire Tasker. | |
| Direct non-resident care staff to the Labor Pool, unless needed on the unit. | |
| Direct resident care staff to return to their assigned unit. | |
| Direct staff to begin "preparation" of residents. See *Resident Packaging Guide* Appendix 8. Additionally, ensure the following:<br>▪ Complete a "*Resident Evacuation Critical Information and Tracking Form"* for each resident and place it in the front of the chart. This provides a summation of the resident for all future care givers. (Appendix 2)<br>▪ Ensure all residents have ID.<br>▪ Ensure the chart (including the MAR and nursing notes) is packaged with the resident.<br>▪ Confirm the location of the Holding Area. | |
| Assign a staff member to document each resident as they leave the unit, using the "*Resident Destination – To Holding Area Form*" (Appendix 13). Also note visitors, vendors and contractors. | |
| Evacuation should not commence until Evacuation Groups are in place on the unit, in the stairwell and in the elevator (if permitted for use). Upon notification from the Command Center, initiate evacuation. Residents should be handed off to the Floor Evacuation Group. Inform evacuation staff of the Holding Area location. | |
| Staff to resident ratios during evacuation will be determined by the Charge Nurse. Additional resources should be requested from the Labor Pool as to the type of personnel necessary. | |
| Unless otherwise notified, the Holding Area locations are as follows:<br>**HOLDING AREA**: Rehabilitation Room<br>**ALTERNATE HOLDING AREA**: 2nd Floor Dayroom | |
| As resident rooms are evacuated, mark rooms with a yellow room marker and yellow tape to identify they are empty. | |
| Once evacuation of the unit is complete:<br>▪ Survey the area to ensure all residents have been evacuated.<br>▪ Account for all staff.<br>▪ Direct all staff to report to the Labor Pool.<br>▪ Report the evacuation status to the Holding Areas and the Command Center.<br>▪ Return the "*Resident Destination – To Holding Area Form*" to the Command Center (Appendix 13). | |
| | |

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Once evacuation of the unit is complete:<br>▪ Survey the area to ensure all residents have been evacuated.<br>▪ Account for all staff.<br>▪ Direct all staff to report to the Labor Pool.<br>▪ Report the evacuation status to the Holding Areas and the Command Center.<br>▪ Return the "*Resident Destination – To Holding Area Form*" to the Command Center (Appendix 13). | |

## 1.8 LABOR POOL UNIT LEADER - TASKER

**Mission:** Manage the Labor Pool and maintain information on the status, location, and availability of on-duty staff and volunteer personnel.

**Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** ________________
**Telephone #:** ______________________ **Radio Title:**______________________
**Position Reports to: Logistics Section Chief**

Attached Forms and Information:

- Labor Pool Staff Log-In and Assignment Forms
- Evacuation Team Log-In Form
- Evacuation Team Handouts (Floor, Stair, Elevator, Discharge)

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Receive appointment and briefing from the Logistics Section Chief. | |
| Read this entire Tasker. | |
| Notify your usual supervisor of your assignment. | |
| Establish a Labor Pool location. Unless otherwise indicated, the Labor Pool will be established in the lobby. | |
| Assign staff member(s) to log all staff in and out of the Labor Pool. Utilize the "*Labor Pool Staff Log-In and Assignment Forms"(Appendix 14)*. Make extra copies as necessary. | |
| Assign staff to set-up and staff the Holding Area. Coordinate efforts with the Holding Unit Leader. Unless otherwise indicated, the Holding Area locations will be established as follows:<br>**HOLDING AREA**: Rehabilitation Room<br>**ALTERNATE HOLDING AREA**: 2nd Floor Dayroom | |
| Assign an Equipment Turn-Around Team as follows:<br>▪ Assign a Team Leader and 3-4 team members.<br>▪ Direct Team to set-up an equipment cleaning station at the location determined by the Transportation Unit Leader. If feasible, consider in or adjacent to the Labor Pool.<br>▪ Obtain appropriate cleaning materials. | |
| Continually update the Logistics Section Chief with the number of staff / volunteers available in the Labor Pool. | |
| Assign Evacuation Group Leaders for the following groups:<br>▪ Evacuating Floor Horizontal Movement Team(s)<br>▪ Elevator Vertical Movement Team(s)<br>▪ Stairwell Vertical Movement Team(s)<br>▪ Discharge Floor Horizontal Movement(s)<br><br>Provide each Evacuation Team Leader with a portable radio, if available. Inform the Discharge Team Leaders of the Transportation Equipment Turn-Around Area. | |
| Instruct Evacuation Team Leaders to assign personnel for their groups from the available Labor Pool Staff. | |

| Full Building Evacuation Related Actions: | √ |
|---|---|
| Obtain elevator keys through the Operations Section and distribute elevator keys to the Elevator Team Leader as necessary. | |
| Upon notification from the Command Center, direct Evacuation Teams to respond to their designated location based upon the site of evacuation. Inform Evacuation Teams that evacuation should not commence until directed through the Command Center.<br>▪ Inform Floor Team Leader and the Transportation Unit Leader of the Evacuation Equipment Requirements for the Unit (equipment/supplies to be brought to the unit that is evacuating) | |
| Consider the need to provide seating, food and beverage to staff for a mid to long term duration incident. | |
| Continue to maintain "*Labor Pool Log-In and Assignment Forms*" (Appendix 14) throughout the duration of the incident. | |
| Continue to advise the Logistics Section Chief of the status of the Labor Pool. Request the implementation of staff call-back if the Labor Pool cannot maintain enough staff or staff becomes overworked. | |
| When the Labor Pool is deactivated, take the "*Labor Pool Log-In and Assignment Forms*" *(Appendix 14)* to the Command Center. | |

## 1.9 LOADING UNIT LEADER - TASKER

**Mission:** Manage the operation of the Holding Area(s) where residents will be tracked and triaged prior to actually leaving the building.

| |
|---|
| **Date:** ________ **Start:** _______ **End:** ______ **Position Assigned to:** ________________ |
| **Telephone #:** ______________________ **Radio Title:** ______________________ |
| **Position Reports to: Operations Section Chief** |
| Attached Forms and Information:<br>▪ Holding Area Arrival Tracking Form<br>▪ Staff and Equipment Tracking Form – Holding Area |

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Receive appointment and briefing from the Operations Section Chief. | |
| Read this entire Tasker. | |
| Notify your usual supervisor of your assignment. | |
| Set-up and manage a Holding Area as instructed by the Command Center. | |
| Request staff to operate the Holding Area from the Labor Pool Unit Leader. Unless otherwise indicated, the Holding Area location and Resident Pick-up Location are located immediately following this Tasker. | |
| Gather and/or request the following equipment for the Holding Area (see form immediately following this Tasker): | |
| Assign an individual(s) to track residents as they **ARRIVE** in the Holding Area. Provide them with the "*Holding Area Arrival Tracking Form"(Appendix 15)*. Make additional copies as necessary (you may choose to track this on an eraser/white board). As residents arrive, ensure the residents medical records and personal belongings accompany them. | |
| Assign an individual(s) to track residents as they **DEPART** the Holding Area. Tracking will take place on the "*Resident Evacuation Tracking Form"*. This should be a triplicate form that accompanies the resident as they arrive. The bottom copy shall remain in the Holding Area while the top and middle copies will accompany the resident. As residents depart, ensure the following:<br>▪ The transportation vehicle driver/crew is aware of the preferred destination and any unique resident clinical needs.<br>▪ The preferred destination is outlined on the "*Resident Evacuation Critical Information and Tracking Form"(Appendix 2)*.<br>▪ The top two copies of the "*Resident Evacuation Critical Information and Tracking Form"* are provided to the transportation vehicle driver/crew.<br>▪ The bottom copy of the "*Resident Evacuation Critical Information and Tracking Form"* is maintained at the Holding Area.<br>▪ If the resident is leaving with family or friends, retain all three copies of the "*Resident Evacuation Critical Information and Tracking Form"*. | |
| Use the "Staff and Equipment Tracking Form" to document any staff leaving the facility to accompany residents. | |
| Continue to advise the Command Center of the status of the Holding Area. Request additional staff, as necessary, through the Labor Pool Unit Leader. | |

| **Full Building Evacuation Related Actions:** | √ |
|---|---|
| Continue to advise the Triage Team Leader of the status of the Holding Area. Request additional staff as necessary through the Labor Pool Unit Leader. | |
| Monitor staff for exhaustion and psychological wellness. Request beverages and food to the Holding Area as necessary. | |
| When the Holding Area is deactivated, take the "*Holding Area Arrival Tracking Forms*" *(Appendix 15)*, "*Resident Evacuation Critical Information and Tracking Forms*" *(Appendix 2)*, "*Staff and Equipment Tracking Forms*" to the Command Center (Appendix16). | |

## 1.10 TRANSPORTATION UNIT LEADER - TASKER

**Mission:** Oversee and coordinate both external transportation resources and internal transportation equipment during an evacuation.

**Date:** _________ **Start:** ________ **End:** _______ **Position Assigned to:** ________________
**Telephone #:** ___________________________ **Radio Title:**____________________________
**Position Reports to: Infrastructure Branch Director**
Attached Forms and Information – N/A

| **Full Building Evacuation Related Actions (Internal vs. External):** | √ |
|---|---|
| Receive appointment and briefing from the Infrastructure Branch Director. | |
| Read this entire Tasker. | |
| Notify your usual supervisor of your assignment. | |
| **External** - Identify what facility owned vehicles could be utilized for external transportation. | |
| **External** - Assist the Liaison Officer in coordinating with external transportation resources (i.e. fire, EMS, ambulance services, buses, other healthcare facilities, etc.). | |
| **External** - Establish vehicle staging areas outside the Holding Area discharge location. Unless otherwise indicated, Holding Areas Loading Areas are: (see table below) | |
| **External** - Continue to advise the Infrastructure Branch Director of the status of external transportation. | |
| **Internal** - Designate staff to collect vertical evacuation equipment and develop an equipment staging location. Consider a location in or near the Labor Pool. | |
| **Internal** - Direct the Labor Pool assigned Equipment Turn-Around Team as they focus on cleaning and re-allocating equipment throughout the evacuation process. | |
| **Internal** - Continually update the Infrastructure Branch Director with the number of staff / volunteers available in the Labor Pool. | |
| **Internal** - Continue to advise the Logistics Section Chief on the need for additional evacuation equipment. | |

| HOLDING AREA | LOADING AREA |
|---|---|
| Primary | Front of building |
| Alternate | Delivery driveway/ staff parking lots |

# APPENDIX 2 - RESIDENT PACKAGING GUIDE

## RESIDENT NOTIFICATION

Inform each resident of the pending evacuation situation and explain the general evacuation process.

## RESIDENT IDENTIFICATION

Ensure resident is properly identified by wristband or other method.

## RESIDENT INFORMATION AND TRACKING

Complete a "*Resident Evacuation Critical Information and Tracking Form*" for each resident prior to evacuation and attach to front of resident's chart.

## MOBILITY CATEGORIZATION

Categorize residents by mobility level utilizing the NYSDOH Standardized Transportation Assistance Levels (TAL) (See Appendix F). Document TAL category for each resident on the "*Resident Evacuation Critical Information and Tracking Form*". Report TAL category totals to the Command Center.

## MEDICAL RECORDS

Collect and prepare the resident's hardcopy chart information including:

Medical Administration Record (MAR)

Physician Orders

Treatment Sheet

Interdisciplinary Care Plan

Advanced Directives and Healthcare Proxy

If the capability exists and time permits, print out key electronic resident information. Otherwise, this will be accomplished off-site.

Attach the "*Resident Evacuation Critical Information and Tracking Form*" to the front of the chart.

## PERSONAL EFFECTS

Personal effects (e.g. eyeglasses, dentures, hearing aids, etc.) are to be placed in a Personal Effects Bag, pillowcase or other bag and labeled to accompany the resident.

Resident prostheses shall be either be utilized by the resident of placed in a Personal Effects Bag, pillowcase or other bag and labeled to accompany the resident.

Valuables should be given to the resident's responsible party or secured by facility, as applicable.

## MEDICATIONS / SUPPLIES

Any supplies or equipment needed for specialized treatment will be packaged and evacuated with the resident (bedside and special medications).

Resident medications to accompany resident, if possible:

- Must be dosage-specific for each resident.
- Must be identified with resident name.

All ordered controlled substances should be evacuated with a resident.

Anyone who is authorized by law to prescribe, dispense, or administer controlled substances may transport these medications.

If an authorized individual is not available to accompany a resident at the time of the evacuation, controlled substances may be taken to a receiving facility by an authorized individual after the evacuation is complete. A controlled substance count will be done and documented at the receiving facility.

**SPECIAL CONSIDERATIONS**

Transmission based precautions shall be maintained where indicated throughout the evacuation process. Transmission Based Precaution signs from their resident room doors shall be packaged with the resident

As needed, request stretchers and wheelchairs, IV pumps and poles, oxygen cylinders with regulators, portable suction units and other applicable equipment from the Command Center.

Staff may need to go with certain resident to the Holding Area as necessary. Staff should then return to the unit. Staff should report to the Labor Pool once the unit evacuation is completed.

Family members/visitors should be taken to a Responsible Party (Resident Family) Area.

Identify any residents with a latex allergy and ensure latex allergy wristband is in place.

If resident is off the unit, gather personal effects, label with resident's name, and prepare to send with chart to area where they are at the time. The area the resident is in should coordinate this process.

**HOLDING AREA**

- When notified by the Command Center, evacuate residents to the internal Holding Area. Staff with evacuation equipment will be sent to the unit to assist.

# APPENDIX 3 RESIDENT EVACUATION CRITICAL INFORMATION AND TRACKING FORM

AWARE PREPARE
KNOWLEDGE IS POWER

Facility Phone ______
Facility Fax ______

42000 06200

## Resident Evacuation Critical Information and Tracking Form

**Receiving Facility**
☐ ______
☐ ______
☐ ______
☐ ______
☐ ______
☐ ______

**Movement Times**
At Holding: ______
At Loading ______
Left Facility ______
Arrived Dest. ______

*Place patient identity label or imprint here or write in resident information*

Name: Last ______ First ______
Age: ______ Gender: ☐ M ☐ F DOB: ___/___/___
Primary Physician: ______ Room or Bed # ____

| Resident Mobility Level / Transportation Assistance Level | Minimum Staff to Loading Area: Clinical | Non-Clinical |
|---|---|---|
| TAL ☐ Behavioral Health (blue) | | |
| TAL1 ☐ Ambulatory (green) | 0 | 1:5 |
| TAL2 ☐ Wheelchair (yellow) | 0 | 1 |
| TAL3 Non-Ambulatory (red) | | |
| TAL3 ☐ Lowest Acuity | 1 | 1 |
| TAL3 ☐ Moderate Acuity | 1 | 1 |
| TAL3 ☐ Critical Care | 1 | 2 |
| TAL3 ☐ Interrupted Procedure (specify) ______ | 2 | 2 |
| TAL3 ☐ Arm Carry | 0 | 1 |

Transport Agency: ______ Unit/Vehicle # ______

**Transport Vehicle**
Transit/School Bus
☐ Wheelchair Van / Ambulette
☐ Other (specify) ______
☐ BLS Ambulance
☐ ALS Ambulance
☐ Air Ambulance / MedEvac
☐ Isolette / Neonatal Ambulance
☐ Resident Accompanied by Guardian

**Equipment / Items to Accompany Resident**
☐ Oxygen
☐ Suction
☐ Infusion Pump
☐ Ventilator
☐ Medications
☐ Critical Supplies
☐ Medical Record
☐ Other ______
☐ Other ______
☐ Other ______

**Isolation Status** ☐ Contact ☐ Droplet ☐ Airborne

**Advance Directives** Name/Contact # ______ ☐ Interpreter Needed? ☐ ASL ☐ Language ______
☐ DNR ☐ DNI ☐ Healthcare Proxy ☐ Living Will ☐ MOLST ☐ Copy Enclosed

**Allergies** ☐ None ☐ Latex ☐ Other: ______

**Mental Status** ☐ Oriented ☐ Alert ☐ Lethargic ☐ Mildly Confused ☐ Severely Confused

**Behavior Problems/Safety Risk** ☐ None ☐ Wanders ☐ Elopement Risk ☐ Verbally Abusive ☐ Physically Abusive

**Fall Risk** ☐ None ☐ Low ☐ High

**Restraint** ☐ Vest/Posey ☐ Wrist/Mitt ☐ 4-Point ☐ Other ______ *Date / Time Applied:* ______

**Special Requirements** ☐ Oxygen (mask) lpm ____ ☐ Oxygen (cannulae) lpm ____ ☐ Suction ☐ Seizure Precautions

**Transfers** ☐ Independent ☐ Supervision ☐ Partial Assist 1 ☐ Partial Assist 2 ☐ Total Assist

**Activities of Daily Living**
☐ Independent ☐ Supervision ☐ Partial Assist ☐ Total Assist
☐ Continent ☐ Incontinent Bowel ☐ Incontinent Bladder ☐ Other ______

**Diet** ☐ Special: ______
☐ NPO ☐ Regular ☐ Regular ☐ Ground
**Consistency** ☐ Aspiration Precautions
☐ Pureed ☐ Thickened ☐ Liquid

**Personal Assistive Devices with the Resident**
☐ None ☐ Cane ☐ Walker ☐ Personal Wheelchair ☐ Glasses
☐ Dentures ☐ Hearing Aid ☐ Prosthesis Type: ______ ☐ Other ______

**Notifications (name/date/time)** Family: ______ Private MD: ______

**Last Actions Prior to Departure** *Document time and findings*
Last Temperature ______ Last Heart Rate ______ Last Blood Pressure ______ Last Accu-Check ______ Last Breath Sounds ______
Last Medications Given (name/dose/route/time) ______ Last Meal (food/date/time) ______

**Next Medications / Intervention Needed** ☐ None until: ______

| Name | Day/Time Needed | Administered? | By | Date | Time |
|---|---|---|---|---|---|
| | | ☐ Yes ☐ No | | | |
| | | ☐ Yes ☐ No | | | |
| | | ☐ Yes ☐ No | | | |

**Notes During Transit** *Document all care given or status updates. Use other side if needed.*

| Time | Note |
|---|---|
| | |
| | |
| | |
| | |

Receiving Facility to confirm receipt of the resident by faxing a copy of this form to: ______

Title: Patient Evacuation Critical Information and Tracking Form | Date Issued 04/09 | Page 1 of 1 | © 2006, Incident Management Solutions, Inc.

# APPENDIX 4 – NYS TRANSPORTATION ASSISTANCE LEVELS (TAL)

NOTE: NYS DOH Transportation Assistance Levels (TAL) are intended to provide a standardized categorization method for use by all healthcare facilities (hospitals, nursing homes and adult care facilities) in New York State. Therefore, not all TAL categories may be applicable to all facility types. However, it is beneficial for all facilities to be familiar with all TAL categories.

| TAL | Category | Criteria | Designation | Staffing | Transportation Asset | Accompaniment |
|---|---|---|---|---|---|---|
| 1 | Ambulatory | *Individuals with disabilities who are able to walk on their own*<br><br>Those who are able to walk the distance from their in-patient location to the designated relocation or loading area without physical assistance, and without any likelihood of resulting harm or impairment | **Fluorescent green** surveyor's tape, wristband, tag, or label | Escorted by staff members, but may be moved in groups led by a single non-clinical staff member or hospital-designated person. The optimum staff-to-patient ratio is 1:5. | Can be transported as a larger group in a passenger vehicle (e.g., bus, transport van, or private auto) | A single staff member or clinical provider (e.g., EMT or paramedic) appropriate to patient condition accompanying a group of patients |
| 2 | Wheelchair | *Individuals who cannot walk on their own but are able to sit for an extended period of time*<br><br>Those who are alert but unable to walk due to physical or medical condition. They are clinically stable, without any likelihood of resulting harm or impairment from wheelchair transport or prolonged periods of sitting, and do not require attached medical equipment or medical gas other than oxygen, a maintenance intravenous infusion, an indwelling catheter or a PEG tube during their relocation or evacuation. | **Fluorescent yellow** surveyor's tape, wristband, tag, or label | Safely managed by a single non-clinical staff member or hospital-designated person | May be transported as a group in a wheelchair-appropriate vehicle (e.g., medical transport van or ambulette) | A single staff member or clinical provider (e.g., EMT or paramedic) appropriate to patient condition accompanying a group of patients |
| 3 | Non-Ambula-tory | *Individuals unable to travel in a sitting position (e.g. require stretcher transport)*<br>Those who require transport by hospital bed, gurney, or stretcher. For emergency movement down stairs, they may be transferred to backboards, basket litters, or other appropriate devices, or rescue- | **Fluorescent red** surveyor's tape, | Require clinical observation ranging from intermittent to 1:1 nursing. | Require an ambulance or specialized vehicle (e.g., helicopter | Must be accompanied by one or more clinical provider(s) |

| Tier | Category | Criteria | Designation | Staffing | Transportation Asset | Accompaniment |
|---|---|---|---|---|---|---|
| | | dragged on their mattresses. These patients are clinically unable to be moved in a seated position, and may require equipment ranging from oxygen to mechanical ventilators, cardiac monitors, or other biomedical devices to accompany them during movement.<br>Non-ambulatory patients may be sub-categorized based on clinical priority:<br>• **Moderate acuity:** Patients who are hemodynamically stable, but at increased risk of deterioration. Examples include post-operative patients, or those who require biomedical equipment to accompany them.<br>• **Critical care:** Patients who are hemodynamically unstable, require invasive monitoring or other life support equipment, and are at greatest risk of harm during evacuation. Shelter-in-place should always be considered as the best option for this group. Any movement should be as a last resort, when the risk of remaining outweighs the risk of evacuation.<br>• **Interrupted procedure:** Patients who were in the midst of an operative or other invasive procedure which was interrupted to effect an emergency evacuation. In addition to their critical care status, these patients may need immediate relocation to a suitable operating suite for procedure continuation or other measures.<br>• **Arm carry:** Neonatal, infant, or child patients who are hemodynamically stable, do not require life support equipment, and can be safely arm-carried without adverse health effect by a staff member or parent/legal guardian. | wristband, tag, or label | Critical cases or interrupted procedures may require a team of physicians and/or clinical specialists to maintain continuity of care. Require a minimum of two staff members (one clinical, one non-clinical) for movement, with additional staff as needed to manage life support equipment. | medevac) for transport | (e.g., EMT, paramedic, nurse, or physician) appropriate to their condition |

# APPENDIX 5 – FACILITY SYSTEMS STATUS REPORT

| FACILITY SYSTEM STATUS REPORT | | | |
|---|---|---|---|
| **1. Operational Period Date/Time** | **2. Date Prepared** | **3. Time Prepared** | **4. Building Name:** |

**5. 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Information Technology System (email/registration/resident tracking and records/time card system/intranet, etc.) | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Nurse Call System | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Paging - Public Address | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Radio Equipment | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Satellite System | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Telephone System, External | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Telephone System, Proprietary | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Video-Television-Internet-Cable | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Fire Detection/Suppression System | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Food Preparation Equipment | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Ice Machines | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Laundry/Linen Service Equipment | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |

| | | |
|---|---|---|
| Structural Components (building integrity: columns, beams, walls, ceiling, roof) | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Surveillance Cameras | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Sanitation Systems | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Water Supplies:<br>Domestic | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | (Reserve supply status) |
| Water Supplies:<br>Industrial | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | (Reserve supply status) |
| Water Removal Systems | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Natural Gas | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |

# APPENDIX 6 – EVACUATION EXTENT MATRIX

| Scope | Definition/ Parameters | Urgency | Authority to Evacuate | Relocation Site | Notifications / Coordination |
|---|---|---|---|---|---|
| **Level 1**<br><br>**Alert for Potential Evacuation** | Information received indicating a situation or event that may require relocation of residents from all or a portion of the facility (e.g., National Weather Service issuance of a hurricane/tornado/flood watch or warning.) | | | | County Office of Emergency Management, NYSDOH |
| **Level 2**<br><br>**Limited Area/Horizontal Evacuation** | Need for horizontal evacuation of residents/visitors/staff from an area of a building (e.g., fire in a single room, storm damage to an isolated area) | Planned | Incident Commander | As planned | Emergency Services, NYSDOH |
| | | Urgent | Incident Commander | As planned | |
| | | Emergent | Person-in-charge in affected area | Adjacent smoke compartment | |
| **Level 3**<br><br>**Limited Area/Vertical Evacuation** | Need for vertical evacuation of residents/visitors/staff from one floor of a building (e.g., smoke condition affecting an entire floor, storm damage affecting a floor) | Planned | Incident Commander | As planned | Emergency Services, County Office of Emergency Management, NYSDOH |
| | | Urgent | Incident Commander | As planned | |
| | | Emergent | Person-in-charge in affected area | Two (2) floors below emergency floor (not below grade) | |
| **Level 4A**<br><br>**Large Area/Entire Building Evacuation** | Need for complete evacuation of residents/visitors/staff from multiple floors or an entire building (e.g., an uncontrolled fire; failure of a commercial power and generator power for an extended duration) | Planned | Incident Commander | As planned – another building on campus, or pre-planned relocation facility(ies) | Emergency Services, County Office of Emergency Management, NYSDOH |
| | | Urgent | Incident Commander | Internal holding area followed by another campus building or transportation loading area pending onward relocation | |

| *Scope* | *Definition/ Parameters* | *Urgency* | *Authority to Evacuate* | *Relocation Site* | *Notifications / Coordination* |
|---|---|---|---|---|---|
| | | | | | |
| **Level 4B**<br><br>**Entire Facility Evacuation** | Need for complete evacuation of residents/ visitors/ staff from the entire<br>Facility (e.g. environmental emergency<br>Requiring regional evacuation | **Planned**<br>**Urgent**<br>**Emergent** | Incident Commander | Pre-planned relocation facility (ies) | County Office of Emergency Management and NY State Department of Health |

## APPENDIX 7 – PLAN NOTIFICATION MATRIX

| Item # | Plan Reference | Notification To | Notification When | Contact Info Location | When Made | Responsible Person | Tracked By |
|---|---|---|---|---|---|---|---|
| 1 | | Emergency Services | | Administration Office | | Administrator/Designee | |
| 2 | | Government Agencies (NYSDOH, Public Health, Office of Emergency Management) | | Administration Office | | Administrator/Designee | |
| 3 | | Off duty staff | | Receptionist | | Administrator/Designee | |
| 4 | | Receiving facilities | | Adm. Office | | Administrator/Designee | |
| 5 | | Transportation resources | | Adm. Office | | Administrator/Designee | |
| 6 | | Families / Responsible parties | | Admission/ Social Service Office | | Director of Social Services | |
| 7 | | Media | | Administration Office | | Administrator/Designee | |
| 8 | | Ombudsman | | Administration Office | | Administrator/Designee | |
| 9 | | Primary physicians | | Nursing office | | DNS | |
| 10 | | Vendors | | Administration Office | | Administrator/Designee | |

## APPENDIX 8 – PLAN MAINTENANCE MATRIX

| Item # | Plan Reference | Issue | How Maintained | Where Maintained | Review/ Maintenance Cycle | Responsible Person | Oversight |
|---|---|---|---|---|---|---|---|
| 1 | | Receiving facility agreements | Disaster manual, office cabinet | Administrators office | As indicated or annually | Administrator | Administrator |
| 2 | | Evacuation equipment | Storage room | Basement, resident units | As needed, quarterly | Director of Environmental Services | Administrator |
| 3 | | Transportation resources | File cabinet | Administrators Office | As needed, Annually | Admin Asst | Administrator |
| 4 | | Resident emergency contacts | Medical record, Admissions and Social Service files | Resident units, Admissions and Social Service office | As needed, at least quarterly | Director of Social services | Administrator |
| 5 | | Notification scripts | | | | | |
| 6 | | Resident specialized treatment supplies | Storage closet | Resident units | As needed | Unit Coordinator | DNS |

## APPENDIX 9 – RECEIVING FACILITY AGREEMENTS

| Local Facility | External Holding Area | Residents Accepted | Special Care Categories | MOU Date | Transportation Available | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Bus | Seats | W/C | Van | Seats | w/c |
| Union Plaza Care Center<br>Phone: 718-670-0700<br>Fax: 718-670-0726<br>Administrator: Dr. Adinah Pelman<br>Facility email: unionplazacares@gmail.com or dluongo@unionplazacares.com<br>Facility Cell Phone: 9179223613 | Meadowbrook Care Center | 105 | B,C,D,H,M, O | | | | | | | |
| | | 100 | J,K | | | | | | | |
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A = Ventilator Care
B = IV Care, peripheral
C = Tube Feeders
D = Wandering Residents
E = Dementia – Locked Unit
F = Hickman Catheters
G = Daily Peritoneal Dialysis
H = Trach Care
I = Physically Aggressive
J = Rehab
K = Ortho
L = Post Traumatic Brain Injury
M = Bariatric Residents
N = Passy Muir Valve
O = PICC Line, Central Line
P = TPN
Q = Pediatric
R = Psychiatric Matters
S = CPR Certified Staff 24/7
T = Severe Behaviors

# APPENDIX 10 – FACILITY RECOVERY AND INSPECTION GUIDELINES

Prior to re-opening a healthcare facility (or portion thereof) that has undergone extensive water, wind, or other damage, or environmental contamination, inspections need to be conducted to determine if the building is salvageable. If the decision is made to proceed with recovery and remediation, building and life safety inspections must be completed before any restoration work is done to the facility. The following information describes those activities that need to be completed. This if followed by guidance for infection control review of facilities to be done before the facility can reopen.

Prior to re-occupying any portion of the facility, adequate support services need to be available to establish and maintain a safe, suitable environment of care. Contracting with outside services may be considered, and should be managed through the Finance Section.

**Structural and Life Safety Inspections**

As conditions warrant, the following should be evaluated by facilities experts:

- Structural integrity and missing/damaged structural items
- Assessment of air quality, including testing for carbon monoxide, hazardous materials, or remnants of products of combustion
- Assessment of hidden moisture
- Electrical system damage, including high voltage, insulation, and power integrity
- Water distribution system damage
- Sewer system damage
- Fire emergency systems damage
- Air handling system damage
- Medical waste and sharps disposal system

**Water Removal**

Water should be removed as soon as possible once the safety of the structure has been verified, using the following process:

- Pump out standing water
- Wet vacuum residual wetness from floors, carpets and hard surfaces
- Clean wet vacuums after use and allow to dry

**Water Damage Assessment and Mold Remediation**

- Open the windows in the damaged areas of the building during remediation
- Remove porous items that have been submerged or have visible mold growth or damage
- Minimize dispersion of mold spores by covering the removed items and materials with plastic sheeting (dust-tight chutes leading to dumpsters outside the building may be helpful)
- Dispose of these items as construction waste
- Seal off the ventilation ducts to and from the remediation area and isolate the work area from occupied spaces, if the building is partially occupied

- Scrub and clean hard surfaces with detergents to remove evident mold growth (If a biocide is used, follow manufacturer's instructions for use and ventilate the area. Do not mix chlorine-containing biocides with detergents or biocides containing ammonia.)
- Dry the area and remaining items and surfaces
- Evaluate the success of drying and look for residual moisture in structural materials (Moisture detection devices [e.g., moisture meters] or borescopes could be used in this evaluation.)
- Remove and replace structural materials if they cannot be dried out within 48 hours

**Inspect, Repair, Disinfect where Appropriate, or Replace Facility Infrastructure**

- HVAC system (motors, duct work, filters, insulation) inspection, disinfection, repair and replacement
- Water system (cold and hot water, sewer drainage, steam delivery, chillers, boilers)
- Steam sources (if piped in from other places e.g., utility companies it will impact autoclaves)
- Electrical system (wiring, lighting, paging and resident call systems, emergency generators, fire alarms)
- Electronic communication systems (telephones, paging and patient call systems, computers)
- Medical gas system
- Hazardous chemicals storage

**General Inventory of Areas with Water, Wind, Mold, or Contaminant Damage**

Determine what furniture can be salvaged

- Discard wet porous furniture that cannot be dried and disinfected (including particle board furniture)
- Disinfect furniture with non-porous surfaces and salvage
- Discard upholstered furniture, drapery, and mattresses if they have been under water or have mold growth or odor
- Discard all items with questionable integrity or mold damage

Determine what supplies can be salvaged

- Salvage linens and curtains following adequate laundering
- Salvage prepackaged supplies in paper wraps that are not damaged, or have been exposed to water or extreme moisture/humidity, smoke, hazardous vapors, or were in a molded environment
- Discard items if there is any question about integrity, moisture, or mold exposure
- Dry essential paper files and records (professional conservators or recovery vendors may be contacted for assistance)

Inspect electrical medical/biomedical equipment

- Check motors, wiring and insulation for damage
- Inspect equipment for moisture damage
- Clean and disinfect equipment following manufacturers' instructions

- Do not connect wet electronic equipment to electricity sources

Inspect interior structures and surfaces

- Inspect, clean, repair, refinish, or replace wallboard, ceiling tiles, and flooring
- Repair, replace, and clean damaged structures

**Review Issues for Reopening Facilities**

The following physical plant requirements must be addressed prior to re-opening a facility:

- Potable water
- Adequate sewage disposal
- Electrical power is restored and reliable
- Adequate waste and medical waste management
- All areas to be opened been thoroughly dried out, repaired, and cleaned
- The number of air exchanges in areas of the facility meet recommended standards

**Post-Reoccupation Surveillance**

Focused microbial sampling may be indicated to determine if residents who are receiving care in the reopened facility acquire infections that are potentially healthcare-associated and that may be attributed to Aspergillus spp. or other fungi, non-tubercular mycobacterium, Legionella, or other waterborne microorganisms above expected levels.

Reference the following:

- The water in the facility's water distribution system meets the microbial quality of the Safe Drinking Water Act (http://www.epa.gov/safewater/sdwa/index.html)
- Mold remediation efforts were effective in reducing microbial contamination in the affected areas of the hospital (http://www.epa.gov/mold/mold_remediation.html)

## APPENDIX 11 - UNIT / AREA EVACUATION STATUS FORM

### For Use by Command Center Checklist for Resident Areas Being Evacuated

| EVACUATION PRIORITY | UNIT / DEPARTMENT | EVACUATED TO HOLDING | | NOTES |
|---|---|---|---|---|
| | | Start Time | Finish Time | |
| | COMPLETE THIS FORM AS PART OF THE PLAN DEVELOPMENT PROCESS.<br>LIST EACH UNIT / AREA. | | | |
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## APPENDIX 12 - EVACUATION DESTINATION FORM

**For Use By Discharge Transfer Team For Planning**
**Forward to Labor Pool Unit Leader to assign staffing**
**Completed form should be given to Operations Section Chief**

**RECEIVING SITE:** ____________________

| RESIDENT NAME | ROOM NUMBER | CHECKED ARMBAND IN PLACE | TRANSPORTATION TYPE (VAN, BUS, AMBULANCE) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
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| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |

**List staff assigned to accompany residents to receiving site:**

______________________________________
______________________________________
______________________________________
______________________________________
______________________________________
______________________________________
______________________________________

**Verified by** ____________________ ____________________ __________ __________

**Signature** **Title** **Date** **Departure Time**

## APPENDIX 13 - RESIDENT DESTINATION – To Holding Area

**Unit** ________________________

**Charge Nurse** ____________________________

**(To be completed as the resident leaves the unit)**

***Once evacuation is completed return this form to the Command Center***
***<u>Please Print</u>***

| RESIDENT NAME | TIME LEFT UNIT | HOLDING AREA DESTINATION |
|---|---|---|
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Make additional copies, as necessary

## APPENDIX 14 - LABOR POOL STAFF LOG-IN and ASSIGNMENT FORM

**To be completed by Labor Pool Unit Leader or designee**

***This form should be returned to the Planning Section Chief at the conclusion of the Incident.***

**Date:** ______________

| EMPLOYEE NAME | EMPLOYEE TITLE | EMPLOYEE TELEPHONE NUMBER | SHIFT AVAILABILITY | ASSIGNMENT SHIFT / LOCATION | TRANSPORTATION NEEDED ? |
|---|---|---|---|---|---|
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## APPENDIX 15 – HOLDING AREA ARRIVAL TRACKING FORM

| TIME IN | RESIDENT NAME | RECEIVED FROM | SPECIAL CONDITIONS / CARE REQUIRED |
|---|---|---|---|
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## APPENDIX 16 - STAFF and EQUIPMENT TRACKING FORM – Holding Area

**To be completed at the point of Holding Area DEPARTURE to**

*A copy of this form should be sent with delivery as well as to the Incident Commander and Logistics Section Chief*

**Indicate total amount of items sent to ____________________ receiving facility**

| ITEM | TOTAL AMOUNT SENT |
|---|---|
| Mattresses | |
| Blankets | |
| Sheets | |
| Pillows | |
| Washcloths | |
| Diapers | |
| Oxygen | |
| Oxygen Concentrators | |
| Med Cart | |
| Suction Machine | |
| Treatment Supplies | |
| | |
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**Make additional copies, as necessary**

**Verified by** ____________________ __________________ ________ ________
**Signature** **Title** **Date** **Time**

**Name of staff transporting supplies** ______________________________

## APPENDIX 17 - EVACUATION TEAM LOG-IN

**To be completed by Evacuation Team Leader, or designee**
***Please Print***

NAME OF TEAM LEADER ______________________________

**Log in staff and wait in Labor Pool until dispatched by Labor Pool Unit Leader**

*Submit this form to Labor Pool Unit Leader before leaving Labor Pool*

TIME LEAVING LABOR POOL: ____________________

LOCATION ASSIGNMENT: ____________________________

| EMPLOYEE NAME | EMPLOYEE NUMBER |
|---|---|
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**Make additional copies, as necessary**

## APPENDIX 18 - DISCHARGE FLOOR HORIZONTAL MOVEMENT TEAM – Leader

A copy of this form should be provided to each Discharge Team Leader as he or she is assigned to a particular location.

**FUNCTION: To move residents from the stairwell or elevator to the appropriate Holding Area.**

NAME OF TEAM LEADER: ______________________________

LOCATION ASSIGNMENT: __________1st Floor Recreation Room__________

TRANSPORTATION EQUIPMENT TURN-AROUND AREA (cleaning): Lobby

MINIMUM # OF PERSONS NEEDED: ________3________

After forming the team, remain at the Labor Pool until directed to report to assigned area by the Labor Pool Unit Leader. Collect equipment (wheelchairs, oxygen cylinders, etc.) as directed by Labor Pool Unit Leader prior to responding to the discharge point of the stairwell / elevator.

Upon arrival at the assigned area, await the arrival of residents from the stairwell or elevator.

Discharge Floor Teams are to be given evacuation destination (Holding Area).

Once a designated resident has been transported to the Holding Area, return to the assigned area for transportation of the next resident. Continue this until transportation of all residents has been completed.

NOTE: If transportation equipment (wheelchair, etc.) requires cleaning after use, take the equipment to the Transportation Equipment Turn-Around area.

Once evacuation of the assigned area is complete, contact the Labor Pool for re-assignment or dismissal.

Team Member Name(s): -

## APPENDIX 19 - STAIRWELL VERTICAL MOVEMENT TEAM – Leader

A copy of this form should be provided to each Stairwell Team Leader as he or she is assigned to a particular location.

**FUNCTION: To receive residents from the Floor Team and to move these residents via the stairs to the Holding Area.**

NAME OF TEAM LEADER: ______________________________

LOCATION ASSIGNMENT: ____________Stairwell North or South____________(circle one)

MINIMUM # OF PERSONS NEEDED: ____4/stairwell____________

* Each stairwell should have a person assigned for observing and ensuring all safety practices.

** This team should have at least one (1) trained person in using vertical evacuation equipment and in vertical evacuation carry techniques.

After collecting personnel, remain at the Labor Pool until directed to report to assigned stairwell by the Labor Pool Unit Leader.

Upon arrival at the assigned stairwell, distribute staff on various levels, as appropriate and await arrival of residents from the Floor Team. This Team will advise you of the specific Holding Area intended for each resident.

Each group of Stair Evacuation staff will pass residents down to the next group of staff, and will inform the next group of staff of the evacuation destination (Holding Area).

**Discharge:**

The Team Leader and the remaining Team personnel not in the stairwell will be at the discharge point of the stairwell. The residents coming out of the stairwell will be passed to the Discharge Horizontal Movement Team. Stairwell Evacuation staff are to inform the Discharge Teams of the evacuation destination (Holding Area).

Once evacuation of the assigned area is complete, contact the Labor Pool for re-assignment or dismissal.
Team Member Names:

## APPENDIX 20 - EVACUATING FLOOR HORIZONTAL MOVEMENT TEAM

A copy of this form should be provided to each Evacuating Floor Team Leader as he or she is assigned to a particular location.

**FUNCTION: To move residents from the evacuating area to the Holding Area or appropriate stairs or elevator**

NAME OF TEAM LEADER: ______________________________

LOCATION ASSIGNMENT: ____nurse's station____________________

MINIMUM # OF PERSONS NEEDED: ____2__________

After forming Evacuation Team, remain at the Labor Pool until directed to report to assigned area by the Labor Pool Unit Leader. Collect equipment (wheelchairs, oxygen cylinders, etc.) as directed by Labor Pool Leader prior to responding to the evacuating area.

Upon arrival at the assigned area, the Evacuation Team will be advised by the unit / area being evacuated when the movement of resident can begin, by which method each resident will be moved, and the evacuation destination (Holding Area).

Higher-acuity residents (non-ambulatory) will be evacuated via elevators, only if approved by the Emergency Authority (i.e. Fire Department). Floor Evacuation staff should inform the Stairwell / Elevator Evacuation Teams of the evacuation destination (Holding Area).

Once evacuation of the assigned area is complete, contact the Labor Pool for re-assignment or dismissal.

Team Member Names:

## APPENDIX 21 BUILDING SERVICES PROVIDERS

| Company Name | Service Provided | Phone Number |
|---|---|---|
| Fire Suppression Services | Fire Pump & Sprinklers | 516-608-8366 |
| All Service | Kitchen Equipment Repair | 718-528-7777 |
| Action | Garbage Removal | 201-376-5032 |
| Digital Office Concepts | Copiers | 718-854-4362 |
| Reliatech/HOCS Consultants | Computers | 718-377-0922 |
| Spectrum business | Internet | 877-227-8711 |
| Parkway | Pest Control | 1-800-220-7275 |
| Tristate | Tube feeding equipment | 718-624-7980 x 229 |
| Day & Nite | Refrigerator Repair COLD Equip | 516-3781176 |
| All Service | Repairs (Kitchen HOT Equip) | 516-378-1176 |
| Windstream (Broadview) | Phone Carrier | 516-348-2561 |
| Protel | Phone/voicemail Hardware Repair | 718-438-3232 |
| Airtech | Air Conditioning Repairs | 718-786-6200 |
| ISPI Integrated Systems | Fire Alarm System | 201-305-6728 |
| Matt Haberlack | Landscape & Gardening | 516-395-8320 |
| Alboro Security | Security Services | 929-280-9888 |
| Paragon Inc. | Boiler/ Heating System | 914-804-7578 |
| Power House | Generator | 877-322-0678 |
| Star Satellites | Satellite TV | 718-496-4552 |
| Dover | Elevator Service | 631-491-3111 |
| APS, Inc. | Carendo & Marisa Lifts | 516-444-5439 |
| Sentry | Cameras | 1-866-573-6879 |
| Tyco | Fire Alarm | 800-289-2647 |
| Integrated Systems & Power | Fire Alarm Panel/System | 212-358-2209 |
| Filta Clean | Range/Hood Cleaning Repair | 718-495-4747 |

## APPENDIX 22 STAFFING AGENCIES

| Company Name | Department | Phone Number |
|---|---|---|
| Advance Care | All | 718-305-6824 |
| Five Star | Nursing | 718-534-7400 |
| Towne | Nursing | 718-535-5485 |
| Blue Leaf | Nursing | 212-382-2935 |
| White Glove | Nursing | 718-387-8359 |
| Favorite Agency | Nursing | 212-682-1745 |
| Staff Pro | Nursing | 718-471-1122 |

## APPENDIX 23 MEDICAL SERVICES PROVIDERS

| Company Name | Service provided | Phone Number |
|---|---|---|
| Americare | Home Care | 347-432-0511 |
| Revival Home Health Care | Home Care | 347-495-0139 |
| Virtair | Oxygen | 718-847-8247 |
| Hospice of New York | Hospice Care | 718-472-1999 |
| Calvary Home Health Care | Home Care | 718-518-2465 |
| Calvary Hospital Hospice | Hospice Care | 718-518-2465 |
| VNS of New York | Home Care | 718-536-3700 |
| Modern Diagnostic Laboratory Inc. | Laboratory | 718-259-0088 |
| Psych Associates | Psychological | 212-851-8100 |
| LogistiCare | Transportation | 877-564-5924 |
| Pharmascript | Pharmacy Services | 908-389-1818 |
| Senior Care | Transportation | 718-430-9700 |
| Patient Care Associates | Radiology | 914-777-3333 |
| MBS | Peg Tube | 718-624-7980 |

## APPENDIX 24 SUPPLIES AND EQUIPMENT VENDORS

| Company Name | Service provided | Phone Number |
| --- | --- | --- |
| Advanced Care | Home Equipment | 516-295-2092 |
| Abaline | Paper Eat/Drink | 732-582-0200 |
| Unitex, Inc. | Laundry & Linen | 732-442-3099 |
| Ronbar | Housekeeping | 718-937-6755 |
| DELT | Hardware Supplies | 888-645-6257 |
| Grainger | Engineering Supplies | 800-706-5501x233 |
| Twin Med | Nursing/Resident | 877-894-6633 |
| Pechters | Breads/Baked | 718-749-8280 |
| Bertram | Food | 908-862-8200 x 101 |
| US Foods | Food | 516-766-1802 |
| Hershey's | Ice Cream/Deserts | 631-462-0259 |
| Med part | Medical Equipment | 718-436-5100 |
| Peter Meats | Meat /Food | 718-659-6328 |
| Island Meats | Meat / Food | 631-434-2700 |
| Nestle Waters | Potable Water | 914-460-2303 |
| Driscoll | Potable Water | 973-672-9400 x119 |
| SMD, Inc. | Bracelet Wanderguard | 800-899-7264 |
| Direct Supply | Engineering/Housekeeping | 888-367-3690 |
| Triple AHA Supplies | Salt | 845-566-4200 |
| USA Wholesale | Electrical Supplies | 855-872-8444 |
| Valmar Surgical | Home Equipment | 888-596-3070 |

## APPENDIX 25 DEPARTMENT HEADS EMERGENCY CONTACT INFORMATION

| INTERNAL CONTACT LIST | | |
|---|---|---|
| Deborah Luongo | Administrator | Cell (917) 909-9709 |
| Angelo Luongo | Assistant Administrator | Cell (347) 287-7153 |
| Jennifer Kaiser | Director of Nursing | Cell (631) 819-2994 |
| Allana Murphy | Assistant Director of Nursing | Cell (631) 682-0097 |
| Dennis Gerick | Director of Maintenance | Cell (917) 566-8747 |
| Maria Montemayor | Inservice Coordinator | Cell 347-225-2968 |
| David Seda | Asst. Director of Housekeeping | Cell (347) 698-3539 |
| Su Jeong Park | Director of Social Services | Cell (917) 609-9093 |
| Nursing Supervisor | All Shifts | Dial "O" Operator, or *2 Overhead Page |
| Eric Martinez | Director of Housekeeping | Cell (917) 846-6213 |
| Larissa Tadjiev | Director of Recreation | (917) 769-5805 |
| Christian Magnayon | Director of Food Services | (646) 352-2177 |
| Betty Colon | Asst. Director of Food Services | (646) 340-7374 |
| Adeboyejo Adesemowo | Supervisor, Security | (929) 485-9148 |
| | Front Desk Emergency Second-Line | (347) 732-9758 |
| | | |

Rev. Jan. 29 2024

| UNION PLAZA CARE CENTER | |
|---|---|
| **Policy Name: E015** - Subsistence Policy | |
| **Policy Date:** | **Policy Revision:** 7/24/24 |

## Purpose:

To ensure adequate supplies and subsistence for all persons in the facility during and emergency event. Provisions include, food, pharmaceuticals, power, HVAC and medical supplies.

## Policy:

The Facility shall maintain for the duration of an emergency or until all its patients have been evacuated and its operations cease:
Contracted service for the supply of medical, pharmacy, food and water for staff and residents.
The facility shall provide an emergency power system maintained in accordance with NFPA 110. This system shall provide power to areas that are critical to resident care such as HVAC, refrigeration, and life safety items. Each department will administer its additional policy.
the facility shall conduct a needs assessment review quarterly to determine any required changes based on the resident population as defined in the facility assessment.

## Procedure:

1. The central supply of medical provisions such as but are not limited to, dressings, stock medications, and wound care will have par levels to provide for 72 hours of care.
2. There shall be an arrangement with the pharmacy for the provision of resident and those staff sheltering in place required medications from a backup source if the provider cannot deliver during the emergency.
3. The dietary department shall have in a separate location sufficient supply of emergency food and water for 72 hours and maintain an agreement with suppliers for emergency delivery of potable water. These emergency supplies shall be based upon the resident assessment of dietary needs. The dietary department shall order additional supplies ahead of any predicted emergency to ensure adequate supplies for any incoming persons who may need shelter in an emergency.
4. If there is a chance of flooding to the central supply areas these emergency supplies shall be relocated to the storage rooms available on the nursing units.
5. The facility shall maintain an emergency generator connected via an manual transfer switch to supply power to mission critical systems such as heat, cooling, fire systems, and lighting. This generator will be tested and inspected in accordance with NFPA 110 and manufacturers recommendation.
6. The facility shall have a service contract for the generator which can also supply a backup in the event of generator failure.
7. The fuel supply for the generator shall not fall below 72 hours and a contract for fuel delivery shall be in place.
8. Maintaining necessary services include the delivery and access to medical gases.

9. The facility shall maintain a supply of clean linen and contracted services for the removal and treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; for safe and appropriate disposal in accordance with nationally accepted industry guidelines.

# EMERGENCY FOOD SUPPLY

Policy:

It is the policy of this facility that 3 day emergency food supply will be available within the facility to ensure that adequate provisions are available.

Procedure:

1. **FSD** and the clinical dietician will establish a 3 day emergency menu. Items on the menu will not require refrigeration / cooking or processing.
2. **FSD** will purchase the needed items and store them appropriately.
3. All items will be dated as to date of delivery and rotated every 6 months.
4. Since emergency may cause power failure, staff will have to use sternos to heat puree foods. All foods will be heated in sternos to a temperature of 175* F and maintained at 140* F during service.
5. All cold foods must be served as soon as possible to avoid temperature increase above 41* F. Staff needs to use ice baths ( if available ) to help maintain appropriate temperatures.
6. All cold foods will be delivered to the Residents in the facility food trucks and disposable items if needed ( disposable use will be based on the emergency ).
7. Facility will also have an appropriate inventory of tube feeding formulas for Residents on tube feeding. In an emergency, facility will store standard formula as the bulk and several cases of diabetic formula ( inventory list will be developed by dietitian on a quarterly basis ).

# REPLACING EMERGENCY FOOD SUPPLY AS ITEMS ARE USED OR ROTATED

## Policy:

It is the policy of this facility that any food items taken away from
The emergency supplies must be replaced by the next food delivery to the facility.

## Procedure:

1. An inventory list is posted in the emergency food storage area. List will indicate the exact number of food items needed to feed **280** residents in the event of an emergency.

2. If food item is taken away from the suppliers for any reasons, **FSD** must be given a written list of what was taken, how much was taken and when it was taken.

3. Once **FSD** is given a list, a food order will be placed for the next possible delivery to the facility.

4. All emergency foods must be dated as to the date if delivery. Food must be rotated every **2** months. **FSD** will do monthly checks to ensure foods are within the expiration periods.

5. A new food order must be placed for all items (food items) that are on the inventory list prior to when the **6** month period is up. Once items are delivered to the facility, foods can be rotated.

Foods cannot be rotated or taken away from emergency food storage are prior to a new delivery being in the facility.

**Union Plaza Care Center**
**Water Emergency Procedures**

**POLICY:**
It is the policy of Union Plaza Care Center to ensure that an adequate supply of water shall continue to be provided to the residents and all other essential areas of the facility in the event of a loss of normal water supply.

**PROCEDURE:**
In the event of an emergency when there is a loss of normal supply of water, the following procedures shall be implemented:

1. An emergency supply of water will be maintained at the facility, at all times, in an area that is readily accessible to staff.
2. The Director of Food Services or designee will immediately contact Meyer's Emergency Water, Inc. so as to provide a continuing supply of water throughout the emergency. The following umber(s) are to be used: Phone Number: 833-636-4030.
3. Central Supply will provide alcohol gel sanitizer to all units and to the dietary department to ensure the maintenance of all infection control procedures
4. Potable water will be delivered to all units to ensure the availability of sufficient supplies for the following:
    1. Drinking water
    2. Medication Pass
    3. Toileting of continent residents and staff
    4. Bed baths for all residents
5. *Dietary* department-will provide extra juices to supplement water provided
6. All showers and baths for residents will be suspended during the emergency
7. The use of disposable plates, trays and silverware will be initiated during the emergency period. Where possible, disposable foil pans will be used for food preparation.
8. Menu substitutions will be-made to minimize the amount of water necessary for cooking and pot cleaning purposes.
9. Pot washing and other necessary water-related cleaning will continue as per all established routines through use of potable water.

# PUREE ITEMS

| QUANTITY | MEASURE OF UNIT | ITEMS |
|---|---|---|
| 3 | CASES | PUREE CHICKEN |
| 3 | CASES | PUREE BEEF |
| 3 | CASES | PUREE GREEN BEANS |
| 3 | CASES | PUREE CARROTS |
| 1 | CASE | APPLE SAUCE |
| 1 | CASE | CREAM OF RICE |
| 1 | CASE | MASH POTATO |
| 1 | CASE | STERNO CAN |
| 1 | CASE | STERNO SHAPING DISH HOLDER |
| 1 | CASE | SHAPING PANS |

# INVENTORY FOR 280 RESIDENTS

| | | |
|---|---|---|
| 3 | CASES | RICE KRISPIES |
| 3 | CASES | CORN FLAKES |
| 3 | CASES | RAISIN BRAN |
| 2 | CASES | DIET JELLY |
| 3 | CASES | GREEN BEANS |
| 2 | CASES | CHOCOLATE PUDDING |
| 1 | CASE | CHOCOLATE PUDDING DIABETIC |
| 3 | CASES | VANILLA PUDDING |
| 1 | CASE | VANILLA PUDDING DIABETIC |
| 3 | CASES | CAN PEACH IN LIGHT SYRUP |
| 3 | CASES | BEAN SALAD |
| 3 | CASES | BEET SALAD |
| 1 | CASE | SANKA |
| 1 | CASE | TEA |
| 1 | CASE | SWEET & LOW |
| 2 | CASES | TUNA |
| 10 | CASES | INSTANT CUP OF NOODLE |
| 3 | CASES | RAVIOLI |
| 5 | CASES | MACARONI & CHEESE |
| 3 | CASES | YELLOW BANANA |
| 25 | CASES | 1 / 6 GALLON WATER |

# 3 DAY EMERGENCY MENU PUREE

## BREAKFAST

| DAY 1 | DAY 2 | DAY 3 |
|---|---|---|
| Orange juice 4 oz. | Apple juice 4 oz. | Cranberry juice 4 oz. |
| Cold cereal / Cream of Wheat 1 pkg. | Cold cereal / Cream of Wheat 1 pkg | Cold cereal / Cream of Wheat 1 pkg. |
| Milk 8 oz. | Milk 8 oz. | Milk 8 oz. |
| Sanka / Tea 6 oz. | Sanka / Tea 6 oz. | Sanka / Tea 6 oz. |
| Sugar 3 pkgs. | Sugar 3 pkgs. | Sugar 3 pkgs. |

## LUNCH

| | | |
|---|---|---|
| Puree Chicken 3 oz. | Puree veal 3 oz. | Puree beef 3oz. |
| Puree green beans 4 oz. | Puree carrots 4 oz. | Puree beets 4 oz. |
| Cream of rice 4 oz. | Cream of rice 4 oz. | Cream of rice 4 oz. |
| Ice cream 4 oz. | Chocolate pudding 4 oz. | Vanilla pudding 4 oz. |
| Sanka / tea 6 oz. | Sanka / tea 6 oz. | Sanka / tea 6 oz. |
| Sugar 2 pkgs. | Sugar 2 pkgs. | Sugar 2 pkgs. |
| Milk 4 oz. | Milk 4 oz. | Milk 4 oz. |

## DINNER

| | | |
|---|---|---|
| Puree beef 3 oz. | Puree turkey 3 oz. | Puree chicken 3 oz. |
| Puree squash 4 oz. | Puree peas 4 oz. | Puree spinach 4 oz. |
| Mashed potato 4 oz. | Mashed potato 4 oz. | Mashed potato 4 oz. |
| Rice pudding 4 oz. | Puree fruit 4 oz. / applesauce | Puree fruit 4 oz. |
| Sanka / Tea 6 oz. | Sanka / Tea 6 oz. | Sanka / Tea 6 oz. |
| Milk 4 oz. / Sugar 2 pkgs. | Milk 4 oz. / Sugar 2 pkgs. | Milk 4 oz. / Sugar 2 pkgs. |

All puree foods will be heated in sternos to a temperature of 175* F & maintained at 140* F.

3 DAY EMERGENCY MENU REGULAR

## BREAKFAST

| Orange juice 4 oz. | Apple juice 4 oz. | Cranberry juice 4 oz. |
|---|---|---|
| Cold cereal / Ricè Krispies 1 box | Cold cereal / Corn Flakes 1 box | Hot or Cold cereal 1 box |
| Milk 8 oz. | Milk 8 oz. | Milk 8 oz. |
| Sanka / tea 6 oz. | Sanka / tea 6 oz. | Sanka / tea 6 oz. |
| Sugar 3 pkgs. | Sugar 3 pkgs. | Sugar 3 pkgs. |

## LUNCH

| Ravioli # 10 cans | Tuna fish 3 oz. | Macaroni & Cheese |
|---|---|---|
| Fruit cocktail 4 oz. | Beets salad 4 oz. | Corn & Pea salad 4 oz. ( marinated ) |
| Ice cream 4 oz. | Crackers 3 pkgs. | Crackers 3 pkgs. |
| Sanka / tea 6 oz. | Sanka / tea 6 oz. | Sanka / tea 6 oz. |
| Sugar 2 pkgs. | Sugar 2 pkgs. | Sugar 2 pkgs. |
| Milk 4 oz. | Milk 4 oz. | Milk 4 oz. |

## DINNER

| Peanut butter 3 oz. & jelly 1 pkg. | Salmon 3oz. | Peanut butter 3 oz. & jelly 1 pkg. |
|---|---|---|
| 3 beans salad | Cucumber salad 4 oz. | Beets salad 4 oz. |
| Crackers 3 pkgs. | Crackers 3 pkgs. | Crackers 3 pkgs. |
| Pudding 4 oz. | Can fruit ( peaches ) 4 oz. | Fruit cocktail 4 oz. |
| Sanka / tea 6 oz. | Sanka / tea 6 oz. | Sanka / tea 6 oz. |
| Sugar 2 pkgs. | Sugar 2 pkgs. | Sugar 2 pkgs. |
| Milk 4 oz. | Milk 4 oz. | Milk 4 oz. |

## Union Plaza Care Center

## Dietary Department

### BREAKFAST

1. All residents will receive 4 oz. juice, 8 oz. milk, 3 pkgs. sugar or sweet & low.
2. In addition regular and chopped will receive 1 box cold cereal
3. Pureed diets will receive 1 package instant cereal. 6 oz. hot water in a covered Styrofoam bowl.

**Direction:**

Pour 6 oz. water into an 8 oz. Styrofoam bowl and cover.

To make cereal:

Uncover bowl, open instant cereal package and pour cereal into hot water. Mix until dissolved.

### LUNCH & DINNER

- Place sterno cans under wire racks.
- Place disposable aluminum water pans into wire racks.
- Pour approximately 2 inches water into pans.
- Light sterno cans ( 2 per wire rack ).
- When water heats up, add top disposable aluminum pan.
- Add canned food, cover with aluminum foil.
- Heat until 140 degree F or above, stirring food occasionally.

**PUREE:** Puree all canned food items for meal, prior to pouring into aluminum pans.

**COLD ITEMS:** Place ice into disposable aluminum pans. Place second aluminum pan on top. Pour canned " cold " menu items unto a depth on no more than 2", cover with aluminum foil. Stir occasionally. Food items should be 41 degree F or colder before serving.

# Union Plaza Care Center

## POLICY and PROCEDURES, & INFORMATION

| | |
|---|---|
| | *Page No.: 1 of 6* |
| *Title: Emergency Preparedness; Optimizing utilization of staff during pandemic crisis* | |
| *Issued By: Administration* | |

| | | |
|---|---|---|
| *Effective Date: 3/30/2020* | *Last Review Date: 1/29/2024* | *Supersedes: Previous* |
| *Distribution: Administration, All Department Heads* | | |

*OBJECTIVE:*

1) To be able to optimize staffing productivity during staffing shortages as a result of a surge capacity.
2) To understand the different levels of surge capacity and be able to prioritize what tasks are essential to resident care and what tasks can be suspended or modified.

**Staffing Surge Capacity-** the ability to manage a sudden, unexpected increase in resident volume or staff shortages that would otherwise be severely challenged or exceed the present capacity of the facility's staffing capability.

**Conventional Capacity-** Measures consist of providing resident care without any change in daily contemporary practices. The staff allocated should be based on the facility's established needs and assessment.

**Contingency Capacity-** Measures may change daily standard practices but may not have any significant impact on the care delivered to the residents or safety of the healthcare provider. These practices may be used temporarily during periods of expected staffing shortages.

**Crisis Capacity-**Measures that are not commensurate with Facility's standards or care. These measures or combination of measures may need to be considered during periods of known staffing shortages.

**Vital Care-** Care that is required to maintain residents' physical safety and clinical stability.

**Nonclinical Services-**Services provided by ancillary departments/staff such as Food Service, Housekeeping, Maintenance, Bookkeeping, Admissions, Secretarial Staff, and Security.

**Clinical Services-** Services provided by both contracted or facility employed staff that directly impact the residents clinical care and wellbeing such as; physicians, physician assistance, nurse practitioners, registered and licensed nurses, certified nursing aids, physical, occupational and speech therapist, clinical dietitians, social workers and activity leaders,

*POLICY:* It is the policy of this facility that during emergency situations, that impacts or limit the facility's staffing patterns, the facility may adopt a series of strategies to optimize the utilization of the staffs' time and only provide care and treatments that are vital to the residents' care and wellbeing.

*PROCEDURE:*

1. When there is an event which results in a surge of utilization of staffing in the facility, the Administrator in conjunction with other designated staff members will meet to determine the following:
    - Identify their staffing needs and the facility's contracted staffing agencies.
    - Identify the current staffing patterns and which facility staff can be cross trained in assisting other departments as indicated.
    - Establish which local healthcare unions, coalitions/associations, federal, state and local public health partners (OEM) will be and have been contacted to find out about additional staffing resources that may be available.
    - Establish a phone/contact list of all key employees and disseminate information to all department heads and place in RNS communication book.

2. The administrator/designee is responsible for maintaining written documentation validating that the above was implemented and ongoing as indicated.

3. The facility will implement all the following changes to optimize the utilization and availability of staffing.

    - Provided employee cross training competencies for specific tasks.
    - Redistribute staffing assignments.

- Maximizing use of telemedicine.
- Cohort residents or relocate residents within the facility to maximize utilization of the available staff.

4. Facility staff will be in-serviced regarding the measures being implemented during the emergency event.

5) Facility residents will be informed ongoing as to the measures being implemented during the emergency event as indicated.

6) Daily, during the ongoing emergency, the facility Nursing and Administrative team will meet to assess the facility's surge capacity and establish strategies on how best to optimize available staff. If indicated, alternative plans may need to be implemented. The following measures or combination of measures may be taken for each surge capacity. The decision will be made by the team, based on the evolving clinical conditions of the residents' and staff availability.

During **conventional capacity**, when there are no expected or known shortages for staffing, the facility will follow the established facility P&Ps for governing the facility and provision of care and services to residents.

During **contingency capacity**, when staffing shortages are expected, the following alternative strategies may be implemented but are not limited to:

**A) For Non-Clinical Care/Services**

1) Contact staffing agencies to requested/secure additional staffing for the expected shortage timeframes.
2) Reassign cross trained staff to needed areas.
3) Alter/suspend tasks or services that are not going to directly affect care and services of the residents. (Tasks that do not directly impact the care and wellbeing of the residents and staff).
   i.e. **Housekeeping staff-** clean resident, visitor and refuse areas.
   **Dietary** -limit cooking/preparation to main entrees and sandwiches as alternative options.
   **Maintenance-** provide repairs to resident care areas and continue to ensure operations of facility infrastructure.
4) Revise/stagger employees work schedules to meet facility's needs.
5) Revise employees job breakdowns to meet facility's needs.
6) Request vital employees, who are out ill or unable come into the facility, to be available via phone to provide guidance as indicated.

7) Implement the use of single use, disposable items, as appropriate, to minimize time and staffing constraints.

B) <u>**For Clinical Care Services**</u>

1) Contact staffing agencies to requested/secure additional staffing for the expected shortage timeframes.
2) Reassign cross trained staff to needed areas.
3) Revise/stagger employees work schedules to meet facility's needs.
4) Suspend non-essential care to residents. (care and treatments that will not impact the overall health and safety of the residents)

Examples include but are not limited to:

a) A reduction in the number of showers/baths from established care plan directives, but personal hygiene care and grooming will continue to be provided.
b) Discontinuing vitamins, minerals and other non-essential medications.
c) A review and discontinuation of finger sticks for those residents with history of stable blood glucose levels.
d) A consolidation of medication distribution times, as applicable.
e) An alteration in out of and back to bed schedules.
f) An alteration in the location and times of the provision of rehab services.
g) An alteration in the location and times of the activity services.
h) Provision of telemedicine as applicable.

***All revisions and alterations in the plan of care will be done in direct correlation with each individual resident's clinical need and facility's staffing availability. The goal is to continue to meet each individual resident's specific need with the available staff.***

During <u>**crisis capacity**</u>, when there are known staffing shortages, the following alternative strategies may be implemented but are not limited to:

**A)** <u>**For Non-Clinical Care/Service**</u>

1) Reassign cross trained staff to needed areas.
2) Provide only essential tasks/services. (Tasks that are required to maintain the safety and wellbeing of the residents and staff).

   i.e. <u>**Housekeeping staff-**</u> clean resident areas only.

   <u>**Dietary**</u>- altering menu to meet staffing demands. Ensure that adequate nutrition is provided, but variety and options are not a priority.

   <u>**Maintenance-**</u> maintain the overall plant operation of facility infrastructure. Only conduct repairs to the maintain stability of the facility's infrastructure.
3) Revise/stagger employees work schedules to meet facility's needs.
4) Revise employees job breakdowns to accommodate facility's needs.

5) Request vital employees, who are out ill or unable come into the facility, to be available via phone to provide guidance as indicated.
6) Implement the use of single use, disposable items, as appropriate, to minimize time and staffing constraints.

B) **For Clinical Care Services**
1) Reassign cross trained staff to needed areas.
2) Revise/stagger employees work schedules to meet facility's needs.
3) Revise employees' job breakdowns to meet facility's needs.
4) Suspend non-essential care to residents. (care and treatments that will not impact the overall health and safety of the residents) Examples include but are not limited to:
   a) Discontinue all showers/baths and grooming. Provide bed baths or assistance with bathing on a case by case need. Peri and hygiene care will continue.
   b) Discontinuing vitamins, minerals and other non-essential medications.
   c) Review and discontinue finger sticks for those residents with history of stable blood glucose levels.
   d) Consolidate medication distribution times, as applicable.
   e) Discontinue out of and back to bed schedules. All residents to remain in bed/in their room.
   f) Discontinue weekly weights and reassess needs for monthly weights for those residents that will negatively be impacted by being taken out of bed for weighing.
   g) relocate rehab staff to resident care units to assist with ADL care and ROM as indicated.
   h) Alter the locations and the times of the activity services.
   i) Provide telemedicine as applicable.

***All revisions and alterations in the plan of care will be done in direct correlation with each individual resident's clinical need and facility's staffing availability. The goal is to continue to provide care and services to maintain residents' safety.***

During **Crisis Capacity when there is no staffing available to provide the care and services required**, the following alternative strategies may be implemented but:

1) Conduct vertical and/or horizontal cohorting of resident and staff, within the facility, to promote/optimize staff to resident ratio and for easy in deliverance of care.

2) Relocate residents to another health care facility that will have the required staffing to meet the residents' healthcare needs and wellbeing as necessary.

UNION PLAZA CARE CENTER

STAFFING AGENCIES

| AGENCY | PHONE NUMBER | EMAIL |
|---|---|---|
| United Staffing Registry In. | 718 639 5475 | Ferdie@unitedstaffing registry.com |
| Promed Staffing | 212 719 9600 | WWW.promed staffing Sources.com |
| Empro Staffing | 718 435 6600 | Vicky@Medistar personnel.com |
| Five star staffing services | 718 534 7400 | 5starstaffing Services.com |
| Exceptional Medical Staffing | 919 949 3503 | drewinner@exmstaffing.com |
| Staffpro staffing Agency | 718 471 1122 | Elly@staffproonline.com |

| Nursing Staff Direct Care – Emergency Staffing | | | |
|---|---|---|---|
| **House** | 1 RN Supervisor | | |
| **Unit 2** | RN: 1 | RN/LPN: 1 | CNA: 4 |
| **Unit 3** | RN: 0 | RN/LPN: 1 | CNA: 3 |
| **Unit 4** | RN: 0 | RN/LPN: 1 | CNA: 3 |
| **Unit 5** | RN: 0 | RN/LPN: 1 | CNA:3 |
| **Unit 6** | RN: 0 | RN/LPN: 1 | CNA: 3 |
| **Unit 7** | RN: 0 | RN/LPN: 1 | CNA: 3 |
| **Unit 8** | RN: 0 | RN/LPN: 1 | CNA: 3 |
| **Housekeeping** | 4 | | |
| **Maintenance** | 1 | | |
| **Dietary** | 1 Dietary Manager | 1 Cook | 8 Dietary Aides |

Reviewed 1/29/2024

| Union Plaza |
| --- |
| **Policy Name:** Emergency Operations Center |
| **Policy Revision:** Revision Date 1/2/2018, 1/29/2024 |

**Purpose:**
The Emergency Operations Center (EOC) is a location from which centralized emergency management can be performed. The EOC is established by the facility to coordinate emergency response and support. The facility will maintain equipment and supplies in an EOC box to be used if the Emergency Operations Center (EOC) needs to be activated during a disaster.

**Procedures:**

- *Primary EOC location in Nursing Home*
  The primary EOC is located in the Union Plaza Conference room
  Telephone number: 718 670-0725

- *Secondary EOC location within Nursing Home*
  In the event that the primary site of the EOC cannot be utilized, the back-up location for the EOC will be set up at Union Plaza Care Center in the 1st Floor Rehabilitation Gym. Senior staff member(s) will relocate the EOC box to the secondary EOC location and make sure that the EOC box is stored back in the primary EOC after the incident is over.

**Activation Responsibility of EOC:**

- The EOC will be activated by the Administrator or Senior Manager upon their determination of the emergency status and need to open the EOC.

- *Determine Circumstances to Activate EOC*
  The EOC will be activated upon any of the following circumstances:
    Upon notification that an internal or external event has the possibility of causing loss of life or infrastructure damage, or having an impact on the normal operations of the facility.
    Activation of Incident Command System (ICS)

**EOC Supply List and Storage:**

EOC supplies and equipment will be stored and maintained in the basement supply room to be ready and operational in the event of an emergency. The Supply List is attached.

**EOC Supply Maintenance Schedule:**

EOC supplies and equipment will be maintained on a quarterly basis or as needed by the Director of Operations.

**EOC Contact Information:**

Coordinating Entity

The AHJ for our facility will be contacted when the need arises for the coordination of assets upon any EOC situation. Our AHJ for this purpose is Commissioner of Fire, Rescue and Emergency Service Office of Emergency management and NYSDOH.

The AHJ has outlined the following protocol and/or criteria for potentially calling for the evacuation of the facility: *As* per Commissioner Office of Emergency Management. The County executive or mayor.

During a community or regional event requiring evacuation, the facility will contact the AHJ. When the AHJ determines that a sufficient threat potential exists, they may wish to evacuate one or more facilities in the immediate area.

Whenever possible, the final evacuation decision should be a joint decision between the facility Incident Commander and the AHJ.

The AHJ will be notified if the facility is evacuating and there is the potential for other healthcare facilities to also be evacuating to ensure coordination of transportation assets and evacuation destinations. The sequencing of evacuation will also be addressed through communication with the AHJ.

# Durable Medical Equipment in Disasters

July 2018

Advances in healthcare delivery and technology, including home-based durable medical equipment (DME), have better enabled members of at-risk populations with access and functional needs to live independently within their communities. New technologies, including many types of life-sustaining and assistive DME enable at-risk individuals to assist, support, or manage their own healthcare needs in non-acute and home settings. This ASPR TRACIE fact sheet provides information on general DME categories and focuses on electricity-dependent DME that may be affected by disasters and emergencies, including power failures. It also includes information to assist healthcare system preparedness stakeholders plan for medically vulnerable populations who rely on DME.

## Durable Medical Equipment

DME is defined by the Centers for Medicare & Medicaid Services (CMS) as equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses. DME must be ordered and prescribed by a doctor and meet these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years

Examples of DME include: wheelchairs (manual and electric), hospital beds, ventilators, oxygen concentrators (and accessories), nebulizers, monitors, traction equipment, canes, crutches, walkers, pressure mattresses, lifts, infusion and feeding pumps, and various other equipment.

DME that Medicare covers includes equipment that can be rented, such as:

- Air-fluidized beds and other support surfaces
- Diabetic supplies including blood sugar monitors and test strips
- Blood sugar (glucose) test strips
- Canes (except white canes for the blind)
- Commode chairs
- Continuous passive motion machine
- Crutches
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs or nutrition)
- Manual wheelchairs and power mobility devices

- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

Millions of individuals rely on DME to meet their activities of daily living needs, manage their chronic medical conditions, or support other functional needs. Disasters or emergencies can result in disruptions to critical infrastructure systems (electricity, power, water) which adversely affect individuals who rely on electricity-dependent DME for activities for daily living and critical life support functions. These disruptions can result in individuals having to evacuate or relocate from their homes and seek assistance to ensure their continued access to their DME or DME suppliers. Lack of ability to use certain types of equipment due to loss of electricity (e.g., CPAP machines), can also impact Medicare coverage and reimbursement. Some DME have a daily minimum usage requirement for coverage.

**Replacing DME from CMS during a Disaster**

CMS provides information on coverage exceptions during a declared disaster and information on DME replacement in a disaster. CMS also provides specific guidance to beneficiaries affected by disasters, including a list of DME Suppliers that are searchable by zip code to assist in replacing damaged DME. Individuals covered by other insurance would need to check with their providers for this kind of information.

## Electricity-Dependent Durable Medical Equipment

Disasters or emergencies, particularly those that disrupt critical infrastructure systems such as power or water, can cause life-threatening situations for those who depend on electricity-powered DME.

Electricity- and power-dependent DME consists of three overarching categories:

**Oxygen and Related Respiratory Devices**—Respiratory therapy equipment that provides treatment of breathing disorders and other cardiopulmonary needs.

- Ventilators
- C-PAP-Continuous Airway Pressure Device
- BiPAP Bi-Level Positive Airway Pressure Device
- Powered Suction Pumps
- Oxygen Concentrators

**Infusion/Intravenous and Feeding Equipment—** Equipment/devices that deliver fluids, nutrients, and medications into an individual's body in controlled amounts.

- Infusion Pumps
- Insulin Pumps

**Mobility Assistive Equipment—**Equipment that provides the ability to perform one or more mobility-related activities of daily living (ADL) or instrumental activities of daily living (IADL) in or out of the home, including access to the community.

- Power Wheelchairs
- Power Scooters
- Semi-Electric Wheelchairs

The following quick reference list outlines key information on electricity-dependent DME.

It is important to note that many healthcare providers do not realize that insurers commonly require a prescription for the DME and a separate prescription for a back-up battery. Many at-risk individuals currently do not have back-up batteries due to lack of awareness across the healthcare system and provider communities. Healthcare providers should be encouraged to determine if their patient's insurance plans require a prescription for both and ensure their patients have both prescriptions to help protect their health in a prolonged power outage, emergency, or disaster.

**Electricity-Dependent DME Quick Reference List**

- **Bi-level Positive Airway Pressure Device (BiPAP)-** Provides pressure-controlled ventilation in a system allowing unrestricted spontaneous breathing at any moment of the ventilatory cycle.
- **Cardiac devices**-Include left, right, and bi-ventricular assist devices (VADs), and total artificial hearts (TAHs). VADs and TAHs are mechanical pumps that are used to support or replace heart function in people who have some form of heart failure.
- **Electric Bed**-Bed designed with features including adjustable height for the entire bed, the head, and the feet, adjustable side rails, and electronic buttons to operate both the bed and other nearby electronic devices.
- **Enteral Feeding Tube**-Medical device used to provide nutrition to patients who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation.
- **IV Infusion Pump**-Used to deliver fluids, medication, or nutrients into a patient's circulatory system. Pumps are often used to deliver antibiotics, chemotherapy drugs, and pain relievers into a patient's body in controlled amounts.
- **Motorized Wheelchair or Scooter**-Useful for those unable to propel a manual wheelchair. They are used by both people with mobility impairments and those with cardiovascular or fatigue-based conditions.

- **Oxygen Concentrator**- Extracts and concentrates oxygen from the air and delivers it to the patient via tubes or masks. Concentrators may be used to provide life-maintaining/saving oxygen 24-7 or during select periods throughout the day to provide supplemental oxygen required for certain respiratory conditions.
- **Suction Pump**- Used by those who have difficulty raising or clearing mucosal secretions inside the air passages. They are often prescribed for conditions pertaining to air passages, the throat or mouth, dysfunction of the swallowing muscles, or tracheostomies.
- **Ventilator-** Provides life-maintaining/saving oxygen for an individual 24/7. Vests provide high frequency chest wall oscillation (inflating and deflating of the chest) to thin mucus and ultimately clear it from the lung airways.

## Healthcare Utilization for Electricity-Dependent DME Needs

Emergencies, particularly with prolonged power outages or that require evacuation, can quickly create life threatening situations for people who depend on DME. Some may seek assistance from local emergency medical services (EMS) or access to care and electricity from local hospitals, other healthcare providers, or available shelters. Others may shelter-in-place and put themselves at risk due to a lack of resources, transportation, and/or the ability to evacuate. Both situations can lead to significant increases in healthcare system stress and potential adverse outcomes for these at-risk populations. It is imperative that healthcare organizations have plans to meet the needs of the electricity-dependent DME populations within the communities they serve.

Special Needs Shelter Planning Resources

- Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters
- Special Needs Sheltering
- Sample Special Needs Shelter Application
- Access and Functional Needs Topic Collection
- Utility Failures Topic Collection

**Electricity-Dependent DME & Shelter Operations**

Certain emergencies or disasters require electricity-dependent DME individuals to evacuate, leaving them inadvertently separated from their critical electricity supplies. In addition to healthcare facilities, electricity-dependent people will also seek support at community-based shelters. Emergency managers and public health providers should plan ahead to ensure that these community members will be able to obtain access to electricity and power sources to support DME equipment.

If electricity is available, priority should be given to electricity-dependent DME users who use life-sustaining (respiratory, cardiac) medical equipment. Those who depend on electricity-powered wheelchairs and scooters for mobility must be able to frequently recharge this equipment to ensure they are able to move about and participate in services offered by the shelter.

## HHS emPOWER Map 3.0 Tool

To help communities address the added risks for these electricity-dependent vulnerable populations, ASPR developed the HHS emPOWER Map tool through a partnership with CMS. The HHS emPOWER Map strengthens the ability of local health departments, healthcare organizations, first responders and their community partners ability to anticipate, plan for, and support response and recovery activities for electricity-dependent DME users and other at-risk individuals with access and functional needs that may be adversely impacted and require assistance in an emergency. The innovative, public, and interactive map provides monthly de-identified Medicare data—down to the zip code level—and an expanded set of near real-time hazard tracking services. Together, this information provides enhanced situational awareness and actionable information for assisting areas and at-risk populations that may be impacted by severe weather, wildfires, earthquakes, and other disasters. Some examples of how this tool can be used include but are not limited to:

- Public health and emergency management officials can determine shelter locations and shelter resource needs, plan for evacuations by identifying potential routes, and develop improved public communications.
- Hospitals, healthcare coalitions, and first responders, including EMS, can identify healthcare resource needs and potential areas of hospital and EMS surge.
- Local electric companies can identify the areas that will require prioritized power restoration to protect health and save lives.
- Community businesses and civic organizations can use the data to identify ways to support the community in an emergency, such as providing charging stations for device batteries.

Public health authorities may access more detailed de-identified data for electricity-dependent populations via the HHS emPOWER Program. A factsheet regarding the HHS emPOWER Program is available under the resources section of the HHS emPOWER Map. Additional inquiries about this data should be directed to your appropriate ASPR Regional Administrator/Emergency Coordinator and the HHS emPOWER Program.

The HHS emPOWER Map has been used for proactive outreach through HHS Joint exercises with City of New Orleans, State of Arizona, Broome County/New York State, City of Chicago, New York City, and real-world emergency responses throughout the country.

## Planning & Response Considerations for Electricity-Dependent DME Users

Public health medical organizations, and other emergency support function partners can incorporate the following considerations in their preparedness and response efforts to meet the needs of electricity-dependent DME users:

- Community collaboration when planning for electricity-dependent populations can ensure a whole community approach to address the unique needs of the at-risk individuals with access and functional needs, including older adults and people with chronic illnesses.

- Ensure special needs registries (for medical and specialty shelter planning) are frequently validated and updated, and identify and address registrants' preparedness resource gaps . These registries should properly coordinate care ahead of time and ensure registrants know what to do, where to go, and what to take with them to a shelter.
- Hospitals should engage their biomedical or clinical engineering departments as there may be an impact with existing policies that hospitals have in place regarding patients bringing, or not being allowed, to use their devices on hospital premises.
- DME suppliers will play a critical role in providing basic and advanced medical equipment to individuals and facilities across the healthcare community; it is imperative to ensure suppliers have emergency and business continuity plans which address supply chain continuity.
- Identify regional CMS-preferred DME suppliers and reach out include them within the planning process. Consider engaging DME suppliers in drills and exercises.
- Healthcare coalition partners, EMS and local public health authorities, should utilize HHS emPOWER Map 3.0 data to identify electricity dependence in their catchment area, anticipate a potential surge in care demands, update their emergency plans, and identify potential mitigation measures to reduce surge in an emergency.
- Coordination along the healthcare continuum can significantly enhance resource utilization. It is important to engage community-based healthcare providers (e.g., outpatient facilities) who may be able to support response efforts by providing electricity (if available) for the types of equipment that only need recharging.

**Related ASPR TRACIE Fact Sheets**

- CMS and Disasters: Resources at Your Fingertips
- Considerations for Oxygen Therapy in Disasters
- EMTALA and Disasters

**Agencies and Organizations**

Centers for Medicare & Medicaid Services (CMS)

- Durable Medical Equipment
- Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims
- Medicare Coverage of Durable Medical Equipment and Other Devices
- Medicare's Durable Medical Equipment Supplier Directory
- Requesting an 1135 Waiver

U.S. Food and Drug Administration

- Emergency Use Authorization of Medical Products and Related Authorities
- FDA Offers Tips about Medical Devices and Hurricane Disasters
- Medical Devices
- Medical Devices that Have Been Exposed to Heat and Humidity

**Electricity-Dependent Medical Equipment Planning Resources**

Anderson, G. and Bell, M. (2012). Lights Out: Impact of the August 2003 Power Outage on Mortality in New York, NY. Epidemiology. 23(2): 189-193.

Beatty, M.E., Phelps, S., Rohner, C., et al. (2012). Blackout of 2003: Public Health Effects and Emergency Response. Public Health Reports. 121(1):36-44.

DeSalvo, K., Lurie, N., Finne, K., et al. (2014). Using Medicare Data to Identify Individuals Who Are Electricity Dependent to Improve Disaster Preparedness and Response. American Journal of Public Health. 104 (7): 1160–1164.

Greenwald, P., Rutherford, A., Green, R. et al. (2004). Emergency Department Visits for Home Medical Device Failure During the 2003 North American Blackout. Academic Emergency Medicine.

Molinari, N., Chen, B., Krishna, N., et al. (2017). Who's at Risk When the Power Goes Out? The At-Home Electricity-Dependent Population in the United States, 2012. Journal of Public Health Management and Practice 23(2): 152–159.

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**Mass Care and Shelter Operations Resources**

Broz, D., Levin, E., Mucha, A., et al. (2009). Lessons Learned from Chicago's Emergency Response to Mass Evacuations Caused by Hurricane Katrina. American Journal of Public Health. 99(8): 1496–1504.

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Jan, S. and Lurie, N. (2012). Disaster Resilience and People with Functional Needs. New England Journal of Medicine. 367(24): 2272-2273.

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National Research Council (US) Committee on the Role of Human Factors in Home Health Care. (2010). The Role of Human Factors in Home Health Care: Workshop Summary. National Academies Press (US), Medical Devices in Home Health Care.

Phillips, S.J., Knebel, A., and Johnson, K. (2007). Mass Medical Care with Scarce Resources: A Community Planning Guide.

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Rathore, F.A., Gosney, J.E., Reinhardt, J., et al. (2012). Medical Rehabilitation after Natural Disasters: Why, When and How? Archives of Physical Medicine and Rehabilitation. 93(10): 1875-1881.

Toner, E.S., McGenty, M., Schock-Spana, M., et al. (2017). A Community Checklist for Health Sector Resilience Informed by Hurricane Sandy. Health Security 15(1):53–69.

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| **Union Plaza** |
| --- |
| **Policy Name:** Emergency Operations Center |
| **Policy Revision:** Revision Date 1/2/2018, 1/29/2024 |

**Purpose:**
The Emergency Operations Center (EOC) is a location from which centralized emergency management can be performed. The EOC is established by the facility to coordinate emergency response and support. The facility will maintain equipment and supplies in an EOC box to be used if the Emergency Operations Center (EOC) needs to be activated during a disaster.

**Procedures:**

- *Primary EOC location in Nursing Home*
  The primary EOC is located in the Union Plaza Conference room
  Telephone number: 718 670-0725

- *Secondary EOC location within Nursing Home*
  In the event that the primary site of the EOC cannot be utilized, the back-up location for the EOC will be set up at Union Plaza Care Center in the 1st Floor Rehabilitation Gym. Senior staff member(s) will relocate the EOC box to the secondary EOC location and make sure that the EOC box is stored back in the primary EOC after the incident is over.

**Activation Responsibility of EOC:**

- The EOC will be activated by the Administrator or Senior Manager upon their determination of the emergency status and need to open the EOC.

- *Determine Circumstances to Activate EOC*
  The EOC will be activated upon any of the following circumstances:
    Upon notification that an internal or external event has the possibility of causing loss of life or infrastructure damage, or having an impact on the normal operations of the facility.
    Activation of Incident Command System (ICS)

**EOC Supply List and Storage:**

\

EOC supplies and equipment will be stored and maintained in the basement supply room to be ready and operational in the event of an emergency. The Supply List is attached.

**EOC Supply Maintenance Schedule:**

EOC supplies and equipment will be maintained on a quarterly basis or as needed by the Director of Operations.

**EOC Contact Information:**

Coordinating Entity

The AHJ for our facility will be contacted when the need arises for the coordination of assets upon any EOC situation. Our AHJ for this purpose is Commissioner of Fire, Rescue and Emergency Service Office of Emergency management and NYSDOH.

The AHJ has outlined the following protocol and/or criteria for potentially calling for the evacuation of the facility: *As* per Commissioner Office of Emergency Management. The County executive or mayor.

During a community or regional event requiring evacuation, the facility will contact the AHJ. When the AHJ determines that a sufficient threat potential exists, they may wish to evacuate one or more facilities in the immediate area.

Whenever possible, the final evacuation decision should be a joint decision between the facility Incident Commander and the AHJ.

The AHJ will be notified if the facility is evacuating and there is the potential for other healthcare facilities to also be evacuating to ensure coordination of transportation assets and evacuation destinations. The sequencing of evacuation will also be addressed through communication with the AHJ.

# Emergency Operations Center (EOC) Supply List

| EOC's supply list. |
| --- |

**Communication Equipment**

- Cellular phone
- Analog phone
- Telephones: handsets, lines, switchboard
- Governmental Emergency Telecommunications System (GETS) card
- Public address system
- Two-way radio network (stationary & portable/handheld) with the ability to communicate with security, safety staff, public safety, other sites in network, etc.
- Bullhorn

**Electronic Equipment**

- Weather radio – hand cranked or battery operated
- Fax machine
- Copy machine
- Television
- Laptop / computer terminals
- Surge protectors
- Digital camera

**Furniture**

- Tables and chairs
- Flip chart, easel & pad
- White boards and markers
- Bulletin board

**Food and Water**

- Bottled water
- Foods with long shelf life such as snack foods, etc.

**Reference and Resource Materials**

- Internal / external telephone contact list
- Staff contact list
- Emergency management plan
- Reference materials (blueprints, maps, facility policy and procedure manuals)
- Notebook to record EOC activities

**Office Supplies**

- Miscellaneous office supplies (i.e., staplers, staples, staple removers, envelopes of various sizes, paper clips, push pins, masking/scotch tape, pencils, pens in assorted colors, assorted rubber bands, binders, writing pads, note pads, name tags, markers)
- Batteries for equipment

**Safety Equipment and Supplies**

- Flashlights & batteries
- Light sticks
- First aid kit
- Cleaning wipes
- Hand sanitizer

**Personal Protective Equipment (PPE)**

- Face shields
- N95 respirators
- Disinfecting wipes
- Surgical masks
- Nitrile gloves

# Map and Directions for Evacuation
# Nursing Home to Alternative Facility

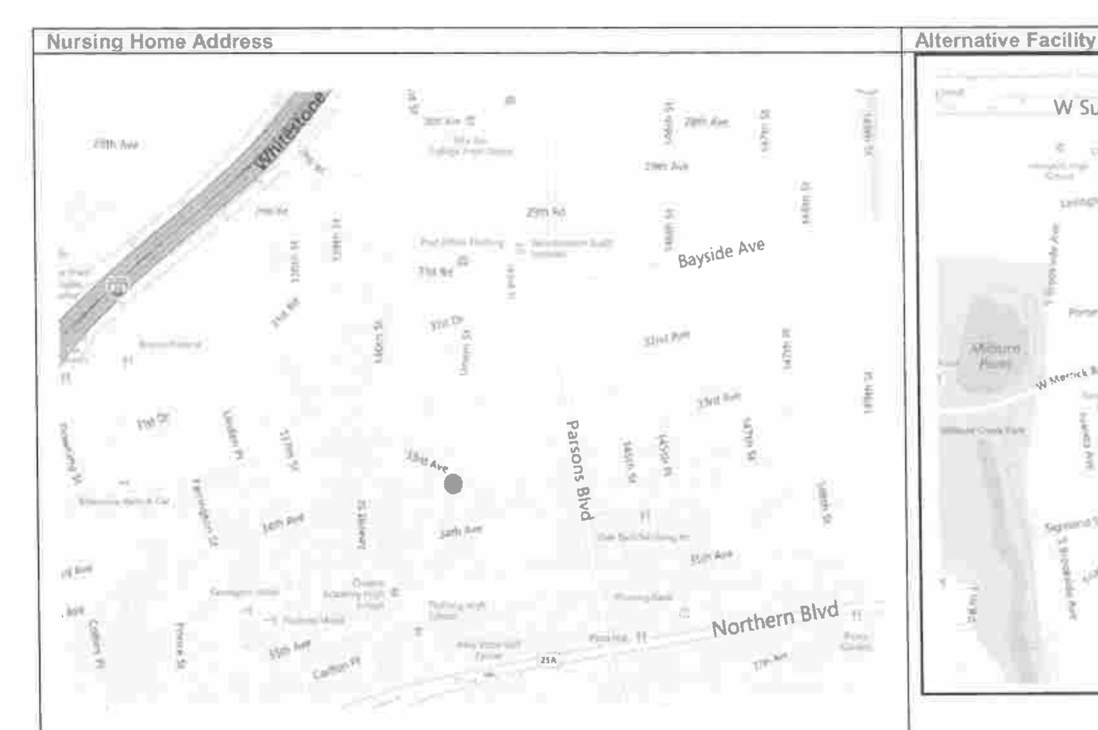
## FACILITY LOCATION

Union Plaza Care Center
33-23 Union street
Flushing New York 11354
7186700700

## ALTERNATE FACILITY LOCATION

**Meadowbrook Care Center**
320 W Merrick Rd, Freeport, NY 11520 · Stearns Park
(516) 377-8200
Mindy Grant Administrator

Nursing Home Address




http://www.bing.com/local?lid=YN631x14467996&id=YN631x14467996&q=Union+Plaza+Care+Center+Flushing+NY&FORM=SNAPST

Alternative Facility Address

W Sunrise Hwy

http://www.bing.com/local?lid=YN633x11057857&id=YN633x11057857&q=Meadowbrook+Care+Center+Freeport+NY&FORM=SNAPST

**Use Google Maps – http://maps.google.com or MapQuest Maps – www.mapquest.com**

## Map and Directions for Evacuation
## Nursing Home to Alternative Facility

### Directions from Nursing Home to Alternative Facility

http://mapq.st/1CKTxLb

| Direction | Distance |
|---|---|
| 1. Start out going south on Union St toward 34th Ave. | 0.2 mi |
| 25A 2. Turn right onto Northern Blvd / NY-25A.<br>• Northern Blvd is just past 35th Ave<br>• If you reach 37th Ave you've gone about 0.1 miles too far | 0.3 mi |
| 25A 3. Keep left at the fork to continue on NY-25A / Northern Blvd. | 0.2 mi |
| SOUTH 678 4. Merge onto I-678 S / Van Wyck Expy S toward Kennedy Airport. | 7.6 mi<br>10 minutes |
| 1E EXIT 5. Take the Belt Pkwy E exit, EXIT 1E, on the left toward NY-27 E. | 0.5 mi |
| 6. Merge onto Southern State Pkwy E / Belt Pkwy E via the ramp on the left toward Eastern L I. | 2.2 mi<br>2 minutes |
| 7. Southern State Pkwy E / Belt Pkwy E becomes Laurelton Pkwy E. | 0.2 mi |
| 23B EXIT 27 8. Merge onto NY-27 via EXIT 23B toward Brookville Blvd. | 8.0 mi<br>17 minutes |

9. Turn right onto S Brookside Ave. — 0.3 mi
    - S Brookside Ave is 0.2 miles past Milburn Ave
    - If you are on W Sunrise Hwy and reach Park Ave you've gone a little too far

10. Turn left onto W Merrick Rd. — 0.4 mi

11. 320 W MERRICK RD is on the left.
    - If you reach S Bayview Ave you've gone a little too far

**MapQuest Maps – www.mapquest.com**

**AGREEMENT BETWEEN**

**THE NEW YORK CITY OFFICE OF EMERGENCY MANAGEMENT**
**and**
Union Plaza Care Center

**AGREEMENT,** effective as of 5/28, 2014, between the City of New York ("City"), acting through the **Office of Emergency Management ("OEM")**, having its principal office located at 165 Cadman Plaza East, Brooklyn, NY 11201, and the Union Plaza Care Center **("The Facility")**, having its principal office located at 33 23 Union st Flushing N.Y. 11354 will be at times collectively referred to as the "Parties".

**WITNESSETH**

**WHEREAS,** The Facility is a skilled nursing facility, as defined under the New York State Public Health Law, that provides in-patient medical care to individuals with various chronic medical conditions; and

**WHEREAS,** OEM is charged with planning and preparing for emergencies, including but not limited to managing the City's Coastal Storm Plan, which organizes the City's response to major weather events, including orderly evacuations of healthcare facilities; and

**WHEREAS,** one of the City's recommendations in the Hurricane Sandy After Action Report is developing a redundant means of communication between the City and its healthcare facilities; and

**WHEREAS,** radios are being purchased in partnership with the New York City Department of Health and Mental Hygiene and will be provided to certain healthcare facilities, including The Facility named in this Agreement, for emergency communication during major emergencies and/or telecommunication failures; and

**WHEREAS,** The Facility will accept and utilize the radio consistent with the terms outlined in this Agreement; and

**WHEREAS,** OEM, in consultation and coordination with other relevant City agencies, has identified the appropriate technology and equipment necessary to support the use of 700 MHz radios in the event of a communications failure;

**NOW, THEREFORE,** in consideration of the mutual promises herein set forth, the Parties agree as follows:

## I. SCOPE OF WORK

OEM will purchase, configure and provide The Facility with one (1) 700 MHz radio, (2) batteries, and a charger, allowing The Facility to have an alternate means of communication during an emergency and/or telecommunication failure.

police report is required.

vii. Upon written request, all aforementioned equipment must be returned to the City.

**OEM**

OEM, in addition to the requirements outlined in **Attachment A**, will:

i. Provide all necessary original training to administrative nursing home staff members
ii. Monitor the radios for emergency calls or alerts, and
iii. Engage in regular radio roll calls with The Facility.

## V. LIABILITY

Parties shall be responsible for the acts and omissions of their own agencies, officers, employees and agents in the implementation of this Agreement. The Parties shall not assert any claim, commence any litigation or seek any recovery from any party (Facility) to this Agreement arising from such acts and omissions of each such party, its own agencies, officers, employees or agents. Nothing herein shall be deemed to affect any defense, immunity or other benefit provided by the Laws of the State of New York, or to create any liability that does not exist under current law. The foregoing provision shall be included in any agreements or standard operating procedures adopted pursuant to this Agreement.

## VI. INDEMNIFICATION

The Facility shall indemnify, defend, and hold harmless the City of New York and their respective officers, employees, and agents from any and all claims, judgments or liabilities to which they may be subject because of any act or omission of The Facility, its employees, agents or representatives in connection with this Agreement, or because of any negligence or any fault or default of the The Facility, its employees, agents and representatives, and for any acts that occur as a result of equipment failure or defect, provided, however, that nothing in this Section shall impose any liability on the The Facility for the acts, negligence or fault of the City or its respective officers, employees and agents or the acts of any other The Facility. This obligation shall survive and continue beyond any termination or expiration of this Agreement.

## VII. MISCELLANEOUS

a. **Modification**. No modification, amendment, waiver, or release of any provision of this Agreement shall be valid or binding, for any purpose, unless in writing and duly executed by the Parties.

b. **Merger**. This Agreement contains all the terms and conditions agreed upon by the Parties hereto, and no other agreement, oral or otherwise, regarding the subject

Each Party represents that it has obtained all necessary approvals, consents and authorizations to enter into this Memorandum of Understanding and to perform its duties under this Memorandum of Understanding; the person executing this Memorandum of Understanding on its behalf has the authority to do so.

**IN WITNESSETH WHEREOF**, the Parties hereto have executed the Agreement of the dates appearing opposite their respective signatures. The terms of this Agreement will become effective on the date that the last party signs this Agreement:

7/23/2014
Date

MORDECHAI GOLDFEDER
New York City Office of Emergency Management
Senior Health & Medical Planner
165 Cadman Plaza East
Brooklyn, New York 11201

8/28/2014
Date

Cyrus Shirvani
Maintenance Mechanic
Union Plaza Care Center
33 23 union St. Flushing N.Y. 11354

**ATTACHMENT A**
NH Radio Plan Guidelines

PHARMSCRIPT

**DISASTER PLAN – PHARMACY AGREEMENT**

**PharmScript, LLC** designated as the provider pharmacy, agrees to deliver medication during a disaster that requires evacuation of the residents of **Union Plaza**, designated as the facility. In the event of evacuation of the facility, the Director of Nursing, or designee, shall notify the pharmacy of the new location and the telephone number. The facility shall be responsible for moving the medications out of the facility, and all necessary records (MAR's, TAR's, POS's, etc) required for proper medication administration. The provider Pharmacy will establish routing of medication deliveries to meet the needs of the residents at the new location.

This agreement shall remain in force for the duration of the Pharmacy Service Agreement between **PharmScript, LLC** and the facility and will terminate with the termination of the agreement.

Agreed to upon this date: **February 19, 2018**

| | |
|---|---|
| | ADINAH PELMAN |
| Pharmscript, LLC | Facility Administrator |
| John Walker, COO | |
| [signature] | [signature] |
| Signature | Signature |

PHARMSCRIPT

**Letter of Commitment for:**

**PHARMACY SERVICES DURING INCLEMENT WEATHER/NATURAL DISASTER**

**PROCEDURES**

PHARMACY SERVICES shall make every effort to provide continuous and necessary pharmacy services during inclement weather such as floods, snow storms and natural disasters such as, hurricanes, tornados and extended power outages.

**Facility Responsibilities:**

1. Upon notification that the threat of inclement weather or natural disaster is imminent, the nursing staff shall check inventory levels of all medications, including house stock supplies, interim or reserve medications and emergency medications.

2. Orders shall be transmitted by the facility to the pharmacy via electronic interface, fax, telephone, courier, or by whatever means available.

3. If during this period of time the residents are transferred to other locations, their medications, Medication Administration Records, Physician Orders and Treatment Sheets shall accompany each resident.

4. The facility shall notify the pharmacy of the location of each resident.

5. The facility shall prioritize their needs and attempt to give the pharmacy new and emergency orders only. In the event a refill is necessary, it must be communicated to the pharmacy by fax or telephone stating "NEED TODAY".

**Pharmacy Responsibilities:**

The Pharmacy will make sure it has adequate medication supplies on hand. The Pharmacy will notify facilities days in advance of their plan based on the current weather model and information received from the National Weather Association.

1. Pharmacy shall fill all necessary orders to assure the facility that they have at least seven (7) days supply of all medications for each resident.

2. Pharmacy shall determine appropriate delivery times based on demand before the disaster occurs and feasibility during and after the event. Pharmacy shall notify each facility's Administrator of Director of Nursing of its proposed delivery schedules, hours of operation, pharmacist-on-call and of any necessary changes.

3. Pharmacy shall concentrate on filling emergency and new orders during the disaster.

4. Refills that are received in the pharmacy will be held from processing until time and facilities permit.

5. In the event, we are unable to get to your facility (i.e. bridge or tunnel closure) we will utilize the back-up pharmacy network assigned to your facility

Union Plaza Care Center

**Dialysis Centers Transfer Agreements**

| | |
|---|---|
| **Bayside Dialysis Center**<br>201-10 Northern Blvd.<br>Bayside, NY 11361<br>718-423-6638 | **Chinatown Dialysis Center, LLC**<br>(Formerly known as China Dialysis Center, LLC)<br>213 Hester Street<br>150 Lafayette Street<br>New York, NY 10013<br>212-925-0404 |
| **College Point Dialysis**<br>23-14 College Point Blvd.<br>College Point, NY 11356<br>718-762-3330 | **Elmhurst Hospital Dialysis Center**<br>79-01 Broadway<br>Elmhurst, NY 11373<br>718-334-3800 |
| **Flushing Hospital Out-Patient Dialysis**<br>4500 Parsons Blvd.<br>Flushing, NY 11355<br>718-670-5949 | **HIS of NY - Queens Dialysis Center**<br>118-01 Guy Brewer Blvd.<br>Queens, NY 11434<br>718-341-6711 |
| **Island Rehabilitative Services**<br>120-46 Queens Blvd<br>Kew Gardens, NY 11415<br>718-793-3341 | **Newtown Dialysis**<br>2920 Newtown Avenue<br>Astoria, NY 11102<br>718-728-2222 |
| **Queens Dialysis Center**<br>34-35 70th Street<br>Jackson Heights, NY 11372<br>718-651-9700 | **Trude Weishaupt Dialysis Center a/k/a NYHQ Dialysis Center**<br>59-28 174th Street<br>Fresh Meadows, NY 11365<br>718-670-1276 |
| **Rogosin Auberndale Dialysis Center**<br>39-20 Utopia Parkway<br>Flushing, NY 11358<br>347-783-7700 | |

# *Emergency SeniorCare Activation for Patient Evacuation (ESCAPE) Plan*

**STEVEN J. TEICHEI**
*Director of Marketin*

855 Brush Avenue, Bronx, NY 10465
**Transportation / Dispatch: 718.430.9100**
Executive office: 718.430.1525
Fax: 718.430.1528
Cell: 347.992.1009

# Memorandum of Understanding And Agreement to Transport Evacuated Patients

## *Emergency SeniorCare Activation for Patient Evacuation (ESCAPE) Plan*

This MEMORANDUM OF UNDERSTANDING, dated **11/30/2005** (the "MOU") is entered into by and between SeniorCare Emergency Medical Services Inc., having an address at 855 Brush Avenue, Bronx, New York 10465 ("SeniorCare") and the undersigned medical facilities. This agreement shall be known as the **E**mergency **S**enior**C**are **A**ctivation for **P**atient **E**vacuation (**ESCAPE**) Plan.

### *Purpose*

The purpose of this MOU is for the undersigned organizations in the New York City metropolitan area to set forth guidelines under which each medical facility will transfer or accept patients in the event of a partial or total medical facility evacuation in an emergency situation, where the coordination and provision of transportation logistics of the evacuation will be provided by SeniorCare. The evacuation of any of the participating medical facilities would occur only in extreme emergencies which would render a participating medical facility, or a portion of a participating medical facility, unusable for patient care. (Examples of such situations requiring evacuation and transfer of patients to other medical facilities would include a major fire or an environmental hazard.)

### *Definitions*

- "Medical Facility" refers to all of the undersigned medical facilities entering into this Memorandum of Understanding.
- "Transferring Medical Facility" refers to a medical facility being evacuated, which must transfer its patients. May also be referred to as the Originating Medical Facility.
- "Receiving Medical Facility" refers to a medical facility receiving patients, which are evacuated from a Transferring Medical Facility.
- "Transportation Logistics" refers to all activities associated with emergency evacuation of patients from a Transferring Medical Facility to a Receiving Medical Facility including, but not limited to:
    - Determining, in consultation with the Transferring Medical Facility, the appropriate mode of transportation (device, vehicle, and level of care provided during transport)
    - Identifying a suitable destination pursuant to this agreement and in concurrence with the Transferring Medical Facility
    - Accepting care of the patient and custody of accompanying patient records, medications (other than controlled substances), medical administration record (MAR), specialized treatment supplies, and personal effects at the Transferring Medical Facility's Ambulance Loading Area

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- Ensuring the patient's safe and timely transportation to the Receiving Medical Facility
- Transferring care of the patient and custody of accompanying patient records, medications, and personal effects at the Receiving Medical Facility's Triage Area
- Tracking the patients, and providing this information to the SeniorCare EOC and the Transferring Medical Facility

NOW, THEREFORE, in order to provide for continuation of care of patients of the medical facilities within the area, the medical facilities and SeniorCare hereby mutually agree as follows:

***Term and Termination***

This MOU shall be effective as of the date set forth above and shall continue for one (1) year thereafter (the "Initial Term"). Following the Initial Term, this MOU shall renew between and among all parties for successive one (1) year terms (each, a "Renewal Term"), unless any party shall provide the other parties with at least thirty (30) days notice prior to the end of the Initial Term or any Renewal Term of its determination not to extend the MOU. The withdrawal or non-extension of any party other than SeniorCare shall not affect the agreement among all other parties.

***General Provisions***

It is understood by all parties that each should fulfill its responsibilities under this Agreement in accordance with the provisions of law and regulations that govern their respective activities. Nothing in this Agreement is intended to negate or otherwise render ineffective any such provisions or operating procedures. If at any time any party is unable to perform its functions under this Agreement consistent with such party's statutory and regulatory mandates, the affected party shall immediately provide written notice to the other parties who agree to promptly perform such functions.

***Agreements***

**A. SeniorCare**

1. SeniorCare maintains an Emergency Operations Center (EOC) capability at their Headquarters, which can be activated with enhanced communications and coordination capability in support of an emergency or other major activity. SeniorCare also maintains a comprehensive resource listing of medical transportation resources that may be used in an evacuation, including basic and advanced life support ambulances, medical evacuation helicopters, ambulette vehicles, medical transport vans, lift-equipped vehicles, and kneeling busses.
2. SeniorCare agrees to activate, staff, and operate their EOC for the purpose of coordination of transfers, patient tracking, and transportation logistics in the event that a participating medical facility requires evacuation. This agreement shall be activated

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immediately upon receipt of a call at the SeniorCare Communications Center via hotline or by telephone (718-430-9700) from a participating medical facility declaring an evacuation emergency. The Communications Center is operational at all times, 24 hours a day, seven days a week.

3. SeniorCare will, as soon as practical following notification, provide an on-scene coordinating officer (OSCO) at the Transferring Medical Facility to direct transportation operations and serve as a liaison to the facility's incident commander. Depending on circumstances, SeniorCare may also provide an on-scene coordinating officer at one or more of the involved receiving facilities to direct transportation operations and serve as a liaison to the facility's incident commander.

4. Based on the Transferring Facility's request and/or on-scene assessment by the SeniorCare OSCO, SeniorCare shall dispatch and coordinate the resources necessary to accomplish the evacuation mission in an efficient and timely manner. Should the evacuation require specialized assets or a quantity of resources beyond SeniorCare's internal capability to provide, SeniorCare shall serve as the coordinating entity for arranging and coordinating provision of sufficient assets that may be necessary, using appropriately trained, equipped, licensed, and certified medical transportation provider agencies as may be necessary.

5. SeniorCare will conduct all emergency response and transportation activities in compliance with applicable provisions of the General Operating Procedures of the Regional Emergency Medical Services Council of New York City under authority of the New York State Public Health Law (Article 30), including, but not limited to, the protocols for *Coordination of Pre-Hospital Resources Protocol* and the *Mutual Aid Mobilization Protocol*. Consistent with these protocols, should an incident be declared a "multiple casualty incident" by the New York City Fire Department (FDNY), and FDNY assumes responsibility for coordination of pre-hospital resources, SeniorCare will continue to provide the transfer coordination and medical facility liaison services to the Transferring Medical Facility as provided herein, in full support, cooperation, and coordination with the FDNY operation.

6. Should circumstances such as an act of nature require the simultaneous evacuation of multiple medical facilities, SeniorCare will operate in accordance with the agreement described herein, and will coordinate transfer activities with those of the FDNY, New York City Office of Emergency Management (OEM), New York City and State Departments of Health, and other agencies participating in the evacuation process.

7. All billing and compensation for transportation services pursuant to this agreement shall be billed and paid through the existing contractual arrangements between SeniorCare and the Transferring Medical Facility at the then-prevailing rates.

## B. Transferring and Receiving Medical Facilities

1. Subject to medical capability and space availability, each medical facility agrees to serve as a Receiving Medical Facility and accept a Transferring Medical Facility's patients in the event of an emergency evacuation.

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2. When notified by SeniorCare of an evacuation emergency and activation of this agreement by a participating medical facility, each potential Receiving Medical Facility shall provide their capacity and capability to accept evacuated patients to the SeniorCare EOC within 30 minutes. The data reported shall include both licensed and surge (over-bedding) capacity in an agreed-upon format.

3. The Receiving Medical Facility will provide applicable medically necessary healthcare services as may be required by patients transported to the Receiving Medical Facility at the Receiving Medical Facility's then-prevailing rates. Each of the medical facilities will follow their standard procedures for admission of patients and their standard protocols for providing care to patients. The Transferring Medical Facility shall not be obligated to pay any charges imposed by the Receiving Medical Facility unless such liability would exist separate and apart from this Agreement. The Receiving Medical Facility will collect such charges from the patient or the patient's third party payer.

4. The Transferring Medical Facility will be responsible for arranging for transportation of any evacuated patients to the Receiving Medical Facility. The Transferring Medical Facility is responsible for arranging transportation of patients from the receiving facility back to the originating facility. The Transferring Medical facility will pay the transportation cost and seek reimbursement by billing the patient or third party payers.

5. Once a Receiving Medical Facility is identified by the SeniorCare EOC, the Transferring Medical Facility will provide the Receiving Medical Facility with as much advance notice as possible of any patients requiring evacuation by calling the Receiving Medical Facility and providing as much information as possible under the circumstances. As conditions warrant, the Receiving Medical Facility shall activate their Emergency Management Plan and Surge Plan/Annex. If the Receiving Medical Facility does not have the medical capability and available space, it may decline to accept any or all patients.

6. The Transferring Medical Facility will assist the Receiving Medical Facility in obtaining proper consents for care.

7. The Transferring Medical Facility will send to the Receiving Medical Facility at the time of transfer such identifying administrative, medical, and related information as may be necessary for the proper care of the transferred patients.

8. At the request of the Receiving Medical Facility, the Transferring Medical Facility shall make clinical and/or ancillary staff available to maintain continuity of care for the transferred patients at the Receiving Medical Facility's location. Such staff may accompany the patient(s) during transport, or other arrangements may be made between the facilities.

9. The Transferring Medical Facility will send with each patient at the time of transfer (or as soon thereafter as possible) patient records, medications (other than controlled substances), medical administration record (MAR), specialized treatment supplies, any information relevant thereto, and the patient's personal effects. In the event that personal effects cannot be sent with an alert and competent patient, the Transferring Medical Facility may elect to secure such personal effects until the crisis is over. The

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Transferring Medical Facility will remain responsible for such items until receipt thereof is acknowledged in writing by the Receiving Medical Facility.

10. This Memorandum of Understanding does not require a Transferring Medical Facility to transfer patients to any medical facility. The Transferring Medical Facility may transfer patients to facilities other than the medical facilities.
11. This Memorandum of Understanding does not require a Transferring Medical Facility to coordinate any or all evacuation or transportation activities through SeniorCare. The Transferring Medical Facility may elect to coordinate activities on their own, and/or utilize transportation assets of their own choosing and arrangement for either emergency evacuation or patient return.
12. The Receiving Medical Facilities may discharge patients in accordance with its standard procedures.
13. The Transferring Medical Facility agrees to readmit patients when services are restored at the Transferring Medical Facility.
14. The Transferring Medical Facility remains responsible for all notifications to, and communications with, the patient being evacuated and their emergency contact/family/responsible party. In addition, the Transferring Medical Facility is responsible for all notifications to local and governmental oversight agencies (e.g., New York City and State Departments of Health; New York City Office of Emergency Management).
15. All participants to this MOU agree to direct, manage, and conduct emergency operations in accordance with the principles of the Incident Command System (ICS) and National Incident Management System (NIMS).

***Miscellaneous***

- Any notices required or permitted to be given under this Agreement shall be sufficient if in writing, and either: (i) delivered personally, (ii) sent by registered or certified mail, return receipt requested, or (iii) sent by overnight courier, in each case to the addresses of the party to whom notice is to be provided as set forth hereinabove (it being understood that any such notice to any party shall be to the attention of the Emergency Management Coordinator or designee).
- Except as may be required by Federal law and regulations applicable to Federal facilities, the laws of the State of New York shall govern this Memorandum of Understanding. Any action relating to this Agreement shall be brought in a court of the State of New York in the County of occurrence. Any changes in the governing laws, rules, and regulations during the terms of this MOU shall apply, but do not require an amendment.
- The invalidity of any provision of this Memorandum of Understanding shall not affect the validity of the remainder hereof.
- This Memorandum of Understanding represents the entirety of the agreement of the parties with respect to the subject matter hereof and may not be amended except by written instrument signed by the affected parties.

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- If any provision of this Agreement or the application of any provision hereof to any person or circumstances is held invalid, it shall be deemed stricken from this Agreement, and the remainder of this Agreement shall not be affected unless the invalid provision substantially impairs the benefits of the remaining portions of this Agreement.
- The parties hereto agree that they will not discriminate against any patient affected by this Memorandum of Understanding on the basis of race, age, creed, color, sex, national origin, inability to pay, or disability.
- Nothing contained herein is intended to permit practitioners who have not been granted privileges to practice within a particular medical facility the right to practice therein without first having obtained clinical privileges from the medical facility in accordance with its customary procedures. Each medical facility, however, agrees to work cooperatively to ensure the patient care is not unduly interrupted, and will work to coordinate care between their respective medical staffs, or to grant temporary privileges to practitioners pursuant to its standard procedures.
- All headings and captions in this Agreement are for convenience only. They shall not be deemed part of this Agreement and shall in no way define, limit, extend or describe the scope or intent of any provisions hereof.
- The parties shall execute and deliver all documents, provide all information and take or forbear from all such action as may reasonably be necessary or appropriate to achieve the purposes set forth in this Agreement.
- Nothing herein shall prohibit a participating medical facility from obtaining the use of emergency medical transportation services for the purposes set forth herein from any other person or entity.
- This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, executors, administrators, successors and permitted assigns.

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IN WITNESS THEREOF, the parties hereto have executed this agreement on the day and year first written above.

Charles-Edouard Gros
By: Administrator (title)
Fairview Nursing Care Center
Date: 12-1-05

Amir Abramchik
By: Amir Abramchik (title) Administrator
Queens Center for Rehabilitation and Residential Health Care
Date: 12-2-05

Jeff Sicklick
By: Jeffrey Sicklick (title) Administrator
Bronx Center for Rehabilitation and Residential Health Care
Date:

Sol Blumenfeld
By: SOL BLUMENFELD (title) ADM.
Williamsbridge Nursing Home
Date: 12/15/05

Avi Katz
By: Associate Administrator (title)
University Nursing Home
Date: 12/8/05

Jason Newman
By: Director of Operations (title)
Bronxwood Home for the Aged
Date: 12/1/05

Michael Vatch
By: Chief Executive Officer
SeniorCare Emergency Medical Services, Inc.
Date:

Adina Pelman, PhD.
By: (title)
Union Plaza Care Center
Date:

Brian Glattstein
By: Administrator (title)
Greenpark Care Center
Date: 12-12-05

Howard Wolf
By: ADM (title)
Grand Manor Nursing and Rehabilitation Center
Date: 12/1/05

Administrator

Eli Grinspan
By: (title)
Split Rock Rehabilitation and Health Care Center
Date: 12/14/05

Chaim Lipschitz
By: ADMINISTRATOR (title)
Haym Solomon Home for Nursing and Rehabilitation
Date: 12/12/05

Helene Stern
By: (title)
Pelham Parkway Nursing Home
Date:

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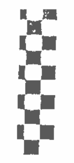

*Upstate Dairy Farms Corp.*
*54 Walworth St.*
*Brooklyn, NY 11205*
*Phone-718-488-0700 Fax-718-488-0795*
*info@upstatedairy.com*

March 16, 2010

Union Plaza Care Center
33-23 Union St.
Flushing N.Y. 11354

Union Plaza Care Center and Upstate Dairy Farms (Golden Flow) enter into an agreement that in event of an emergency, Golden Flow will deliver necessary potable water in one (1) gallon containers, as long as it is necessary, in order to meet the needs of the resident population.

Golden Flow will deliver water within a four- (4) hour time period, after notification, seven days a week.

Sincerely,

Marton Guttman

Marton Guttman
President

Meyers Emergency Management, Inc.
160-04 Cross Bay Blvd
Howard Beach, NY 11414 US
833-636-4030
www.meyersem.com

**ADDRESS**
Lennox White
Union Plaza Care Center
33-23 Union Street
Flushing, New York 11354
United States of America

**SHIP TO**
Lennox White
Union Plaza Care Center
33-23 Union Street
Flushing, New York 11354
United States of America

## Scope of Work 1006

**DATE** 12/30/2019

**EXPIRATION DATE** 01/31/2020

| DATE | ACTIVITY | DESCRIPTION | QTY | RATE | AMOUNT |
|---|---|---|---|---|---|
| 01/01/2020 | **Blue Can Emergency Drinking Water - Pallet** | Pallet (2,400 cans/225 gallons) of Blue Can emergency drinking water. Blue Can features a 50 year shelf-life, and is provided on stackable pallets to save space. | 3 | 2,695.00 | 8,085.00T |

Thank you for considering Meyers Emergency Management to handle your emergency and disaster related needs. With this email, please find your estimate for services.

We are happy to discuss the estimate for services with you. Please contact your Emergency Management Consultant for a detailed discussion regarding your estimate.

We look forward to working with you!

Patrick S. Meyers
President
Meyers Emergency Management, Inc.

| | |
|---|---|
| SUBTOTAL | 8,085.00 |
| TAX | 788.54 |
| DISCOUNT | -885.00 |
| SHIPPING | 800.00 |

**TOTAL** **$8,788.54**

Accepted By *Aleizah Petman*

Accepted Date 1/1/20

# Emergency Management Institute

# FEMA

**This Certificate of Achievement is to acknowledge that**

**JOHN F. KERNEY**

**has reaffirmed a dedication to serve in times of crisis through continued professional development and completion of the independent study course:**

**IS-00195**
**Basic Incident Command System**

*Issued this 17th Day of August, 2005*

1.0 CEU

**Stephen G. Sharro**
*Director, Training Division*

**Kaiser Permanente**
Emergency Management

**Hazards - SITE & ADDRESS**
**Hazard Vulnerability Assessment Tool**

| Alert Type | PROBABILITY | ALERTS | ACTIVATIONS | SEVERITY = ( MAGNITUDE - MITGATION ) | | | | | | RISK |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS | INTERNAL RESPONSE | EXTERNAL RESPONSE | |
| | Likelihood this will occur | | | Possibility of death or injury | Physical losses and damages | Interuption of services | Preplanning | Time, effectiveness, resources | Community/Mutual Aid staff and supplies | * Relative threat |
| SCORE | 0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High | Number of Alerts | Number of Activations | 0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High | 0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High | 0 = N/A<br>1 = Low<br>2 = Moderate<br>3 = High | 0 = N/A<br>1 = High<br>2 = Moderate<br>3 = Low | 0 = N/A<br>1 = High<br>2 = Moderate<br>3 = Low | 0 = N/A<br>1 =High<br>2 = Moderate<br>3 = Low | 0 - 100% |
| Active Shooter | 0 | 0 | 0 | 3 | 3 | 1 | 2 | 2 | 1 | 0% |
| Act of Terrorism | 1 | 0 | 0 | 1 | 3 | 1 | 3 | 3 | 1 | 13% |
| Air Quality Issue | 3 | 0 | 0 | 1 | 0 | 0 | 2 | 2 | 0 | 17% |
| Bomb Threat | 1 | 0 | 0 | 3 | 2 | 3 | 3 | 2 | 1 | 16% |
| Building Move | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 3% |
| Chemical Exposure, External | 1 | 0 | 0 | 3 | 2 | 1 | 3 | 2 | 2 | 14% |
| Chemical Exposure, Internal | 1 | 0 | 0 | 3 | 2 | 1 | 3 | 2 | 2 | 14% |
| Chemical Spill | 1 | 0 | 0 | 2 | 2 | 1 | 2 | 2 | 1 | 11% |
| Child Abduction | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Civil Unrest / Protesting | 1 | 0 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 13% |
| Communication / Telephony Failure | 3 | 0 | 0 | 0 | 0 | 3 | 2 | 2 | 2 | 30% |
| Dam Failure | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Drought | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Earthquake | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 3 | 2 | 10% |
| Epidemic | 3 | 0 | 0 | 3 | 0 | 3 | 1 | 1 | 1 | 30% |
| Evacuation | 1 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 1 | 8% |
| Explosion | 1 | 0 | 0 | 3 | 3 | 3 | 2 | 2 | 2 | 17% |
| Fire, External | 1 | 0 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 13% |
| Fire, Internal | 2 | 0 | 0 | 2 | 3 | 3 | 2 | 2 | 2 | 31% |
| Flood, External | 2 | 0 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 27% |
| Flood, Internal | 2 | 0 | 0 | 1 | 2 | 2 | 2 | 2 | 2 | 24% |
| Forensic Admission | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Gas / Emmissions Leak | 1 | 0 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 13% |
| Generator Failure | 1 | 0 | 0 | 2 | 1 | 3 | 2 | 1 | 1 | 11% |
| Hostage Situation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Hurricane | 2 | 0 | 0 | 1 | 2 | 2 | 3 | 3 | 3 | 31% |
| HVAC Failure | 2 | 0 | 0 | 0 | 0 | 1 | 3 | 2 | 1 | 16% |
| Inclement Weather | 3 | 1 | 0 | 1 | 2 | 2 | 1 | 1 | 2 | 33% |
| Infectious Disease Outbreak | 2 | 1 | 0 | 2 | 1 | 2 | 1 | 1 | 1 | 22% |
| IT System Outage | 3 | 0 | 1 | 1 | 1 | 3 | 2 | 2 | 2 | 41% |
| Landslide | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Mass Casualty Incident - Hazmat | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Mass Casualty Incident - Medical | 1 | 0 | 0 | 3 | 1 | 2 | 1 | 1 | 1 | 10% |
| Mass Casualty Incident - Trauma | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Medical Gas Disruption | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Natural Gas Disruption | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Pandemic | 1 | 0 | 0 | 2 | 1 | 3 | 1 | 1 | 1 | 10% |
| Patient Elopement | 2 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 3 | 20% |
| Patient Surge | 1 | 0 | 0 | 1 | 1 | 3 | 3 | 2 | 2 | 13% |
| Picketing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Planned Power Outage | 1 | 0 | 0 | 1 | 1 | 2 | 2 | 2 | 2 | 11% |
| Power Outage | 2 | 0 | 0 | 1 | 2 | 3 | 2 | 2 | 2 | 27% |
| Radiation Exposure | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Seasonal Influenza | 3 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 2 | 27% |
| Sewage Failure | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 3 | 1 | 7% |
| Shelter in Place | 2 | 0 | 0 | 1 | 2 | 2 | 2 | 2 | 2 | 24% |
| Strikes / Labor Action / Work Stoppage | 1 | 0 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 13% |
| Suicide | 1 | 0 | 0 | 3 | 0 | 0 | 1 | 1 | 1 | 7% |
| Supply Chain Shortage / Failure | 1 | 0 | 0 | 2 | 1 | 2 | 3 | 3 | 2 | 14% |
| Suspicious Package / Substance | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 3 | 11% |
| Temperature Extremes | 2 | 0 | 0 | 1 | 2 | 2 | 2 | 2 | 2 | 24% |
| Tornado | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Transportation Failure | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 2 | 10% |
| Trauma | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Tsunami | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Utility Failure | 1 | 0 | 0 | 0 | 0 | 2 | 2 | | 2 | 7% |
| VIP Situation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0% |
| Water Contamination | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 2 | 10% |
| Water Disruption | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 2 | 10% |
| Weapon | 2 | 0 | 0 | 2 | 1 | 2 | 2 | 2 | 2 | 24% |
| Workplace Violence / Threat | 1 | 0 | 0 | 1 | 1 | 2 | 2 | 2 | 2 | 11% |

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Continuity of Operations (COOP)[1] | |
| **Policy Date:1/2/2018** | **Policy Revision:** Revision Date **1/2/2018, Reviewed 1/29/2024** |

**Purpose:**
It is the policy of to restore essential functions as rapidly as possible following an emergency that disrupts those essential functions. As soon as the safety of residents, visitors, and staff has been assured, the nursing home will give priority to providing or ensuring resident care.

**Continuity of Operations Goals and Planning Elements**

Union Plaza Care Center will take the below actions to increase its ability to maintain or rapidly restore essential functions following a disaster to ensure patient, visitor and personnel safety. (See Appendix for Essential Functions)

1. Develop, train on and practice a plan for responding to internal emergencies and evacuating the nursing residents, staff and visitors when the facility is threatened. See Appendix for Evacuation & Alternate Location Map.

2. Provide continuous performance or rapid restoration of the nursing home's essential functions during an emergency. This includes plans to obtain needed medical supplies, equipment and personnel. See Appendix for External Contact List.

3. To the extent possible, protect medical records from fire, damage, theft and public exposure. If the nursing home is evacuated, provide security to ensure privacy and safety of medical records.

4. Protection of vital records, data and sensitive information

    - Ensure offsite back-up of financial and other data.
    - Store copies of critical legal and financial documents in an offsite location.
    - Protect financial records, passwords, credit cards, and other sensitive financial information.
    - Update plans for addressing interruption of computer processing capability.
    - Maintain a contact list of vendors who can supply replacement equipment.
    - Protect information technology assets from theft, virus attacks and unauthorized intrusion.
    - Protect medical and business equipment

5. Compile a complete list of equipment serial numbers, dates of purchase and costs. Provide Appendix list to the Comptroller and store a copy offsite via external hardrive or other means necessary.

- Protect computer equipment against theft through use of security devices.
- Use surge protectors to protect equipment against electrical spikes.
- Place fire extinguishers near critical equipment, train staff in their use, and inspect according to manufacturer's recommendations.

6. To the extent possible, staff will be cross-train to perform the essential functions. This will ensure multiple staff will be capable of carrying out the essential functions in the absence of staff shortage.

# Emergency Management Staff Training Strategy Tool

| Emergency Preparedness Training Topic | Main Concepts of Training | Staff Who Will Receive Training | Frequency of Training | Method of Training | Has the Curriculum been completed for this Training (Yes / No) |
|---|---|---|---|---|---|
| • What emergency preparedness concepts will your site provide training to staff about?<br><br>• Record trainings currently offered to staff and new trainings that must be offered.<br><br>• Consider topics such as fire and life safety, staff personal preparedness, Incident Command System team, general emergency preparedness, clinical emergency preparedness, emergency communications, N-95 respirator. | What are the main concepts and competencies that this training will address? | Which staff will be required or offered the training? | How often will the training take place? What do statutes, accreditations, or organization policies require or recommend? | What methods will your site utilize to provide training on this topic? Consider topic, availability of internal & external resources, number of staff who require training, frequency of training, and available curriculum resources.<br><br>Commonly used methods for staff training include group trainings, videos, online trainings, pre & post-test, and posters. | What external resources can be leveraged for this internal training? (E.g. Ready NY, NYC DOHMH, NHTAS, NY SDOH, PCDC Pilot Project material) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Use this tool to assist in planning and prioritizing emergency preparedness staff training activities at your Nursing Home. The first row contains questions designed to help utilize the chart, and your site's emergency preparedness staff training strategy can be recorded in the blank rows below.

# Emergency Management Training Guide

## Purpose

The purpose of this guide is to describe essential elements of an emergency management training program.

## Desired Outcomes

There are three major outcomes that your nursing home should expect to obtain as a result of the trainings:

- Staff will perform effectively in protecting the health and safety of Residents, staff, visitors, family, property and the environment;
- Staff will be prepared to work effectively with other emergency response and recovery organizations, by appropriate and timely use of resources, and by recovery of damages and operating costs, to the extent possible; and
- Staff will work in a safe manner to prevent injury to themselves and others.

## Evaluation of Training Effectiveness

Formal training requires evaluation so that the Nursing Home can be assured of the program's effectiveness and modifications can be made as needed. The Nursing Home shall provide some minimum evaluation instruments for each formal classroom experience to ensure the objectives of the course(s) have been achieved. Exercises, which by definition will have some form of evaluation as a formal record of the activity (HSEEP).

Additional measurement devices are used after exercises in the form of critiques, After Action Reports (AARs) and Improvement Plans (IPs). External audits to be used as a tool to evaluate the total training curriculum effort.

## Maintaining Training Records

A record must be kept of any training methodology that was performed for the Nursing Home, including who received the information and the results of any evaluation. Records of required training elements and participation must be kept with the individual's in-service record.

## Curriculum

Will include reading assignments, briefings, classroom instruction (with or without examinations), videotapes, online instruction and or demonstrations.

1. Emergency manual
2. Attend drills
3. FEMA website training
4. Homeland Security website training
5. Yonkers CERT training
6. Other added items as defined during drill after action reports.

### I. Reading Assignments

The reading assignment shall be accompanied with a "read and sign" sheet to be returned to the Administrator or Department Head. This will be copied and archive in Human Resources. The staff assigned to read materials will also keep a copy of the "read and sign" sheet for their personnel files.

### II. Briefings

Briefings provide precise instructions or essential information. They often involve fewer individuals than would be featured in classroom presentations. Sometimes a briefing is for a specific individual. There must be compelling reasons to hold briefings. These can include:

- Changes that require immediate awareness and change of behavior
- Warnings regarding impending threats to safety, health, the environment, or property
- Updates on current issues that can impact staff morale
- Directives from the Administrator or Department Head that require immediate attention
- Updates on information that a staff was not able to acquire because of a missed training opportunity—this fulfills a legal requirement to keep all of the organization properly trained in accordance with their assigned training curriculum

### III. Classroom Instruction

Classroom instruction provides an environment for transmitting information that can become acquired knowledge to the participant. Some classroom instruction can be provided by specialized training organizations. Some of these organizations can come

directly to the nursing home. Other training organizations may require staff to travel to another site. Training can be provided through such diverse organizations as:

- New York State Department of Health
- Nursing Home Trade Association
- Yonkers Department of Health & Mental Hygiene
- Yonkers Office of Emergency Management
- The Federal Emergency Management Agency (FEMA), Emmetsburg, Maryland
- The American Red Cross (ARC) through its local chapter
- Local colleges and universities specializing in emergency management courses

[1] FEMA Independent Studies can be assessed at http://training.fema.gov/IS/crslist.aspx

## IV. Videotape

The Nursing Home should keep an emergency management videotape/digital library for staff. The videos should include:

- Recordings of classroom presentations held recently
- Overview of Incident Command System
- EOC facility layout and operations
- Public Information
- Other specific interests as noted by staff (e.g. specific hazards, command and control, evacuation

Videotapes cannot be used to replace formal training requirements such as classroom training, drills and exercises.

## V. Online Instruction

The nursing home can post emergency management, self-guided training on its website for its staff. This can include short video presentations and Power Point slide shows. Other formal, accredited courses can be taken online through FEMA's website[1]. This training does not replace required formal nursing home classroom, drill, or exercise activities.

## VI. Demonstrations

Demonstrations develop skills for a limited function. This helps staff perform properly in drills, exercises and actual events. Typical demonstrations for the nursing home include:

- Use of computers along with software in the Emergency Operations Center (EOC)
- Use of fax machines and copiers (including electronic faxing and scanning of documents)
- Set up of the EOC or set up of a triage or isolation area
- Practice drills

## Multi-Year Training & Exercise Plan (TEP)

The purpose of the TEP is to document the NH's overall training and exercise program priorities for a specific time period. Items to consider when developing the TEP:

1. Enter all the participating community partners on the left side of the schedule.
2. Enter trainings and exercises by month indicating the type of training or exercise and intended audience.

**YEAR - ____**

| Organization | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Organization 1 (E.g. Local Hospital) | | | | | | | | | | | | |
| Organization 2 | | | | | | | | | | | | |
| Organization 3 | | | | | | | | | | | | |
| Organization 4 | | | | | | | | | | | | |
| Organization 5 | | | | | | | | | | | | |

Unit: ____________

____________________
(COMPLETED BY)

Date Last updated: __________

| | DNR | DNH | AMBULATORY | WALKER | CANE | WHEELCHAIR | RECLINER | 1 ASSIST | 2 ASSIST | HOYER LIFT | WANDERGUARD | SP TUBE | FOLEY CATHETER | PACEMAKER | NEBULIZER TX | O2 USE | IV FLUIDS | DIALYSIS | AMPUTEE | VERBAL | ALERT X 0 1 2 3 | CONFUSED | NPO | HONEY CONSIST | NECTAR CONSIST | DIABETIC | TUBE FED | FLUID RESTRICT | LANGUAGE<br>E=ENGLISH<br>K=KOREAN<br>C=CHINESE<br>SP=SPANISH<br>G=GREEK<br>R=RUSSIAN<br>GER=GERMAN<br>Y=YUGOSLAV |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 05A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 06A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 07A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 07B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 08A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 08B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 09A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 09B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Unit: ________________

________________________
(COMPLETED BY)

Date Last updated: __________

| | DNR | DNH | AMBULATORY | WALKER | CANE | WHEELCHAIR | RECLINER | 1 ASSIST | 2 ASSIST | HOYER LIFT | WANDERGUARD | SP TUBE | FOLEY CATHETER | PACEMAKER | NEBULIZER TX | O2 USE | IVFLUIDS | DIALYSIS | AMPUTEE | VERBAL | ALERT X 0 1 2 3 | CONFUSED | NPO | HONEY CONSIST | NECTAR CONSIST | DIABETIC | TUBE FED | FLUID RESTRICT | LANGUAGE<br>E=ENGLISH<br>K=KOREAN<br>C=CHINESE<br>SP=SPANISH<br>G=GREEK<br>R=RUSSIAN<br>GER=GERMAN<br>Y=YUGOSLAV |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Contact List Policy | |
| **Policy Date:** | **Policy Revision:** Revision Date 1/13/17<br>**Policy Reviewed:** 1/29/24 |

**Purpose:**
To ensure that essential personnel contact records are readily available to support continuity of care during emergency.

**Policy:**
The Facility shall maintain records available until all its patients have been evacuated and its operations cease. The contact information shall be updated as required to keep current.

Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians

(iv) Other facilities.

(v) Volunteers.

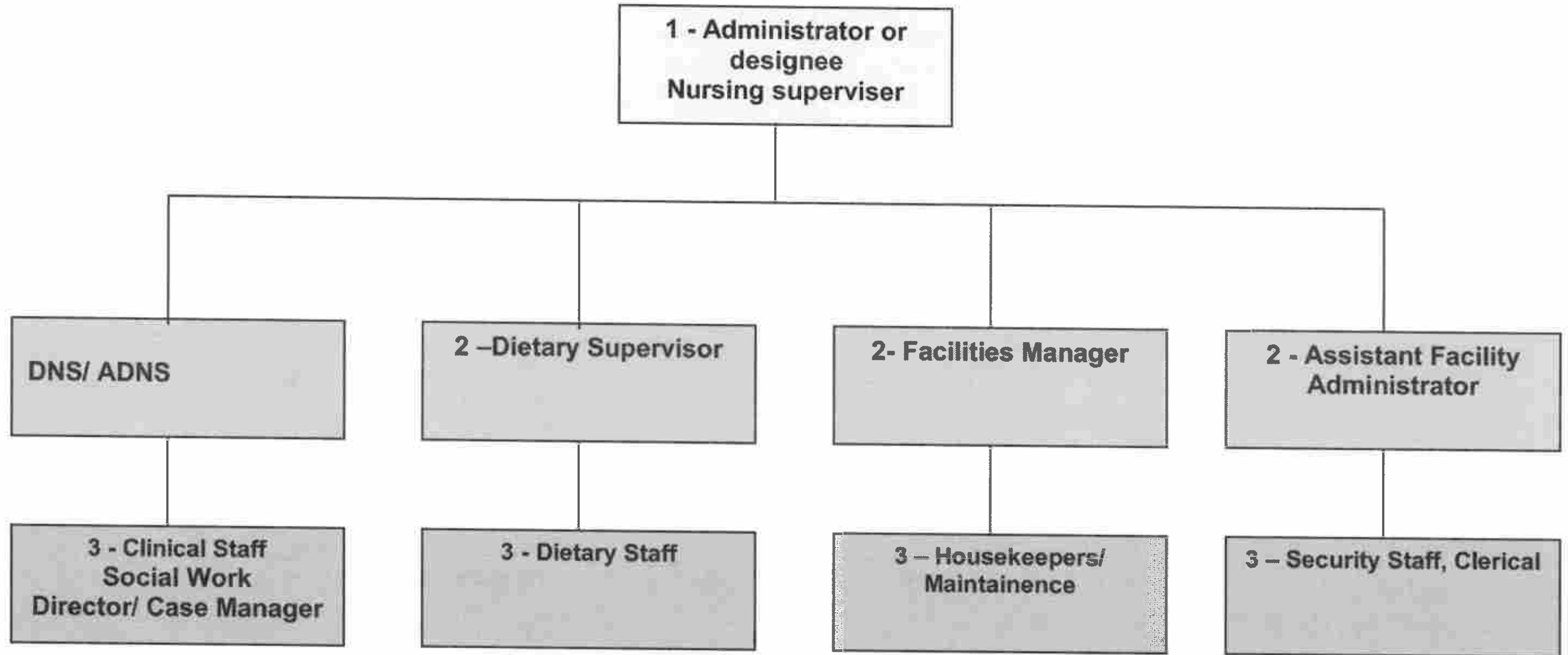
(vi) Next of kin, guardian, or custodian.

(vii) Volunteers.

**Procedure:**

1. Staff contact shall be updated on the time clock system which is accessible via the internet.
2. Service companies shall be listed on the following attachment.
3. Physicians will be noted in the medical record and a list with alternates maintained in the nursing office.
4. Facilities with transfer arrangements shall be listed on the attachment
5. Next of kin shall be kept by social service and in the medical record.
6. The Volunteers list is maintained by the recreation department, those reporting as CERT volunteers will listed in the NHICS logistics sign in.

## Phone Tree




*A phone tree is one method of contacting staff to provide them with critical message prior, during or after an emergency or disaster. Staff members are contacted in the order shown in the diagram above. To begin the phone tree, the top member of the tree (shown in green) contacts the first members of the tree (in pink), and they in turn contact those individuals on their phone tree list (shown in purple). If a first member (in pink) is not reached, the top member of the tree (in green) must contact those on that branch of the tree (in purple) in the first member's absence.*
*The top members of the tree (in green and pink) must have all of the contact numbers for the entire tree in the event that they are asked to assist in calling another branch of the tree.*

**Physician Information**

| |
|---|
| Hong, Jae Kwang<br>Tel. 718-886-5252<br>Cell. 718-838-0642<br>Jaekhong2018@yahoo.com |
| Lowell, Bruce K.<br>Tel. 516-482-0091<br>Cell. 516-972-4728<br>brucelowellmd@gmail.com |
| Tolia, Jitendra N.<br>Tel. 718-429-4444<br>Cell. 917-683-2567<br>jntolia@gmail.com |
| Jaglall, Neil<br>Tel. 917-225-2165<br>Cell. 516-433-8106<br>neiljaglall@gmail.com |

# Union Plaza Care Center

33-23 Union Street, Flushing NY 11354 Tel: 718-670-0700 Fax: 718-670-0726

UPDATED 7/1/24

| Department | Contact | Ext. | Alternate Contact |
|---|---|---|---|
| **Administration** | Deborah Luongo, RN, Administrator | 721 | d.luongo@unionplazacarecenter.com |
| | Angelo Luongo, Asst. Administrator | 722 | a.luongo@unionplazacarecenter.com |
| | Simon Pelman, Exec. Officer | 723 | unionplazaceo@aol.com |
| | Jonathan Pelman, Chief Officer | 724 | j.pelman@unionplazacarecenter.com |
| | Esther Friedman, Exec. Dir. | 724 | |
| | Diana Badia, Exec. Secretary | 720 | d.badia@unionplazacarecenter.com |
| | **Administration Conference Room** | **725** | |
| | Andrew Liu, Concierge – (Chinese) | 792 | 917-992-8513 |
| | Abi Lee, Concierge – (Korean) | 792 | 646-628-4444 |
| | | | concierge@unionplazacarecenter.com |
| | | | Fax. 718-670-0726 ***Public Pay Phone Lobby*** 646-448-2985 |
| **Admission** | Chris Leong, Director | 713 | admissions@unionplazacarecenter.com |
| | Sung Joon (Cory) Lim, Admission Asst. | 714 | c.lim@unionplazacarecenter.com |
| | Chaochi Jenny Chung, Admission Asst | 790 | J.Chung@unionplazacarecenter.com |
| | | | Fax. 718-670-0701 |
| **Bookkeeping** | Moishe Lipschutz, Comptroller | 741 | m.lipschutz@unionplazacarecenter.com |
| | Sita Ramsundar, Bookkeeper | 745 | s.ramsundar@unionplazacarecenter.com |
| | Ka Yi (Dora) Hung, Bookkeeper | 740 | d.hung@unionplazacarecenter.com |
| | Elizabeth Ahn, Patient Fund/Bookkeeper | 744 | e.ahn@unionplazacarecenter.com |
| **Purchasing** | Esther Sabzon, Bookkeeper | 743 | bookkeeping@unionplazacarecenter.com |
| | Karen Kochner, Medicaid Coordinator | 748 | k.kochner@unionplazacarecenter.com |
| | Erin Reynolds, Account Receivable | 779 | e.reynolds@unionplazacarecenter.com |
| | | | Fax. 718-670-0742 |
| **Social Services** | SuJeong Park, Ph.D., MSW, Director | 711 | socialservices@unionplazacarecenter.com |
| | Clara S. Hahn, BA, SW | 712 | c.hahn@unionplazacarecenter.com |
| | Hezhen (Jane) Li, SW | 717 | h.li@unionplazacarecenter.com |
| | , SW | 710 | |
| | Binh (Christopher) Hong, MSW (Part-Time) | 715 | Fax. 718-670-0767 |
| | | | **Social Service emergency cell #** (646) 682-0203 |

| Diet[illegible]s | Julia Nam, MS, RDN, CDN<br>Chief Clinical Dietitian/Director | | j.nam@unionplazacarecenter.com |
|---|---|---|---|
| | Yu Ju (Teresa) Lee, MS<br>Chief Clinical Dietitian/Director | 755 | t.lee@unionplazacarecenter.com |
| | Yu-Hsin (Rosie) Wang, RD, RDN | 752 | yh.wang@unionplazacarecenter.com |
| **Dietary** | Christian Magnayon, Dir. of Food Services<br>Betty Colon, Assistant Dir. of Food Services<br><br>**Kitchen**<br>**Staff Dining Room** | 750<br>751/101<br><br>**101**<br>**100** | c.magnayon@unionplazacarecenter.com<br>b.colon@unionplazacarecenter.com<br><br><br>Fax. 718-670-0757 |
| **Central Supply** | Marvin Segundo | 124/119 | |
| **Recreation** | Larissa Tadjiev, Director<br>Esther Kim, Asst. Director<br>Catherine Scott<br>Elizabeth Cruz<br>**Staff Development Room, 9th floor**<br>**Recreation Room 9th floor**<br>**Solarium Room** | 760<br>761<br>761<br>761<br>**737**<br>**160**<br>**109** | larissat@unionplazacarecenter.com<br>e.kim@unionplazacarecenter.com |
| **Engineering** | Dennis R. Gericke, Director<br>Luis Saquicaray<br>Carlos Medrano<br>James Valdez | 777/778<br>777<br>777 | dennis@unionplazacares.com. Cell # 917-5668747 |
| **Housekeeping** | Eric Martinez, Assistant Director<br>David Seda, Supervisor | 759 | e.martinez@unionplazacarecenter.com |
| **Medical Director** | Dr. Neil Jaglall | Page | |

| | | | | |
|---|---|---|---|---|
| Nurs | Jennifer Kaiser, RN, DNS | [illegible] | c.garcia@unionplazacarecenter.com | |
| | Allana Murphy, RN, ADON | | a.murphy@unionplazacarecenter.com | |
| | Golda Fried, RN, Associate DNS | 763 | g.fried@unionplazacarecenter.com | |
| | Eryka Purcell, MDS Data Entry/HMO MLTC Coordinator | 735 | e.purcell@unionplazacarecenter.com | |
| | Youne (Esther) Kim, MDS | 754 | yh.kim@unionplazacarecenter.com | |
| | Dydre L. Edwards, Staffing Coordinator | 730 | dydrenursing@gmail.com | |
| | Natalia Granada, Transport Coord. | 739 | n.granada@unionplazacarecenter.com | |
| | Maria (Tec) Teresita Montemayor, RN, Infection Control/Inservice Coord. | 733 | m.montemayor@unionplazacarecenter.com | |
| | Erica Shiverick, Data Entry | 765 | e.shiverick@unionplazacarecenter.com | |
| | Marina Sandler, Risk Management | 719 | m.sandler@unionplazacarecenter.com | |
| | | | Fax. 718-670-0738 | |
| **MDS-Lower Lobby** | Gyoo Hwa Lee, RN., MSN, MDS Coordinator | 732/198 | mds@unionplazacarecenter.com | |
| | Han, Kum Mi, RN | 628 | k.han@unionplazacarecenter.com | |
| | Kim, Young RN, BSN | 198 | y.kim@unionplazacarecenter.com | |
| | Song, Hua, RN, BSN | 120 | h.song@unionplazacarecenter.com | |
| | | | | ***Public Pay Phones*** |
| **Unit 2** | **Dr. Jaglall /** Mrs. Yelena Rabiyera, RNS & Ms. Eunji Cho, RNS | 602/612 | Fax. 718-799-0085 | 2nd floor 646-448-2986 |
| **Unit 3** | **Dr. Hong** / Ms. Ying (Stella) Ni, RNS | 603/613 | Fax. 718-799-0091 | 3rd floor 646-448-2987 |
| **Unit 4** | **Dr. Jaglall** / Ms. Moxam, RNS | 604/614 | Fax. 718-799-0036 | 4th floor 646-448-2988 |
| **Unit 5** | **Dr. Lowell** / | 605/615 | Fax. 718-799-0069 | 5th floor 646-448-2989 |
| **Unit 6** | **Dr. Tolia** / Ms.Qing Han, RNS | 606/616 | Fax. 718-799-0035 | 6th floor 646-448-2990 |
| **Unit 7** | **Dr. Hung/** , RNS | 607/617 | Fax. 718-799-0046 | 7th floor 646-448-2991 |
| **Unit 8** | **Dr. Tolia** / Ms. Chun, C., RNS | 608/618 | Fax. 718-799-0034 | 8th floor 646-448-2992 |
| **Evening** | Ms. Ding, RNS 3-11 | | Page | |
| | Ms. Vanessa Lacar, RNS – 3-11 | | | |
| **Night Spvr. Wknd 7/3-3/11** | Ms. Won Jeon, RNS 11-7 | | | |
| | Mr. Ramesh Kumar, RNS | | | |
| **Dialyze Direct Lower Level** | Dr. Mourhege Alsaloum | 788 | In-House | |
| | Dr. Chaim Charytan | | | |
| | Dr. Alla Goldberg | | | |
| **Nephrology Associates, P.C** | Dr. Sheng Kuo | | | |
| | Dr. Nishita Parikh | | | |
| | Dr. Ritesh Raichoudhury | | | |

| | Dr. Bruce Spinowitz | | |
|---|---|---|---|
| **Dentist** | Dr. Schevon, Michael | 123 | On-Call |
| **Audiologist** | | 120 | On-Call |
| **Beauty Parlor**<br><br>**Covid-19 Swabbing station** | | 120<br><br>774 | |
| **Rehab** | Dr. CK Lee, Rehab Director<br>Catherine B. Zamora, RPT<br>Martin Cayabyab, OTR/L<br>Angela Ward, NOMNC Discharge Mgr.<br>**Rehab Gym** | 771<br>771<br>770<br>770/126<br>**126** | Fax. 718-670-0784 |
| **Speech Therapist** | Ji Su Sung, Speech-Language Pathologist<br>Abigail Michalak, Speech-Language Pathologist | 776<br><br>772 | |
| **Medical Record** | Ora Nisanov, Director<br>Natalia Granada, Medical Record Asst. | 758<br>739 | medicalrecords@unionplazacarecenter.com |
| **Clinical Psych Associates Group** | Weizhen Yu, Ph.D.<br>. | 773 | |
| **Psychiatry** | Seok Cheol Ahn, Ph.D., M.D. (Korean)<br>Louisa LH Chan, NP (Chinese)<br>**To contact Chinese Psychiatry call Brighid Gannon, NP 718-757-0684** | | (c) 917-863-3224 |
| **Physiatry-National Health Rehabilitation** | Xiaolin (Selena) Zheng, MD, DABRM, MS | | (c) 917-770-6929<br>(o) 201-654-6397<br>Tues/Fri- In-House |
| **PharmScript** | Michael Segal, Executive VP of Operation | | (o) 888-319-1818<br>(c) 908-720-0845 |

| | | | |
|---|---|---|---|
| **Pharmacist- Long Term Solutions** | Jodie Orphal, Pharmacist | | (c) 646-423-3348<br>Email: jorphal@ltsrx.com |
| **Laboratory Centers Laboratory - Bay Ridge** | 1412 Bay Ridge Avenue<br>Brooklyn, NY 11219<br>Yitzy Grinspan, Laboratory Administrator | | (o) 718-837-5222<br>(c) 516-717-7637 |
| **Patient Care Associates Inc.** | X-Ray-<br><br>Main Office:<br>141 Halstead Ave. Suite 302<br>Mamaroneck, NY 10543<br>Mr. Leonard J. Tanzer, President | | 914-777-7100<br><br>T. (914)377-4477<br>F. (914)377-4794 |
| **Oxgen Equip.** | Virtair- William Wasserman Sales Manager<br>115-58 Dunkirk Ave.<br>St. Albans, NY 11412 | | 718-847-8247 |
| **Unitex** | Laundry Services<br>Francisco, Sales Rep.<br>Raco, District Manager | | (o) 718-681-2966<br>(f) 718-293-9622 |
| **Towne Nursing Staff, Inc.** | David Greisman, President | | 718-998-4660 |
| **Five Star Nursing** | Nursing Staff Srvs. – Lillian Serano | | (o) 718-851-3800<br>(f) 718-851-3801 |
| **Temana Ambulette** | Roman | | 718-380-0580 |
| **Senior Care Ambulance**<br><br>**Main office** | Joseph Weiss<br>Customer Relations<br><br>Transportation/Dispatch<br>700 Havemeyer Ave.<br>Bronx, NY 10473<br>CEO: Michael Vatch | | (o) 718-430-1525<br><br><br>718-430-9700 |
| **H & R Healthcare** | Bernadette Forster, RN<br>Territory Manager<br>(Special Mattress) | | 800-801-5533<br>Ext. 151<br>732-367-5533 |

| Sup[illegible]rt Surfaces | | | Fax: 732-367-6231 |
|---|---|---|---|
| **Elevators Phone Numbers** | Elevator 1<br>Elevator 2<br>Elevator 3<br>Elevator 4 | 201<br>202<br>203<br>204 | |
| **Emergency Cell Number**<br><br>**Land-Line**<br><br>**Freight Elevator Area** | Located in Nursing Department<br><br>Located in the Administration Department<br><br>Telephone number | | 917-992-1302<br><br>347-732-9758 |

**Updated 4/5/2024**

UNION PLAZA CARE CENTER -

33-23 Union Street, Flushing, NY 11354 Tel: 718-670-0700 Fax: 718-670-0726

# EMERGENCY PREPAREDNESS

The Emergency Preparedness Plan shall be kept in: ADMINISTRATION (Lobby Level), DIRECTOR OF NURSING (Lobby Level), DIRECTOR OF MAINTENANCE (Lower Lobby) & the SECURITY DESK (Lobby)

| INTERNAL CONTACT LIST | | |
|---|---|---|
| Deborah Luongo | Administrator | Cell (917) 909-9709 |
| Angelo Luongo | Assistant Administrator | Cell (347) 287-7153 |
| Jennifer Kaiser | Director of Nursing | Cell (631) 819-2994 |
| Dennis Gericke | Director of Maintenance | Cell (917) 566-8747 |
| SuJeong Park | Director of Social Services | Cell (917) 609-9093 |
| Nursing Supervisor | All Shifts | Dial "O" Operator, or *2 Overhead Page |
| Eric Martinez | Director of Housekeeping | Cell (917) 846-6213 |
| Larissa Tadjiev | Director of Recreation | (718) 544-8299 |
| Christian Magnayon | Director of Food Services | (646) 352-2177 |

**Rev. July 24,2024**

| NAME | CONTACT PERSON | TELEPHONE # | FAX # |
|---|---|---|---|
| ALL SERVICE DAY & NIIGHT | JENINE | 516 – 378-1176 | |
| ABALINE | HERSHAL | 732 – 582-0200 | 732 – 596-1308 |
| BERTRAM | INDRA | 908 – 862-8200 ext. 2 | 815 – 377-3860 |
| BETTER PLASTIC | | 718 – 875-5555 | 718 – 875-5702 |
| DRISCOL | ROSA | 973 – 672-9400 ext. 119 | |
| GOLDEN FLOW | ACCT # 5041 | 718 – 400-0700 ext. 6 | 718 – 488-0795 |
| HERSEY'S ICE CREAM | BRANCH # 631 – 410-7250 ext. 105 | 631 – 462-0259 | 631 – 462-0753 |
| ISLAND WHOLESALE | DAN JR. | 631 – 434-2700 | 631 – 434-27777 |
| KIM CHI | SONGS | 347 - 728-2222 | |
| MIRON PRODUCE | | 718 – 378-5983 | |
| ND LABS | MIKE | 516 – 612-4900 | 516 – 504-0289 |
| PECHTERS | ANTHONY 718 – 749-8280 | 718 – 439-9600 | 718 – 439-9601 / 9109 |
| PETER'S WHOLESALE MEAT | | 718 – 659-6328 | 718 – 738-2986 |
| POMERANTZ SUPPLY | JASHUA POMERANTZ<br>WAREHOUSE | 718 – 207-5451<br>201 – 246-8800 | 201 – 246-8801 |
| RONBAR | | 718 – 937-6755 | 718 – 786-1109 |
| UNITEX | ACCT # 7688 | 718 – 324-5900 | |
| YORKVILLE | LARRY 917 – 539-7741 | 718 – 768-4848 | 718 – 768-0539 |

Rev. 2/17

# NHICS Order Succession Wo

Note: It is suggested that first and second tier be identified for all work shifts (Day/N

| NHICS Position | Shift | First Tier | |
|---|---|---|---|
| | | *Title* | *Contact Info* |
| INCIDENT COMMANDER | Day | | |
| | Night | | |
| Lisason Officer | Day | | |
| | Night | | |
| Public Information Officer | Day | | |
| | Night | | |
| Safety Officer | Day | | |
| | Night | | |
| Medical Director/Technical Specialist | Day | | |
| | Night | | |
| OPERATIONS SECTION CHIEF | Day | | |
| | Night | | |
| Resident Services Branch Director | Day | | |
| | Night | | |
| Admit/Transfer Branch Director | Day | | |
| | Night | | |
| Nursing Unit Leader | Day | | |
| | Night | | |
| Psychosocial Unit Leader | Day | | |
| | Night | | |
| [illegible] | Day | | |
| | Night | | |
| Dietary Unit Leader | Day | | |
| | Night | | |
| Environmental Unit Leader | Day | | |
| | Night | | |
| Physical Plant / Security Unit Leader | Day | | |
| | Night | | |
| PLANNING SECTION CHIEF | Day | | |
| | Night | | |
| Situation-Status Unit Leader | Day | | |
| | Night | | |
| Documentation Unit Leader | Day | | |

| | | | |
|---|---|---|---|
| | Night | | |
| **LOGISTICS SECTION CHIEF** | Day | | |
| | Night | | |
| Service Branch Director | Day | | |
| | Night | | |
| Support Branch Director | Day | | |
| | Night | | |
| Communications Hardware Unit Leader | Day | | |
| | Night | | |
| IT / IS Unit Leader | Day | | |
| | Night | | |
| Transportation Unit Leader | Day | | |
| | Night | | |
| Supply Unit Leader | Day | | |
| | Night | | |
| **FINANCE SECTION CHIEF** | Day | | |
| | Night | | |
| Time Unit Leader | Day | | |
| | Night | | |
| Procurement / Cost / Claims Unit Leader | Day | | |
| | Night | | |

# ksheet

ight/Weekends) within the Nursing Homes.

| Second Tier | |
|---|---|
| ***Title*** | ***Contact Info*** |
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| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Patient Record Policy | |
| **Policy Date:** | **Policy Revision:** Revision Date 1/13/17 |

**Purpose:**
To ensure that patient records are secure and readily available to support continuity of care during emergency.

**Policy:**
The Facility shall maintain medical records available until all its patients have been evacuated and its operations cease a system which can be transferred or connected to for continued patient care. In addition to any existing requirements for patient records found in existing laws, under this policy, does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this adds to such policies and procedures. Shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information.

**Procedure:**

1. The resident medical record shall be logged and transported with any transfer of the resident.
2. The facility EMR will be maintained on an offsite server with access control.
3. The Nursing HIPPA policy shall be followed.

**Survey Procedures**

**• Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or potential and actual donor for OPOs) information, and secures and maintains availability of records.**

**UNION PLAZA CARE CENTER**

**VOLUNTEERS**

**DEPARTMENTS: ALL**

**Policy:** In the event of an emergency or disaster, the facility may utilize volunteers to address staffing surges. The facility will ensure all volunteers meet the criteria for volunteering in a nursing facility.

Volunteers are a part of our facility team to promote quality of life for our residents.

**Procedure**

I. The nursing home shall also conduct a health status assessment of all volunteers whose activities are such that a health impairment would pose a risk to residents or personnel, in order to determine that the health and well-being of residents and personnel are not jeopardized by the condition ofsuch volunteers. The nursing home shall require the following of all personnel as a condition of volunteer affiliation:

- Complete an application, including a criminal background check
- Take a tour of the facility
- Review the guidelines for volunteers
- Introduction to staff and/or residents
- Provide a physical that includes a PPD test (facility will provide if needed).
- Orientation that includes Residents Rights/Abuse Prevention, HIPPA guidelines, Infection Prevention and Control. Communication, as well as any other In-services needed.

II. Volunteer Health Care Professionals

- The facility will locate the Health Professionals' information on the state Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to ensure appropriate licenses, credentials, accreditations and privileges.
  - https://www.phe.gov/esarvhp/Pages/about.aspx
- Individuals who may be deployed under this provision may include:
  - Advanced practice nurses, Registered nurses and Licensed practical nurses
  - Behavioral health professionals
  - EMTs and paramedics
  - Physicians
  - Pharmacists
  - Medical and clinical laboratory technicians
  - Respiratory therapists
- Based on the individual's license and credentials, they may perform healthcare-related tasks within their scope of practice as designated by the Medical Director and/or Director ofNursing.

III. Non-Medical Volunteers

- Volunteers will report to the Volunteer Staging Area where they will receive instructions from the Administrator and/or Director of Nursing

## The Following is a guide for Nursing Home volunteers.

1) **Residents' Right to Privacy:**
   a) Medical and personal care are private. Volunteers must respect the privacy of a resident at all times. Confidentiality is a requirement under HIPPA and is an important component of our facility's commitment to resident care.
   b) If deemed necessary, access to residents' medical records will be granted **only** volunteer healthcare professionals.

2) **Resident Safety**
   a) If you see a fire, activate the nearest fire alarm. If an alarm occurs then you are to follow staff guidance for resident safety.
   b) If a resident falls while in the building, have the resident to remain in their current position and call out for assistance. Stay with the resident and wait for a staff member. Do not attempt to move the resident.
   c) At no time is a volunteer to move, reposition, or take a resident to the bathroom.
   d) Nursing must be notified to assist the resident with any personal care. A volunteer must call for assistance from nursing staff for any and all resident care.
   e) Do not give a resident food or drink, whether or not they ask for something specific, without asking the resident's nurse first.

3) **Infection Control**
   a) Use proper hand washing and sanitizing techniques at all time. This is as much a protection for you as it is for our residents.
   b) Hand sanitizer is available throughout the nursing home. Use it as often as needed.
   c) If any type of Personal Protective Equipment (PPE) is needed the RNS will inform any volunteer. As part of orientation hand hygiene, use of PPE and Transmission Precautions will be in serviced

4) **Volunteer Guidance:**
   a) Dress code for volunteers is business casual.
   b) Volunteers will wear a nursing home provided name badge while volunteering.
   c) If you are unable to work your shift, and/or have questions/concerns please contact the Activities Director, if unavailable, or it is outside of normal business hours, please ask the receptionist to direct your call to voicemail.

# UNION PLAZA CARE CENTER

## e-FINDS
## Evacuation of Facilities in Disasters System

POLICY:
It is the policy of Union Plaza Care Center that in the event the NYSDOH activates the use of the e-FINDS Scanner and Wristbands system, Union Plaza will implement the additional tracking of the location of our residents while evacuating our residents.

PROCEDURE:
Once the Disaster Plan has been initiated by Administration and/or the NYSDOH - the designated on-site Supervisor will:

1) Contact the NYSDOH Duty Officer at 866-881-2809 and inform them of the initiation of the "Evacuation" and/or utilize the NYC OEM Emergency Radio (kept at the front desk) to inform the NYC OEM of the initiation of a facility-wide evacuation.

2) The hand-held SCANNER & WRISTBANDS will be stored in a brown box in the Nursing Suite. It will be brought up to the identified unit by a staff member designated by the Administrator/ DNS/Designee.

3) The Hand Held Scanner will be connected to the laptop kept in the nursing suite.

4) In addition to the use of the scanner and Wristbands - the "RESIDENT EVACUATION IDENTIFICATION TAG" Form will also be used and completed to keep a hard copy log (see attached).

## Evacuating Facility: Generates Barcoded PDF Log OR Uploadable Barcode Spreadsheet

**e-FINDS Administrator Role Only**

1. Click **Manage Barcodes > Generate Barcodes Spreadsheet.**
2. Select or verify the current location.
3. Enter Start and End barcode numbers, e.g., 4—13 for ten patient/residents to be relocated.
4. Select the PDF if you want a scannable barcode log OR select EXCEL for the upload patient/resident option.
5. Click **Generate.**
6. Print the PDF OR save the Excel spreadsheet to your computer.

**Note:** PDF files cannot be uploaded, but could be sent with transport. The Excel file can be updated with patient/resident information and uploaded to e-FINDS. See upload instructions below.

## Evacuating Facility: Uploads Multi Patient/Resident File

1. Click **Register Patient/Resident > Patient/Resident Upload File.**
2. Verify the Evacuation Operation and current Location.
3. Click **Browse.**
4. Locate the Excel file with **saved** patient/resident information. Hint: search for nys_e-FINDS file name with facility id, date and time.
5. Click **Open** to add file.
6. Click **Upload.**
7. Verify the patient/resident information is updated, and edit information as needed.
8. Click **Save All Patients/Residents.**

**Note:** If the Excel file has no patient or resident information, then the file cannot be uploaded.

## Shelter-in-Place (SIP)

If an evacuating facility determines that a patient or resident would be safer if **not** moved to another location, then the patient or resident will shelter in place. If the patient or resident is already registered in e-FINDS, then click Shelter-In-Place to change the Intended Destination to the current location.

## Quick Search

1. Click **Home** on the e-FINDS menu bar.
2. Scan a barcode, enter a barcode number, OR enter first or last name in Quick Search (located top right). If necessary click **Quick Search.**
3. Locate the correct patient/resident record.
4. Click the Barcode (Serial ID) link.
5. Verify: Patient/Resident is found. You can update the information.
6. View, Add, or change the necessary information.
7. Click **Update Patient/Resident.**

**If a person has never been to your facility, you will NOT be able to search for them.**

## Receiving Facility: Updates Patient/Resident with Scanner

1. Click **Update Patient/Resident > With Scanner**
2. Scan a barcode and click **Submit,** if necessary.
3. Confirm message: Barcode is located. You can register new Patient/Resident with it OR Patient/Resident is found. You can update the information.
4. Enter or confirm information, including Evacuation Operation and the current patient/resident location.
5. Click **Register**, **Update,** or **Override.**
6. Confirm message: Patient/Resident info is updated.

## Receiving Facility: Updates Patient/Resident without Scanner

1. Click **Update Patient/Resident > Multi Patient/Resident Update.**
2. Verify your location.
3. Select **Checking in Patients/Residents into this location.**
4. Verify the patient or resident is correct.
5. Click **Select All** OR **Update** for each patient or resident being received.
6. Click **Check in Selected Patient/Resident.**
7. Confirm Message: Successfully updated {correct #} of Patient/Resident.

# FINDS Evacuation of Facilities in Disaster Systems

## Getting Started

The **e-FINDS** Data Reporter and **e-FINDS** Administrator role have access to the patient tracking application. From the **My Account** link, on the menu bar (top right) of the Health Commerce System (HCS), click See what roles I hold to verify that you are in one of the e-FINDS roles. If you are not in an e-FINDS role, please contact your facility's HCS Coordinator. Locate your coordinators from **My Account** > Look up my coordinators. Click Update or verify my contact information to access and update your business and emergency contact information to receive communications.

## Open e-FINDS

1. Log on to the HCS (https://commerce.health.state.ny.us). If you cannot remember your user id or password, please call Commerce Accounts Management Unit at 1-866-529-1890.
2. Click **e-FINDS** in the **My Applications** panel (left side). If you do not see e-FINDS, then you are not in an e-FINDS role (see Getting Started).
3. Select your current location from the dropdown list.
4. Click **Submit,** and proceed to one of the following actions.

**Always VERIFY your location, if affiliated with more than one!**

## Evacuating Facility: Registers Multiple Patient/Resident

e-FINDS Administrator Role Only

1. Click **Register Patient/Resident > Multi Patient/Resident Input.**
2. Verify Evacuation Operation and Current Location.
3. Select Intended Destination.
4. Enter the number of barcodes to be assigned.
5. Click **Generate Fillable Spreadsheet.**
5. Enter known information, such as first name, last name, date of birth (mm/dd/yyyy), and gender.
6. Click **Save all Patient/Resident.**
7. Verify message: Successfully saved {correct # being evacuated} Patient/Resident and click **barcode** to view or update the patient or resident information.

## Evacuating Facility: Register Patient/Resident with Scanner

**Evacuating facilities may not have time to complete the registration process, so multiple time saving options are available**

1. Scan a barcode
   OR click **Register Patient/Resident > With Scanner.**
2. Confirm message: Barcode is located. You can register a new Patient/Resident with it.
3. **If time allows**, enter first name, last name, date of birth (mm/dd/yyyy), gender, etc.
4. Verify the Evacuation Operation OR select another operation from the list.
5. Verify the patient/resident current location is correct.
6. Select the Intended Destination Organization type, if necessary.
7. Select the Intended Destination.
8. Enter the Bulk Group; such as bus no. or transportation description.
9. Click **Register**. If the required fields are not complete, you will receive an error message. Click **Override** to bypass the error.
10. Confirm message: Patient/Resident info is updated.

## Evacuating Facility: Updates Multiple Patient/Resident

e-FINDS Administrator Role Only

1. Click **Update Patient/Resident > Multi Patient/Resident Update.**
2. Verify your location.
3. Select the Action Type:
   **Releasing Patient/Resident From this Location,** OR
   **Change Operation for Patient/Resident at this Location.**
4. Select the Intended Destination.
5. Enter the Bulk Group, for example transport via bus.
6. Click **Load All Patient/Resident.**
7. Select All OR select Update for each patient/resident.
8. Click **Release Selected Patient/Residents OR Change Operation for Selected Patient/Resident.**
9. Verify Successfully updated {#} Patient/Resident.

| Union Plaza | |
|---|---|
| **Policy Name:** Tracking and Accountability | |
| **Policy Date:** 1/2/2018 | **Policy Revision/Review:** **1/29/2024** |

**Purpose:**

Tracking and Accountability:

To ensure all staff, residents and others involved during any evacuation or emergency relocation are identified and located.

**Procedures:**

Resident Tracking

A Resident Evacuation Critical Information and Tracking Form (Appendix 3) will be available in each resident's chart upon admission. The form will be completed for each resident. This form will track residents throughout the entire evacuation process including:

- Leaving the unit
- Arriving at an internal holding area
- Arriving at an internal loading area
- Departure of the facility
- Arrival and departure at an external holding area (where applicable)
- Arrival at a receiving facility

If time permits, the form will be initially completed by clinical staff members on each resident unit otherwise, the form will be completed in a holding area.

This will be in addition to the Efinds system utilized by NYS DOH.

**Evacuation Room Markers**

The charge nurse is responsible to verify each room has been evacuated and appropriately marked.

Room markers are located on each residents' room door frame. The yellow tape will be located in the nurses' office on each unit. The staff will be directed to utilize the tab on the room door frame pushing it to yellow to indicate a room has been evacuated and will place a strip of yellow tape on the outside of the resident's door.

The Liaison Officer will inform Emergency Services personnel of the room indicator method as they arrive to assist with evacuation efforts.

Staff Accountability

Staff accompanying residents to other healthcare facilities will be tracked at the resident loading area. All other staff leaving the building will be tracked through the labor pool. All staff will exit the building through the labor pool.

UNION PLAZA CARE CENTER

# Evacuation and Shelter

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## Overview

**Purpose:**

The purpose of this plan is:

- To direct the activities required to implement sheltering-in-place, partial evacuation/internal relocation or full evacuation
- To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation
- To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the NHICS

**General Plan/Policy Guidelines:**

- Sheltering-in-place, relocation, and evacuation activities:
- May occur as standalone response or may be implemented in a progression, if necessary, as the incident evolves
- May be implemented in a proactive response to impending hazards
- May be implemented in response to an acute incident

- The following are examples of factors that could lead to activation of the shelter-inplace / relocation / evacuation plan:
  - Loss of environmental support services including heating, water, air conditioning, electrical power, and medical gases.
  - Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.
  - External emergencies including natural and man-made disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminated victims/toxic agents, radiation exposure, explosions and police actions.
- The evacuation of the facility shall only be initiated as a last resort in response to disruption of services caused by an internal or external disaster.
- The responsible individual for the activation and implementation of this plan is the Incident commander, Administrator or

**Supporting Plans**

If necessary, based on the incident, any or all the following plans may also be activated in support of the evacuation / shelter in place plan:

- Emergency operations plan (EOP)
- Command center operations
- Department-specific evacuation plans
- Lockdown procedures
- Active shooter/threat
- Facility closure, restoration and start up and Business continuity

## Operational Definitions

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP.

- When SIP is done in an active shooter or active threat situation, it can be called Defend in Place. Refer to Active Shooter/Threat Plan

**Evacuation:** The movement of patients, personnel and visitors from a dangerous location to one of relative safety.

- **Partial Evacuation or Relocation:** Movement within the facility.
- **Horizontal Evacuation:** Evacuation on the same floor, often to the other side of a set of fire barrier doors.
- **Vertical Evacuation:** Evacuation to a safe place on another floor, can be upward or downward.
- **Total or Complete Evacuation:** The full evacuation of a facility to an outside area which may also require transfer of patients (and possibly personnel) to another healthcare facility or alternate site.

**Emergent Evacuation:** An evacuation that is conducted in quick response to an acute emergency.

**Planned or Phased Evacuation:** An evacuation that is conducted in a planned or phased manner in response to an impending emergency such as hurricane or flood.

**Refuge Area**: A location within a building that is identified as having relative safety. May be used in SIP situations or partial evacuation/relocation.

**Assembly Point or Collection Area:** A pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

## Plan Activation

The responsible individual for the activation and implementation of this plan is the Senior staff member on duty.

The decision to implement whole or parts of the evacuation plan should be determined based on the incident assessment, information and/or recommendations from other facility personnel or community response partners such as the local fire or police department. Decision making resources available are:

- Decision Tree - Appendix, page 23
- Decision Matrix - Appendix, page 24
- Incident Assessment Worksheet, Incident Management

**Establish Command and Control**

- The overall management of incident response and recovery is the responsibility of the Incident Commander as designated in the Emergency Management Plan.
  - All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
  - Every department is responsible for implementing their activities within the evacuation plan.
- The Incident Commander will notify and activate:
  - Activate Code [Code phrase] .
- Activate NHICS Incident Management Team members as needed by the incident.
  The NHICS Incident Response Guide for Evacuation may serve as a guide
  - Activate the Command Center. If the primary location is not available, notification must include the new alternate location.

  ICS and Command Center operations shall be guided by:
  - This plan, and other plans activated in support of this incident.
  - ICS Job Action Sheets.

- All information related to the incident shall be coordinated and released through the Command Center.
- The Command Center will coordinate with outside agencies, other healthcare facilities and facility administration regarding facility status, evolving situational needs, and overall status of the evacuation/shelter in place process.

**Roles and Responsibilities**

In addition to the use of the position Job Action Sheets, the following identifies some key activities and responsibilities for certain NHICS IMT members and all personnel. Additional resources available:

- Initial Critical Action Sheet for an Emergency Evacuation - Appendix, page 25
- Initial Critical Action Sheet for Emergent Shelter in Place - Appendix, page 26
- Defend in Place for Active Threat/Shooter - Appendix, page 27
- Command Personnel Checklist for Shelter, Relocation, & Evacuation - Appendix, page 30

- HICS Evacuation Incident Response Guide

*Incident Commander*

Has the full authority and responsibility for the decision-making processes for this response.

*Public Information Officer*

- Coordinate media communications regarding the status of the facility, including the need to evacuate.
- Establish a family information center to notify and respond to queries from family members regarding the status and location of patients who have been evacuated. Utilize the tracking information provided to the Command Center by the Planning Section Chief.
- Assign personnel to notify the patients/residents emergency contact person.

*Liaison Officer*

- Notify local agencies to notify that you are experiencing an adverse incident that requires sheltering or evacuation and update your operational status (capabilities, resources needs, etc.).
- Ensure the facility is placed on ambulance diversion
- All Facilities: Notify DOH
  - Notify community response partners, including:
    ○ Local fire department (may be able to assist with evacuation; provide information on the incident, etc)
    Local police department (may be able to assist with securing the facility / area; provide information on the incident, etc)

*Safety Officer*

- Oversee the immediate stabilization of the facility
- Recommend areas for immediate evacuation to protect life
- Ensure the safe evacuation of patients, staff and visitors
- Conduct initial and ongoing analysis of existing evacuation practices for health and safety issues related to personnel, patients, and facility, and implement corrective actions to address

*Operations Section Chief*

- Coordinate the processes necessary to safely evacuate a portion or all of the facility.
- Identify appropriate staging areas for the receipt and movement of patients/residents, personnel and visitors.
- Work with the Medical Care Branch Director to identify (number and acuity levels), prioritize, and evacuate patients in a systematic and orderly manner.

Communicate with the Infrastructure Branch Director to determine the need for — and orderly implementation of — the operational reliability and/or shut down of utilities and structural support systems.

- Coordinate with the Infrastructure Branch Director to determine and supply necessary utilities and medical gases to the sheltering or evacuation assembly points.
- Coordinate with the Liaison Officer to determine the number and type of transportation vehicles that will be necessary to evacuate patients to alternate care sites.
- Work with the Security Branch Director to establish access and control of key areas of the facility and campus during the evacuation.
- Interface with the Business Continuity Branch Director to assure that the security and availability of vital patient/resident health record, and other key information is maintained.

*Planning Section Chief*

- Establish and implement processes to track the location of patients/residents, personnel and resources who have been moved from one location to another — including evacuation to alternate sites of care.

*Logistics Section Chief*

- Work with the Operations Section Chief to provide the necessary medical equipment, beds, medications, and supplies to safely relocate patients to alternate locations. Caches of equipment, supplies, and medications pre- positioned to manage an influx of casualties can be used if they are not required for their intended purpose.
- Assure an adequate supply of personnel and other human resources to safely evacuate patients/residents and visitors to alternate locations.
- Ensure that potable water and basic food supplies are brought to the sheltering area or assembly points.
- Collaborate with the Operations and Planning Section Chiefs to identify and address both internal and external transportation needs.
- Establishing a family information center to notify and respond to queries from family members of personnel regarding the status and location of personnel who have been evacuated.

*All Personnel*

- All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
- Assist patients/residents with sheltering or evacuating as indicated

## Communication

Internal notification and external communications should be conducted according to the Emergency Operations Plan. Key communications for facility evacuations include, but are not limited to:

- **Personnel, on duty**: Notification of potentially unsafe situation(s) at the facility. If evacuation activities are possible, an 'evacuation standby' notification should be made as soon as possible so that units may begin accessing appropriate supplies and collecting belongings and records.
- **Personnel, off duty**: Notification of potentially unsafe situation(s) at the facility. Provide guidance on whether personnel should report to duty as usual or not.
- **Patient families**: Notification of patient/resident families of evacuation destinations
- **Medical providers**: Notification of evacuation destinations
- **Personnel families**: Notification of incident status and evacuation destinations
- **Public safety**: Communication links to facilitate coordination with public safety agencies (security and traffic control), EMS and other transport providers (buses, etc), and fire agencies (lifting assistance)
- **Media**: Public information reflecting the capabilities of the facility

## Initial Notification Chart

See Appendix, page 43.

## Estimate How Many Will Need to Be Evacuated or Need Sheltering Resources

See Appendix, page 44, to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

## Sheltering in Place Procedures

When the threat does not permit safe relocation or evacuation, the following actions may be taken. **Patient care and administrative departments are authorized to initiate these actions upon recognition/notification of threat** (in conjunction with notification of supervisors or other actions under the emergency management plan):

*Weather* – wind, hail, or other weather threat.
Remain calm.
Move patients/residents and personnel away windows as possible.
Close drapes/blinds and exterior doors/windows.
Ensure personnel and visitors also advised of weather situation.
Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
Personnel will remain with patients/residents

- *Security emergency – bomb threat, individual posing security threat, external civil unrest* ○ Remain calm.
  - Refer to Active Shooter/Bomb Threat policy. ○ Implement department-specific access controls.
  - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed. ○ Ensure personnel and visitors are aware of the situation.
  - Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
  - Personnel will remain with patients/residents.

- *Hazardous materials (HAZMAT) incident* ○ Remain calm.
  - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
  - Ensure visitors and personnel aware of threat – location and actions to take. ○ Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
  - Personnel will remain with patients/residents.

## Evacuation - General Guidelines

**Authority and Decision Making**

- All personnel are authorized to take immediate patient/resident relocation actions in response to an immediate life safety emergency.
- Initiation of a vertical or complete evacuation, with the exception of persons in immediate danger, will be coordinated by the Incident Commander/Command Center.

**Evacuation Priorities**

In an emergency:

1. Persons in immediate danger, If persons are not in immediate danger, personnel shall WAIT for evacuation orders.
2. Ambulatory persons
3. Non-ambulatory persons
4. Critical patients will be moved last when the maximum number of personnel and equipment is available.
5. Personnel will remain with patients/residents.
6. Evacuation shall be completed in a calm and orderly fashion.

**Evacuation Routes**

Evacuation and specific guidance for travel route and in-house transportation must be a systematic, coordinated effort in order to remove all patients/residents, visitors, and personnel from affected areas in a safe and timely manner.

- Evacuation shall be completed in a calm and orderly fashion.
- When possible, horizontal evacuation is preferred over vertical evacuation.
- Departments should have pre-identified evacuation routes.
- Incident specific evacuation routes may be necessary and must be communicated by the Command Center quickly to affected areas.
- Only when absolutely necessary should evacuation result in patient/resident leaving the interior of the facility.
- Visitors, personnel, and ambulatory patients should walk to the designated assembly point. If vertical evacuation is necessary, stairs — not elevators — should be used for these individuals. Personnel should be assigned at key points along the evacuation route to direct individuals to the assembly points.
- Elevators — if operational — are reserved for transporting non-ambulatory patients. Engineering / maintenance personnel should be assigned to take operational control of the elevators using the bypass key to take elevators directly to / from the affected areas. Do not use elevators in a fire or earthquake.
- If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down stairwells using assist devices, blanket carry, or two-man carry techniques.
- Human Chain - can be used if you have large numbers of ambulatory patients. Two personnel members are needed, one in the front and one in the rear. Have the first patient put his/her hand on the shoulder of the first personnel member, and everyone

else do the same to the person in front. The last person in the chain should be the second personnel member.

**Return to Facility**

Do not re-enter the facility for any reason unless:

- Assisting with evacuation of patients/residents, visitors or other personnel/equipment
- Authorized by the Incident Commander/Command Center
- An order to repopulate / reopen the facility has been approved by Licensing and Certification

## Moving to a Safe Refuge - Horizontal Evacuation

Refuge areas are used for internal evacuation or relocation. They are internal locations that will receive and hold patients/residents, personnel and visitors for a period of time until they can return to their original location or are evacuated.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor.
3. Identify the next functional smoke compartment (i.e., beyond the next set of double fire doors).
4. Movement shall be completed in a calm and orderly fashion.
5. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
6. Move patients/residents, personnel and visitors who are closest to the hazard to the next functional smoke compartment or identified refuge area. If you are moving patients to another floor, follow instructions for vertical evacuation.
7. Ambulatory patients should be assisted to the new location, and non-ambulatory patients moved on beds, carts, wheelchairs, or via blanket carry.
8. If possible, take with you the necessary patient/resident care equipment and supplies from the hazardous area.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated ( How marked ?)
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*Planning Note: pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet,* etc).
13. The area supervisor will identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And

marked as clear (*Planning Note: pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).

14. Relocation does not involve formal gathering of medical records, unless this relocation is part of a phased evacuation, then gather patient records.
15. Continue to care for all patients/residents during transport and relocation.
16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.
17. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command Center.
18. Ensure personnel and visitors are aware of the situation.
19. Personnel will remain with patients/residents.

**Safe Refuge Areas and Horizontal Evacuation Area Chart** - see Appendix, page 41

**Horizontal Evacuation: Personnel Responsibilities**

- Affected area personnel – assist with patient care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

## Vertical Evacuation Procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and relocation area.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Evacuate patients/residents, personnel and visitors from the hazard
7. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
8. Elevators — if operational — are reserved for transporting non-ambulatory patients. ○ Do not use elevators in a fire or earthquake.
    - ○ If elevators are non-operational, and vertical evacuation is required, nonambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc*).
13. The area supervisor will identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etcr*).
14. Continue care for all patients/residents during transport and at the assembly point.
15. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. NHICS Form 255 may be used.
16. Keep patient/resident files and records with the patient.
17. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.

18. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command Center.
19. Ensure personnel and visitors are aware of the situation.
20. Personnel will remain with patients/residents.

**Vertical Evacuation Route Chart** - see Appendix, page 48

**Vertical Evacuation: Personnel Responsibilities**

- Affected area personnel – assist with patient/resident care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

## Complete Evacuation Procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and external assembly point.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Each patient who is evacuated should have the following accompany them: o Their medical record – which should remain in their possession during the entire evacuation process
   - Necessary medications along with their medication administration record o Their addressograph plate or name labels o Personal belongings (if time permits)
   - Ideally, these items should be placed in a large plastic belongings bag and the bag marked with the patient's name and medical record number with indelible ink.
7. Evacuate patients/residents, personnel and visitors from the hazard
8. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
9. Elevators — if operational — are reserved for transporting non-ambulatory patients. o Do not use elevators in a fire or earthquake.
   - If elevators are non-operational, and vertical evacuation is required, nonambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
10. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
11. Each room should be marked as evacuated (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
13. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. *pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*
14. The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator.*
15. Continue care for all patients/residents during transport and at the assembly point.

16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. HICS Form 255 may be used.
17. Keep patient/resident files and records with the patient.
18. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources to manage your patients/residents.
19. Ensure personnel and visitors are aware of the situation.
20. Personnel will remain with patients/residents.

**Guidelines for Evacuating Specific Patient Care Areas**

*Hemodialysis*

The following personnel are responsible for ensuring the safety of the patients:

- Operating Suite - the surgeon in charge of each case.
- Hemodialysis - The Nurse Manager or designee and physician will direct activities of the personnel.
- Obtain equipment and services required for completion of the procedure.
- Keep list of anticipated supplies and prepare to procure additional supplies as needed.
- Patients on ventilators: when central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
- Patients with IVs, arterial lines and Swan-Ganz: Disconnect transducer from patient cable-take pressure bag with patient. Saline lock all non-critical IV lines.

*Ventilator Unit*

- The Nurse Manager or designee shall evaluate the ICU patients with the house officer to determine possible transfers and/or discharge.
- Patients on ventilators: when central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
- Transfer as many patients as possible to medical surgical or step-down units, if safe to do so.
- Use gurneys, beds and evacuation equipment to move patients to refuge areas.
- Collaborate with house officer and respiratory therapists to evaluate appropriate shutoff of oxygen, ventilation equipment and other gases to preserve resources.

**Evacuation of Non-Patient Care Areas**

Overall, the evacuation of non-patient care areas will follow the same general guidelines.

1. Remain calm.

2. Recognize local threat or receive evacuation instructions from the Command Center or authorized personnel according to facility plan and move personnel to the pre-identified assembly point.
3. Persons in immediate danger should evacuate first.
4. In areas where there are visitors, escort the visitors to your department's assembly point.
5. Unless otherwise indicated, evacuation should proceed from offices farthest from the evacuation route to closest.
6. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
7. Each room should be marked as evacuated (*your facility should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
8. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate.
9. The department head should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear
10. Personnel/visitors with disabilities may require assistance. Each department head must identify which of their personnel may have difficulty during an evacuation and pre-plan the best way to aid their movement to a safe location.
11. Visitors should remain at the assembly point until the Command Center declares an "all clear" or other directions are given.
12. Account for personnel at assembly point (conduct roll call). If you have time, conduct roll call prior to evacuation, and again at the assembly point.
13. Initiate continuity of operations plan actions.
14. Update the Command Center on your operational status and impact on personnel and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources. Send personnel to the labor pool is requested.
15. Ensure personnel and visitors are aware of the situation.

**Complete Evacuation: Personnel Responsibilities**

- Since all areas will be affected, all personnel will assist with patient care and evacuation of current patients from their units, and perform follow up care at the assembly point.
- Non-clinical personnel – all functions will cease, and personnel will evacuate to their designated assembly point, and assign personnel to the labor pool for further instructions.

**Vertical/Complete Evacuation Transport Devices**

If there is a need to relocate patients horizontally, residents shall be moved using normal patient transportation equipment and routes of travel.

The following resources can be used in patient evacuation:

- Wheelchairs can be used to move ambulatory, minimally ambulatory patients and non-ambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then it can be used to move the patient/resident/personnel to the assembly point.
- Beds/gurneys: can be used to move non-ambulatory patients, but very difficult for vertical movement.
- Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

Additional resources may be needed during evacuation flashlights, spotlights, electrical cords, water stations, personal protective equipment, work gloves, portable ventilators, and other non-patient related equipment may be needed.

Specialized evacuation transport devices (chairs, stair stretchers, sleds, infant carry slings, motorized gurneys, blankets) are located within the facility and are intended for use in vertical and complete evacuations.

See Appendix, page 50, for a complete list of devices and location.

## Evacuation Assembly Points

In the event of a complete or total evacuation, residents, personnel and visitors will evacuate to external assembly points. Each department is pre-identified to evacuate to a specific assembly point.

### Determining Assembly Points

Assembly points are assigned based on the care provided in the department. Departments with the most acute patients will assemble together near the emergency department where additional resources and ground transportation will be the most available. Departments without patients will evacuate to the remotest locations.

Non-department based assembly points are identified for the Command Center, Labor Pool, Communications Center, and Personnel First Aid.

### Assembly Point Key Activities

- Roll call of all patients/residents, personnel and visitors
- Patient assessment and care

### Assembly Point Resource Needs

Resources may be brought with personnel as they evacuate. Other resource needs shall be filled by the Command Center from external disaster caches.

- Food and water
- Communication devices for personnel to keep updated
- Environmental protection (tents, umbrellas, blankets, sheets, etc.)
- Chairs, flashlights/light sticks, basic first aid kits
- Medical supplies - depending on the care provided

**Evacuation Assembly Point Chart - see Appendix, page 49**

## Resident Transfer to Alternate Facilities

**Internal Coordination**

Internal organization of residents should be implemented concurrently with the External Coordination procedures.

*Organizing Residents*

Categorize and physically organize patients/residents as follows:

- Those who have their own transportation and are being discharged to home
- Those who need to be evacuated to an alternate acute care facility
- Those who need to be evacuated to a skilled nursing facility
- Those who are being discharged home but require transportation

Once the resident's evacuation status has been determined, it should be noted on a sign, sticker, or other mechanism and placed prominently on the resident. This tag should remain on the resident always until the evacuation destination is reached.

*Resident Information*

As each patient/resident is placed in their appropriate category, their medical record (which should have accompanied them) should be reviewed to collect information necessary to track and discharge / transfer the resident.

See Appendix, page 54 and 55, for forms.

*Patient/Resident Tracking*

- Patient tracking information is to be maintained in the area with copies forwarded to the Command Center and kept with the Patient Tracking Manager.
- Standard inter-facility transfer forms are to be completed on each patient/resident sent to an alternate care site, along with a copy of the medication administration record, and other pertinent medical record information.
- Patients/residents discharged to home should be provided with standard discharge instructions.
- If home health follow-up is necessary, send pertinent medical information home with the patient as well.
- Patient Tracking Manager and/or deputies will contact alternate care sites to ensure patient arrival until all patients have been verified as arriving and HICS form 255 is completed.

*Personnel Tracking*

- Facility shall coordinate personnel who may accompany patients/residents being transferred to alternate care sites.
- If personnel are to remain at these sites, then implement the mutual aid agreements established with these facilities.

- The record will be maintained of the name, title, and the facility that they were assigned to with the transfer log.

**External Coordination**

- If residents need to be transferred to another facility for ongoing medical care, **identify available beds** by the following procedures:
  1. Coordinate with other facilities in the same healthcare system
     - 
  2. Skilled Nursing Facilities: If the above resources are unavailable or inadequate, request assistance from Licensing and Certification:
     - Contact Licensing and Certification: 800-228-1019
     - Provide the number of residents by type of acuity that require evacuation Provide the number of patients by type of bed (critical care, medical/surgical, etc) that require evacuation
- **Obtain transportation resources** by contacting your contracted ambulance providers If not feasible or additional resources are needed from the County, contact the EMS Agency
- Transferred patients should have **medical records and medications** sent with them

**Transportation Resource Needs Matrix**

Estimate the type and quantity of transportation resources needed using the tool in Appendix, page 53. Use this information when requesting assistance through your usual transportation providers or the County EMS Agency.

**Evacuation Triaging and Transportation Tag**

An Evacuation Transportation Tag System shall be used to track patients who are evacuated from the facility.

- Clinical personnel are responsible for patient assessment/triage which will dictate mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement of patients from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

See Appendix, page 46, for the evacuation triage system color code.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of the evacuation tags at each patient care unit.
- Coordinating the distribution of evacuation tags during the incident.
- Tracking patients who are evacuated from the facility.

## Closure of a Portion or All of the Facility Following Evacuation

The decision to close all or a portion of the facility is made by the Incident Commander in collaboration with senior Command Center personnel. Closure of the facility (all or in part) is indicated if:

- The facility ceases the operational capability to provide safe and adequate care.
- The environment of care is no longer capable of supporting safe and adequate care.
- Closure has been directed by an external agency having legal authority to do so.

Facility operations during an evacuation will be under the direction of the Infrastructure Branch Director. This position will coordinate all facility control operations as needed during an evacuation. The first step in this process is to have the current status of all facility systems evaluated and documented using the NHICS 251 Facility System Status Report. From this status report, the Infrastructure Branch Director may call for additional support (e.g., local utilities companies/vendors).

**General Guidelines**

- Whenever possible, operationally capable areas should continue to provide care, treatment, and service as long as possible.
- Affected / hazardous areas will be closed first. Once cleared, these areas will be locked and utilities to the area shut down.
- Non-essential areas should be closed next. Once cleared, these areas should be locked and utilities to the area shut down.
- Resident care areas should be closed based on operational and environmental conditions. Closure should proceed from the most at-risk to the least at-risk areas. Once cleared, these areas should be locked and utilities to the area shut down.
- If time and circumstance permit, patient care areas should be scavenged for available supplies, equipment, medication, beds, transport devices, etc. These material resources should be brought to appropriate assembly points or as otherwise directed by the Command Center.
- Information Services should conduct a full backup of all information systems prior to shutting down mainframe computers and network systems. Individual proprietary systems should be backed up to external hard drives for removal from the facility.
- If time and circumstances permit, medical records should be boxed and removed and transported to an off-site storage location. Records should be removed — if possible — from most recent admissions going backward.
- If time and circumstances permit, personnel records should be boxed and removed from human resources and transported to an off-site storage location.
- Unless safety issues are present, utilities should be maintained until the affected areas are fully cleared and ready for closure. At that point, Engineering should implement

standard and/or emergency shut-down procedures as warranted. Once utilities are shut down, they should be locked out / tagged out and the area secured as able.

- Controlled substances are secured at all times except during administration. If the facility were to close, these items would be secured by default. ○ If medications are to be moved or evacuated with patients, they must be secured with licensed personnel.
- Process to secure diagnostic radiology areas / medications / isotopes in accordance with state law.

**Securing the Facility**

Usual procedures to secure the facility will be implemented. Focus areas include:

- Maintaining general security, especially during prolong incidents or when resources are scarce
- Establishing a perimeter around the facility, especially patient care areas OR establishing a perimeter around affected high risk area areas within the facility
- Controlling access and movement in and between facilities
- Maintaining traffic control on grounds
- Ensuring only authorized persons re-enter the facility after evacuation
- Coordination with local public safety, as needed

**Stay Team**

If the facility has been evacuated, but personnel need to remain to stabilize the incident and restore functionality, designate a Stay Team. This may include members of the Incident Management Team including the Safety Officer, emergency management personnel, facilities/engineering, risk management, human resources, etc.

See Facility Shut Down and "Stay Team" Member Check List - Appendix, page 62.

## Recovery: Restoring the Facility after Evacuation

Recovery - Assure that restoration and reimbursement issues and planning for facility start-up are addressed through the facility continuity of operations plan or business continuity plan.

**General Guidelines**

- Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by DOB , fire marshal and Licensing & Certification.
- Prioritize which departments and personnel to repatriate
- Restoration and testing of infrastructure – water, electricity, HVAC, medical gases

- All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.).
- Procedures to assess the need for and implementing cleaning and decontamination
- Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are reestablished
- Notification of reopening to other hospitals/healthcare facilities, EMS Agency, Resident families, media
- Procedures for repatriation of resident including:
    - Patient transportation coordination with sending hospital/healthcare facility
    - Medical records management
    - Transportation coordination
    - Attending assignments
    - Room assignments

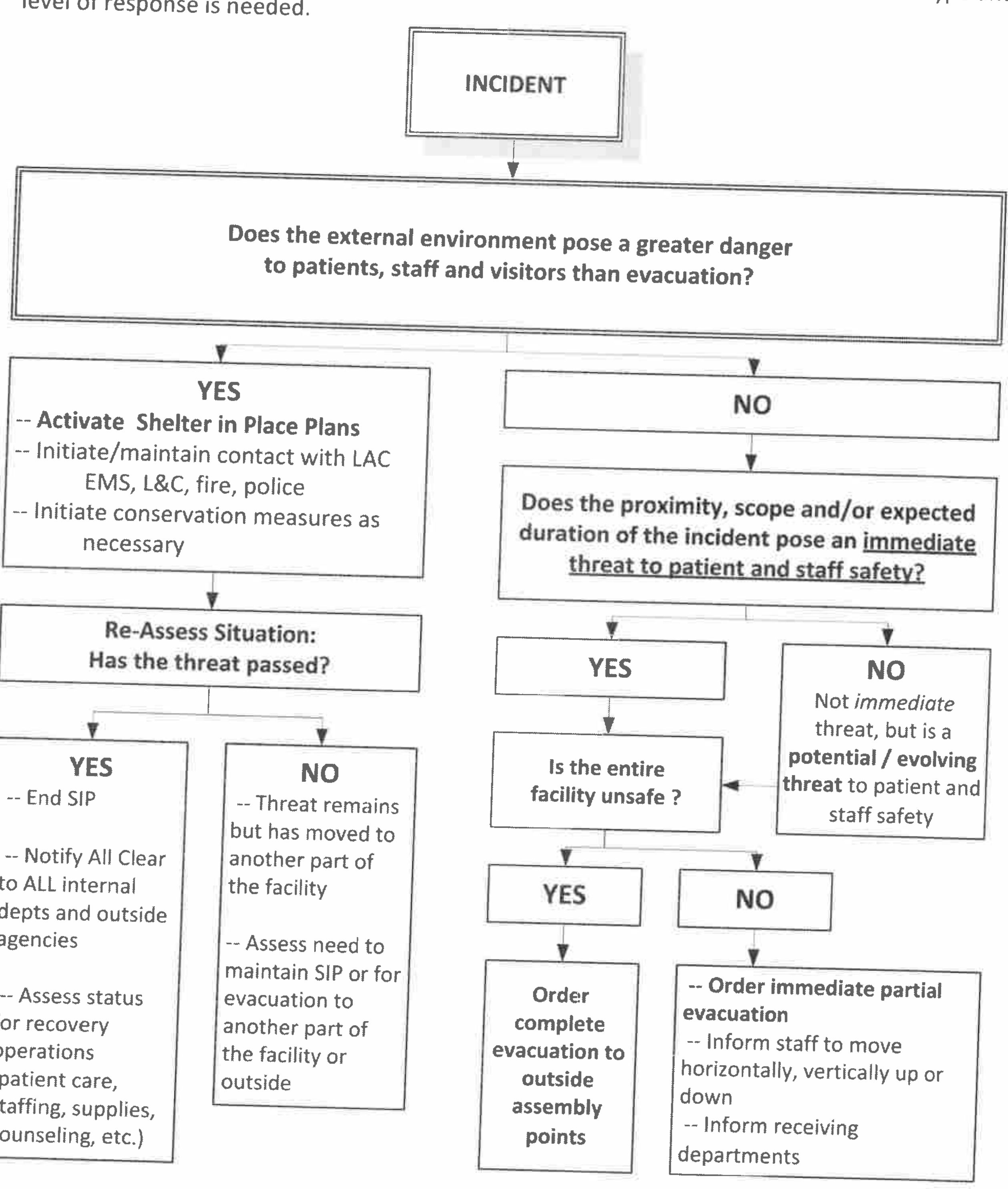
For additional resources, see


- Incident Management Team Recovery Responsibilities - Appendix, page 63
- Hierarchy of Repopulation Approval(s) - Appendix, page 64
- General All-Hazards Re-Population Factors / Steps - Appendix, page 65

## Appendix:

### Decision Tree

When the decision is made to activate, the magnitude of the emergency response must be determined. The Incident Commander will utilize the Decision Tree to determine what type and level of response is needed.



## Appendix:

### Decision Matrix

When the decision is made to activate, the magnitude of the emergency response must be determined. The Incident Commander will utilize the Decision Matrix to determine what type and level or response is needed add triggers for facility if needed.

| **Incident requiring facility to consider whether an evacuation plan or shelter in place plan should be activated.** | |
|---|---|
| **SCENARIO #1**<br>**The external environment* would pose a greater danger** to residents, personnel, and visitors than evacuation.<br>* External may mean inside - but outside of the affected area; or external - outside the facility | **YES**<br>• **Activate Shelter in Place Plans**<br>• Initiate/maintain contact with OEM, or L&C, local fire, local police<br>• Initiate conservation measures as necessary |
| **Assess situation: Threat has passed.** | **YES**<br>• End SIP<br>• Notify All Clear to ALL internal depts & outside agencies<br>• Assess status for recovery operations (patient care, supplies, counseling, staffing, etc.) |
| | **NO**<br>Threat remains but has moved to another part of the facility. Assess need to maintain SIP or for evacuation to another part of the facility or outside. |
| | |
| **SCENARIO #2**<br>The proximity, scope and/or expected duration of the incident pose an **immediate threat to resident and personnel safety.** | **YES**<br>• **Order immediate partial evacuation**<br>• Inform personnel to move horizontally, vertically up or down<br>• Internal Relocation: Inform receiving departments<br>• **OR Order complete evacuation to pre-identified assembly points** |
| | **NO** – not immediate threat, but threat exists, follow steps for Scenario #3 |
| | |
| **SCENARIO #3**<br>**Potential / evolving threat** to resident and personnel safety | **YES**<br>Decision to make: Partial or Total Evacuation? |
| **Assess situation: Is the entire facility unsafe for patients/residents or personnel?** | **YES**<br>• Activate Complete Evacuation Plan<br>• Determine evacuation sequence of departments |
| | **NO**<br>Activate Partial Evacuation or Relocation Plan<br>• Inform personnel to move horizontally, vertically up or down<br>• Internal Relocation: Inform receiving departments |

## Appendix:

### Initial Critical Action Sheet for an Emergent Evacuation

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

**Upon initial notification that an incident has occurred:**

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

**If the decision is made by the AOD to evacuate:**

- ❑ Activate the Evacuation Plan
- ❑ Contact the operator to overhead page "Code xx"
- ❑ Notify and activate the NHICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Determine type of evacuation needed: vertical, horizontal, complete ○ Will patients and personnel stay in the building, or will they need to evacuate to the outside?
- ❑ Order the organized and timely evacuation of the facility. Prioritize departments to be evacuated, based on:
    - ▪ Danger / risk level - high danger, evacuate first
    - ▪ Ease of movement - more ambulatory, evacuate first ○ Instruct departments to gather as much medical information, medications, medical supplies and equipment as possible
  - ○ Instruct departments to follow the designated evacuation route
  - ○ Instruct department to evacuate to their designated assembly point and conduct roll call of personnel, patients, and visitors
- ❑ Notify fire, EMS, L&C, and law enforcement, local emergency management agency ○ Establish Unified Command with first responder agency, if applicable
- ❑ Establish the external Command Center, if doing a complete evacuation
  - ○ Have Operations / Infrastructure Branch assess the status of the facility ○ Try to maintain life support operations (power, water, communications) until all are evacuated
    Determine if any of the assembly point areas are unsafe
- ❑ Have Operations / Medical Care Branch assess if resident care is being compromised and if transfer will be required
- ❑ Have Logistics establish a Labor Pool
- ❑ Have Logistics deploy the evacuation disaster supplies cache ○ Deploy radios to assembly points
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of nonessential personnel

## Appendix:

### Initial Critical Action Sheet for Emergent Shelter in Place

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

**Upon initial notification that an incident has occurred:**

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ For an active threat, contact law enforcement immediately ○ Upon arrival, establish Unified Command with first responder agency
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

**If the decision is made by the AHJ to shelter in place:**

- ❑ Activate the Shelter in Place Plan
- ❑ Contact the operator to overhead page "Code xx" or page instructions (sample message: "May I have your attention, please. Authorities have advised us of an emergency nearby. For your safety, everyone is requested to stay inside and shelter in place until we are notified that the emergency is over.")
- ❑ Notify and activate the NHICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Order the organized and timely shelter in place of the affected area
  - ○ HazMat or severe weather instructions for the affected area
    - ▪ Shelter in a location with few windows and doors, and with access to restrooms and drinking water
    - ▪ Close and lock windows. Secure doors; lock if possible
    - ▪ Seal cracks around doors and windows (and any vents that do not close) with damp towels, duct tape, plastic sheeting, etc.
  - ○ Active threat (e.g., shooter) instructions for the affected area
    - ▪ Hide out of the active shooter/threat's view
    - ▪ Lock the door and blockade with heavy furniture
    - ▪ Silence cell phones and pagers
    - ▪ Turn off any source of noise (e.g., biomedical equipment, radios, TVs) ▪ Hide behind large items
    - ▪ Remain quiet
    - ▪ If have access to a phone, call security. If you cannot speak, leave the line open allow security to listen
- ❑ Notify fire, EMS, and Police
- ❑ HazMat: Have Operations / Infrastructure Branch assess the status of the facility ○ Shut off heating, air conditioning or other ventilation system so outside air is not drawn indoors, or prevent circulation throughout the facility if the source is internal
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of nonessential personnel

## Appendix:

### Defend in Place for Active Threat/Shooter

**Characteristics of an Active Threat/Shooter Situation**

- An active threat/shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area
- Typically use firearms, but may also use knives, or other weapons
- Most commonly, victims are selected at random, however a disgruntled patient/family member or staff member may target their victim
- Unpredictable and evolve quickly
- Law enforcement is usually required to end an active shooter situation
- Because active threat/shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active threat/shooter situation

**How to Respond When an Active Threat/Shooter is in Your Vicinity**

Quickly determine the most reasonable way to protect your own life. Remember that patients are likely to follow the lead of employees and managers during an active threat/shooter situation.

*Option 1. Evacuate*

If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

 Remain calm

- Have an escape route and plan in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active threat may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe

*Option 2. Hide out or Defend in Place*

If evacuation is not possible, find a place to hide where the active threat is less likely to find you. Your hiding place should:

- Be out of the active threat's view
- Provide protection if shots are fired in your direction (i.e., a room or office with a closed and locked door)
- Not trap you or restrict your options for movement
- To prevent an active threat from entering your hiding place: ○ Lock the door
    - Blockade the door with heavy furniture ○ Call 911 when safe to do so

- If the active threat is nearby: ○ Lock the door
    - Silence your cell phone and/or pager
    - Turn off any source of noise (i.e., biomedical equipment, radios, televisions) ○ Hide behind large items (i.e., cabinets, desks)
    - Remain quiet

*Option 3. If evacuation and hiding out are not possible*

- Remain calm
- Dial 911, if possible, to alert police to the active threat's location
- If you cannot speak, leave the line open and allow the dispatcher to listen

*Option 4. Take action against the active shooter*

As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Act as aggressively as possible against him/her
- Throw items and improvising weapons
- Yell
- Commit to your actions

**How to Respond When Law Enforcement Arrives**

Law enforcement's purpose is to stop the active shooter as soon as possible.

*What to Expect from Officers' Actions*

- Officers will proceed directly to the area in which the last shots were heard or threat is identified to be
- Officers usually arrive in teams of four (4)
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment
- Officers may be armed with rifles, shotguns, and/or handguns
- Officers may use pepper spray or tear gas to control the situation
- Officers may shout commands, and may push individuals to the ground for their safety

*How to React When Law Enforcement Arrives*

- Remain calm, and follow officers' instructions
- Put down any items in your hands (i.e., bags, jackets)
- Immediately raise hands and spread fingers
- Keep hands visible at all times
- Avoid making quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming and/or yelling
- Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises

- The first officers to arrive to the scene will not stop to help injured persons
- Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

*Information to Provide to Law Enforcement or 911 Operator*

- Location of the active shooter/threat
- Number of shooters, if more than one
- Physical description of person making the threat
- Number and type of weapons held by the person making the threat
- Number of potential victims at the location

**Managing the Consequences of an Active Threat/Shooter Situation**

After the active shooter has been incapacitated and is no longer a threat, facility Incident Command should engage in post-incident assessments and activities, including:

- Account for all individuals at a designated assembly point to determine who, if anyone, is missing and potentially injured
- Determine a method for notifying families of individuals affected by the active threat/shooter, including notification of any casualties
- Assess the psychological state of individuals at the scene, and refer them to health care specialists accordingly
- Identify and fill any critical personnel or operational gaps left in the organization as a result of the active threat/shooter

## Appendix: Command Personnel Checklist for Shelter, Relocation, & Evacuation

*Does not replace N HICS Job Action Sheet – Use as an Incident-Specific Supplement*

The Incident Commander can use this checklist to assign tasks to Command and General Personnel.

| Task | Assigned | Complete |
|---|---|---|
| **Initial assessment** | | |
| Review threat intensity and likely duration | | |
| Review any department-based relocations that are occurring and anticipate needs in those areas | | |
| Determine, based on the department-based impacts, the need for sheltering vs. relocation of displaced patients vs. partial or full evacuation to other institutions (*see relevant sections below*) | | |
| Assure damage and utilities impact assessment being conducted by Infrastructure Branch Director | | |
| **Shelter in place** | | |
| Instruct Infrastructure Branch Director to shut down air intakes if there is a plume threat or shut down internal ventilation | | |
| Implement necessary access controls and monitoring in response to threats (Security Branch Director) | | |
| Communicate protective actions (door and drape closings, etc) to affected departments as well as any incident details | | |
| **Relocation - Movement within the Facility** | | |
| Determine affected departments and actions taken | | |
| Determine facility capacity for relocated patients – if insufficient see evacuation, below | | |
| Assure resources (personnel and supplies) transferred to departments absorbing relocated patients | | |
| Assure all residents accounted for and information transferred to receiving departments | | |
| Determine timeframe to recover affected departments and any effects on admissions, | | |
| **Evacuation** | | |
| Determine scope of evacuation (partial for subset of residents/ areas complete for total facility evacuation) based on threat | | |

| | | |
|---|---|---|
| Consider appointment of Evacuation Branch Director under Operations if Operations has multiple other issues (fire, etc) to address | | |
| Activate any appropriate facility response plan alerts | | |
| Announce evacuation order to affected units / facility | | |
| **Task** | **Assigned** | **Complete** |
| Determine whether usual assembly points can be used and announce alternatives if needed | | |
| Assign Staging Manager and Transportation Officer (NHICS positions) to coordinate patient and vehicle staging according to evacuation plans | | |
| Initiate coordination between Planning Chief and Resource Unit on transportation and facilities to accept residents and report back to IC | | |
| Contact County OEM/DOH Agency for coordination assistance; | | |
| Security to implement appropriate access controls – no family or visitors inside during evacuation | | |
| Security coordinates with local law enforcement regarding traffic controls external to facility | | |
| Logistics Chief to assure pharmaceuticals and supplies to staging areas | | |
| Distribute personnel and resources to affected areas to facilitate movement to staging areas | | |
| PIO to communicate facility status to media and families | | |
| Assure matching of residentss to appropriate transfer facility | | |
| Assure resident tracking by transportation officer at time of loading | | |
| Assure prioritized movement of residents to and through staging (in non-emergency evacuation Staging Manager should call units to sequentially evacuate them) | | |
| Determine if any personnel need to accompany residents to receiving facilities | | |
| In case of complete evacuation – appoint Stay Team Unit Leader | | |

## Appendix: Incident Assessment Worksheet

Use this worksheet to assess the impact that the incident will have on the facility. Sources of this information may come from the affected departments, Liaison Officer, other community response partners / facilities/ or engineering department, news media, etc.

| INCIDENT CHARACTERISTICS | |
|---|---|
| **Arrival** | |
| *Note: The amount of time until the event combined with the anticipated time to evacuate determines how long an evacuation decision can be deferred* | |
| **When is the incident expected to impact the facility?** | |
| **How variable is the impact timeframe?** | |
| **Magnitude** | |
| *Note: The magnitude of the event predicts potential damage to a facility and utilities, which could cut off the supply of key resources, or otherwise limit the ability to shelter-in-place and care for patients.* | |
| **What are the expected effects on the facility?** | |
| **What are the expected effects on the community?** | |
| **How likely is the event to be more or less severe than predicted – what are the impacts?** | |
| **Area Impacted** | |
| *Note: Competition for resources needed to evacuate patients (especially vehicles) increases when more facilities evacuate simultaneously.* | |
| **How large is the geographic area affected?** | |
| **How many vulnerable healthcare facilities are in this geographic area (LTC, hospitals, others)?** | |
| **Duration** | |
| *Note: The duration of the incident affects how long facilities have to operate on backup, alternative, or less predictable resources.* | |
| **How long is the incident expected to last?** | |
| **How variable is the expected duration?** | |

| ANTICIPATED EFFECT OF THE INCIDENT ON KEY RESOURCES | |
|---|---|
| **Water** | |
| *Note: Water loss of unknown duration (more than 1-2 days) is almost always cause for evacuation.* | |
| **Is the facility or main city water supply in jeopardy? Already non-functional?** | |
| **Is there a backup water supply (well, nearby building with intact water mains)?** | |
| **If not, how soon will city water return?** | |
| **Heat / Air Conditioning** | |
| *Note: Loss of heat especially during a northern winter, or loss of air conditioning in summer, is often a cause for evacuation—often within 12 hours.* | |
| **Is the HVAC system in jeopardy (steam, water for boilers, etc.)? Already non-functional?** | |
| **Is there a backup (intact nearby building that still has power/HVAC)?** | |
| **If not, will the building be too cold/hot for patient safety before adequate temperature stabilizes?** | |
| **Electricity** | |
| *Note: Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.* | |
| **Is power at risk? Just for the facility or a wider area?** | |
| **Are backup generators functional?** | |
| **How long can they run without refueling?** | |
| **Is refueling possible given the situation?** | |
| **Can some sections/wings be shut down to reduce fuel consumption and stretch fuel supplies?** | |
| **Facility Structural Integrity** | |
| *Notes: Structural damage may cause rooftop water tanks to fail, flooding the building. Safety/ integrity may not be obvious to untrained occupants.* | |
| **Is the building obviously/visibly unsafe? All of it or only portions (e.g., can people be consolidated in safer sections)?** | |

| | |
|---|---|
| **Is there a water tank on the roof, and is it intact?** | |
| **Is a structural engineer needed to make an assessment?** | |
| **ANTICIPATED EFFECT OF THE INCIDENT ON THE COMMUNITY** | |
| **Road Conditions** | |
| *Notes: There may be a limited window of opportunity to carry out a ground-based evacuation. Increased use of helicopters to evacuate patients may be required. Personnel may not be able to get to the facility to relieve existing personnel or assist in the evacuation.* | |
| **Are any major routes from the hospital to potential receiving care sites closed or threatened?** | |
| **Will evacuation traffic clog major routes from the hospital to potential receiving care sites?** | |
| **Are access routes to the hospital cut off or threatened?** | |
| **Community/Building Security** | |
| *Note: If patient and personnel safety cannot be assured, the decision needs to be made whether sheltering in place is safer or if evacuation will be necessary.* | |
| **Have any nearby areas experienced increases in civil disorder or looting?** | |
| **Are local law enforcement agencies understaffed due to self-evacuations or significant additional responsibilities?** | |
| **Are additional private security officers available to secure the hospital?** | |
| **Evacuation Status of Other Nearby Health Care Facilities** | |
| *Notes: If other healthcare facilities are evacuating: the competition for ambulances, wheelchair vans, and buses may be substantially increased; you may be asked to accept additional patient; patients may have to be relocated to facilities further away than anticipated.* | |
| **Are other healthcare facilities already evacuating or planning to evacuate, or have they decided to shelter-in-place?** | |
| **State/County/Local Evacuation Order** | |
| *Note: You may have no choice but to evacuate.* | |
| **Have evacuation orders been issued in areas closer to the incident?** | |

| | |
|---|---|
| **Have any public or private statements been issued regarding the possibility of an evacuation order?** | |
| **Have any other incidents occurred that increase the likelihood that an evacuation order will be issued?** | |
| **Availability of Local Emergency Response Agencies** | |
| **Unavailability of local fire agencies increases the risk of sheltering-in-place.** | |
| **Are local emergency response agencies understaffed or less available due to other responsibilities?** | |

## Triage Officer Checklist - Evacuation

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that patients/residents are properly triaged to determine their most appropriate disposition for the most optimal care, and prepare for transfer if applicable.

| Task | Assigned | Complete |
|---|---|---|
| **Initial tasks** | | |
| Ensure basic medications, any needed IV fluids or resident care supplies are available or requested via the Staging Manager | | |
| Assist in identifying and clearing space for Green/Yellow/Red patients/residents | | |
| Assess residents arriving to the Staging Area for:<br>• Discharge home – (depending on situation may be held for discharge or transferred to another safer location nearby for discharge)<br>• Transfer to other facility: ○ Green – ambulatory, low acuity (bus, etc.)<br>○ Yellow – non-ambulatory, non-critical care (WC or BLS vehicle) ○ Red – critical care (ALS / critical care) | | |
| Assure evacuation tag applied and reflects priority for transfer accurately | | |
| **Subsequent tasks** | | |
| Group patients for transport loading by acuity | | |
| Direct personnel to provide necessary resident care during staging period | | |
| Coordinate with Staging Manager (or Officer, if several staging sites) and Transport Officer regarding supplies, patient loading priority, appropriate vehicle for transport, and flow issues | | |
| **Demobilization** | | |
| Ensure equipment and supplies are retrieved/returned | | |

## Evacuation Staging Manager Checklist

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

| Task | Assigned | Complete |
|---|---|---|
| **Immediate (Operational Period 0-2 Hours)** | | |
| Determine need for and appropriately appoint Evacuation Staging Team Leaders, distribute any corresponding Job Action Sheets and position identification. | | |
| Brief the Evacuation Staging Team Leaders on current situation; outline branch action plan and designate time for next briefing. | | |
| Identify appropriate area(s) to serve as Staging Area(s) based on resident acuity for the preparation of transporting residents and their equipment from facility to an accepting facility. | | |
| Coordinate staging needs of residents and their equipment and all evacuation staging team members. Requesting additional or rotation of personnel to evacuation staging areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader | | |
| Instruct all Evacuation Staging Team Leaders to evaluate situation, including, equipment, supplies, and medication inventories and personnel needs in collaboration with Logistics Section Supply Unit Leader; report status to Operations Section Chief and Supply Unit. | | |
| Continue coordinating transport of residents and their equipment from staging to the transport area, working with the Transport Manager as needed. | | |
| **Extended (Operational Period Beyond 12 Hours)** | | |
| Continue to monitor the Evacuation Staging Team's ability to meet workload demands, personnel health and safety, resource needs, and documentation practices. | | |
| Coordinate assignment and orientation of personnel sent to assist patient/resident | | |
| Rotate personnel on a regular basis. | | |
| **Demobilization/System Recovery** | | |
| As needs for Evacuation Staging Area decrease, return personnel to their normal jobs or release and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader. | | |

## Evacuation Staging Team Member Checklist

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that patients/residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

| Task | Assigned To | Completed |
|---|---|---|
| **Initial tasks** | | |
| Receive patieresidents into Staging Area and | | |
| Confirm transfer information is complete and accurate for each resident (including: evacuation tag, Patient Medical Information Form, and Patient Evacuation Tracking Form NHICS 260) | | |
| Assure resident comfort and medical needs are met (personnel, medication, water, blankets) | | |
| Communicate any care needs to Staging Team Leader | | |
| Communicate any resource needs to Staging Team Leader | | |
| **Subsequent tasks** | | |
| Group residents for transport loading by acuity or destination (dependent upon size of event and number of staging locations) | | |
| At the end of shift, brief Evacuation Staging Team Leader on any current problems or any outstanding issues | | |
| Complete and submit any documentation to Evacuation Staging Team Leader | | |
| **Demobilization** | | |
| Ensure equipment and supplies are retrieved/returned | | |
| Upon deactivation of your position brief, Evacuation Staging Team Leader on any current problems or any outstanding issues | | |
| Complete and submit any documentation to Evacuation Staging Team Leader | | |

## Department Shelter in Place and Evacuation Plan

| | |
|---|---|
| Relocation: Horizontal (first option) to: | ADJACent WING |
| Vertical (second option) to: | FLOOR Below |
| Vertical evacuation route/path: | Stair A North B South |
| Evacuation assembly point: | |
| Department shelter in place supplies/equipment location: Central Supply | |
| Department evacuation supplies/equipment location: | Stairs |
| Estimated number of patients/residents at peak: | 200 |
| Estimated number of personnel at peak: | 160 |
| Estimated number of visitors at peak: | 75 |

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
  - ○ Move patients/residents and personnel away from windows as possible.
  - ○ Close drapes/blinds and exterior doors/windows.
    - *Security emergency – bomb threat, individual posing security threat, external civil unrest*
      - ○ Refer to Active Shooter/Bomb Threat policy.
      - ○ Implement department-specific access controls.
      - ○ Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
  - ○ If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

**Evacuation:** The movement of residents, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement from the facility to another institution. Complete facility evacuation is undertaken as a last resort. Each department has an Assembly Point, a pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

**Anyone recognizing an imminent danger to residents or others shall take immediate steps to safeguard those in danger including patient movement.**

**Charge Nurse/Administrator Responsibilities upon notice of evacuation decision:**

- □ Remain calm.
- □ Receive instruction from the Command Center.
- □ Notify department personnel and reassign personnel as needed.
- □ Compile a list of patients and all facility personnel currently working in your area.
- □ residents, personnel, and visitors in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third.
- □ Confirm assembly point destination is available
- □ Triage residents for movement / transport using evacuation tags (with equipment)
  - ○ Tag color reflects priority: green patients are ambulatory (move first), yellow non-ambulatory, red unstable/critical care (move last)
  - ○ Tag all residents and attach tear-off band from tag to belongings
  - ○ Determine ambulatory status of patients and assign personnel to move them. All patients capable of ambulating should form a chain by holding hands (if capable) and be lead to the new location by personnel member(s).
  - ○ Assess acuity and resource needed to LOAD, MOVE, and CARRY non-ambulatory residents. Will depend on elevator status, etc. In non-emergency assure that staging is ready for yellow/red residents prior to moving.
- □ Assign a person to check all rooms to assure:
  - ○No occupants remain and no safety issues
  - ○ Evacuated rooms are marked with (*pre-determined room clear indicator)*
- □ If time and resources allow, assign person(s) to transport your area's medications.
- □ Documentation: ○ Emergency: Take patient summary sheet with demographics, allergies, medications, problem list, emergency contact information. Bring full chart if possible.
  - ○ Non-emergency: Above plus medication administration record and facility chart.
- □ Upon arriving at assembly point, complete resident and personnel head count. Personnel shall remain at safe location until reassigned or dismissed. residents shall be directed to remain at staging location until further instructions are given for discharge or transportation.
- □ Special Considerations:
  - ○ Patients on ventilators: When central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
  - ○ Patients with IVs
    - ▪ Saline lock all non-critical IV lines

- Nasogastric or gastrostomy tubes should be disconnected from suction, or collection system and kept open to drain by gravity.
- Evacuate tracheostomy patients with an obturator and a spare tracheal tube, as well as a bulb syringe for suction.
- Clamp peritoneal dialysis tubing, disconnect from solution, and cap the tubing end. (Do not evacuate bottles, bags, or octopus attachments).
- Remove cardiac monitors, leaving leads in place.
- Disconnect oxygen prior to evacuation.

| **Shelter In Place Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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| **Evacuation Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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## Support and Administrative Department Shelter in Place and Evacuation Plan Template

| Relocation: Horizontal (first option) to: | DAY Room |
|---|---|
| Vertical (second option) to: | N/A |
| Vertical evacuation route/path: | N/A |
| Evacuation assembly point: | 33RD + Union St |
| Department shelter in place supplies/equipment location: | Nursing office |
| Department evacuation supplies/equipment location: | " |
| Estimated number of patients/residents at peak: | 0 |
| Estimated number of personnel at peak: | 20 |
| Estimated number of visitors at peak: | 5 |

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
  - Move patients/residents and personnel away from windows as possible.
  - Close drapes/blinds and exterior doors/windows.
    - *Security emergency – bomb threat, individual posing security threat, external civil unrest*
      - Refer to Active Shooter/Bomb Threat policy.
      - Implement department-specific access controls.
      - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
  - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

**Evacuation:** The movement of residents, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement

from the facility to another institution. Complete facility evacuation is undertaken as a last resort.

**Anyone recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement.**

**Supervisor Responsibilities upon notice of evacuation decision:**

- ☐ Remain calm.
- ☐ Receive instruction from the Command Center.
- ☐ Notify department personnel and reassign personnel as needed.
- ☐ Compile a list of all facility personnel currently working in your area.
- ☐ Patient/residents, personnel, and visitors in imminent danger should be moved first, ambulatory persons second and non-ambulatory persons third.
- ☐ Confirm assembly point destination is available.
- ☐ Prior to leaving work area secure any hazardous chemicals, safes, and other potential hazards.
- ☐ Take any 'go-kits' or continuity supplies for your unit.
- ☐ Assign a person to check all rooms to assure: ○
  No occupants remain and no safety issues
  - ○ Evacuated rooms are marked with *(pre-determined room clear indicator)*
- ☐ Upon arriving at assembly point, complete head count. Personnel shall remain at safe location until reassigned or dismissed.

| **Shelter In Place Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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| Evacuation Supplies and Equipment Stored in this Department | |
|---|---|
| **Resource** | **Purpose** |
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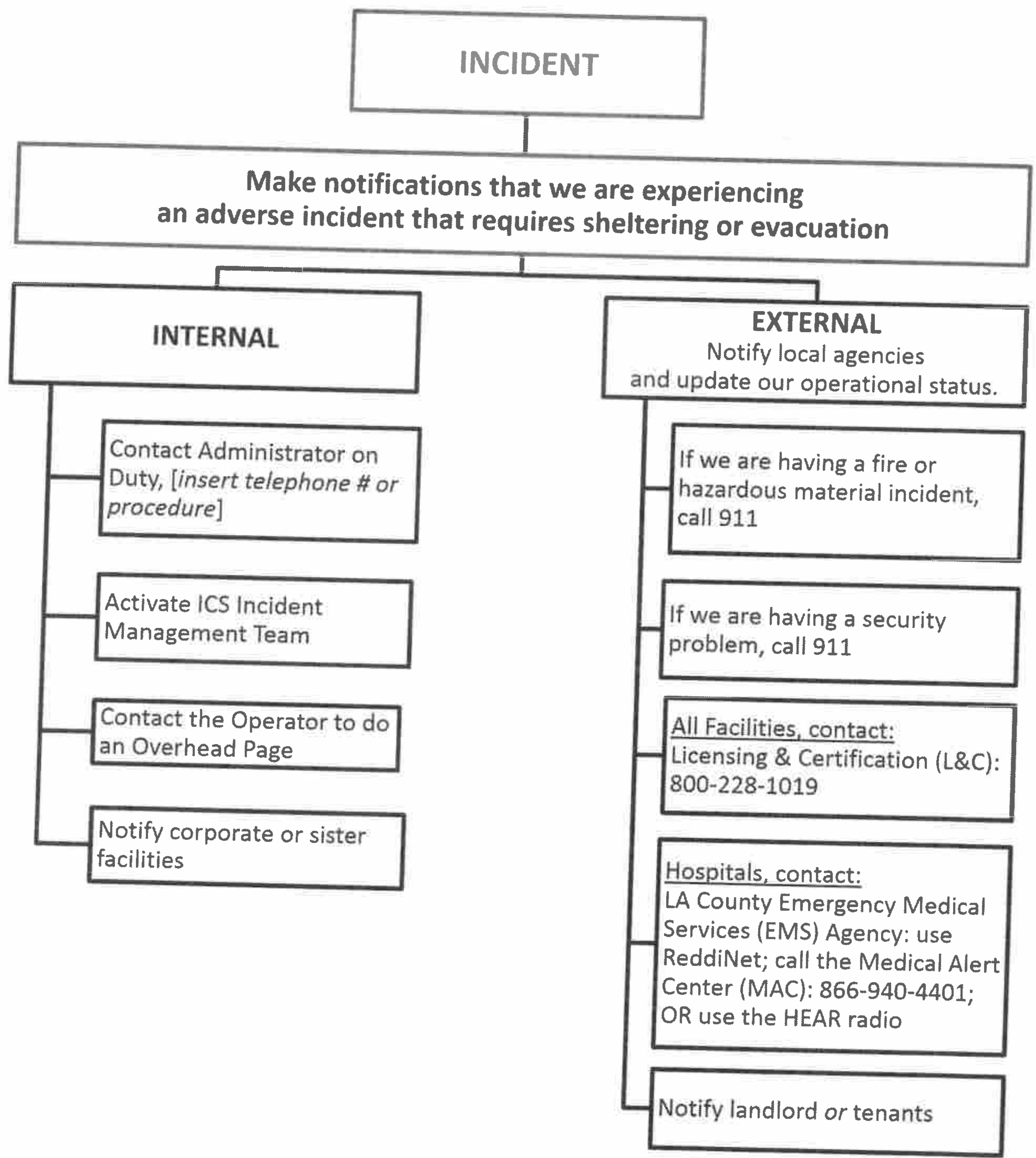
## Appendix: Initial Notification Chart



## Estimate of How Many Will Need to Be Evacuated or Need Sheltering Resources

Use this table to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

| **Personnel, Patient/Resident and Visitor Census at Its Lowest** | | | | | |
|---|---|---|---|---|---|
| **Day of the Week:** | | | **Time of Day:** | | |
| **Department or Area** | **Location** (Floor, etc.) | **# of All Personnel*** | **# of Ambulatory Patients** | **# of Nonambulatory Patients** | **# of Visitors** |
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* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

## Evacuation Triage and Transportation Tag

An evacuation triage and transportation tag system shall be used to track residents who are evacuated from the facility.

- Clinical personnel are responsible for assessment/triage which will dictate priority and mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of and coordinating the distribution the evacuation tags at each patient care department. ○ If tags are not available or you run out, use any piece of

| EVACUATION TRIAGE LEVEL | PRIORITY FOR EVACUATION FROM PATIENT CARE UNIT (Reversed START Triage) | PRIORITY FOR TRANSFER FROM THE TRANSPORT STAGING AREA TO ANOTHER HEALTHCARE FACILITY (Traditional START Triage) |
|---|---|---|
| RED | These are evacuated LAST from the unit because they require maximum assistance to move. These may<br>require 2-3 personnel members to transport | • These are transported FIRST as transfers from your staging area to an alternate healthcare site.<br>• These require maximum support to sustain life in an evacuation. |
| YELLOW | These require some assistance and should be evacuated SECOND in priority. may require wheelchairs or<br>stretchers and 1-2 personnel members to transport. | These will be transported SECOND in priority as transfers from your staging area to an alternate healthcare site. |
| GREEN | These equire minimal assistance and can be evacuated FIRST from the unit.<br>are ambulatory and 1 personnel member can safely lead several patients who fall into this category to the assembly point. | These will be transported LAST as transfers from your staging area to an alternate healthcare site or released to home. |

## Safe Refuge Areas and Horizontal Evacuation Area Chart

| Department | Floor | Primary Horizontal Evacuation Area | Secondary Horizontal Evacuation Area |
|---|---|---|---|
| Rereation | 9 | Roof top | Solarium |
| Nursing | 8 | North or South | Non Available |
| " | 7 | " | " |
| " | 6 | " | " |
| " | 5 | " | " |
| " | 4 | " | " |
| " | 3 | " | " |
| " | 2 | " | " |
| ADmin | 1 | " | outside |
| HK + Diet | LL | " | PT |
| | | | |

## Vertical Evacuation Route Chart

| Department | Floor | Designated Stairwell | Designated Elevator (for non-ambulatory residents; if operational) |
|---|---|---|---|
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## Evacuation Assembly Point Chart

This chart identifies each department with their primary exit stairwell and external assembly point.

| Department | Location | Exit Stairwell # | Assembly Point |
|---|---|---|---|
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>> Insert Map of Assembly Points

## Vertical/Complete Evacuation Transport Devices

The following specialized evacuation transport devices (chairs, stair stretchers, sleds, motorized gurneys, blankets) are located within the facility and are intended for use in vertical and complete evacuations. Just in time training may be done by personnel already trained in use of the equipment.

| Device | Location | Purpose |
|---|---|---|
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The following existing resources can be used in vertical evacuation but are more difficult to use:

- Wheelchairs can be used to move ambulatory, minimally ambulatory patients and nonambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then it can be used to move the evacuee to the assembly point.
- Beds/gurneys can be used to move non-ambulatory patients, but very difficult for vertical movement.
- Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

## Carry Evacuation Techniques

Below are emergency carry techniques for evacuation of non-ambulatory patients/residents, personnel or visitors. These techniques would be used as a last resort.

**PACK STRAP CARRY – One Rescuer**

- This method should be used when the patient can stand, but not walk, and limited personnel are available.
- Have the patient stand at the side of the bed directly behind you.
- Have them place their arms over your shoulders and cross them in front.
   Grasp the opposite arm, bend your knees, lean forward and lift.
- This method can be used for short distances, or if the patient is very light.

**ONE-PERSON ARM CARRY – One Rescuer**

- Hold the patient around the patient's back and under the knees.
- This method can be used for short distances, or if the patient is very light.

**BLANKET DRAG – One Rescuer**

- Lower the bed as much as possible, and put blanket along the side of the bed, make sure some of the blanket is under the bed. Leaving two to three feet extra at the top.
- Kneel on your left knee, and put your left arm under the their shoulders. Place your right arm under their knees, and pull their legs and hips off the bed, allowing the head and torso to follow.
- Use your left arm to support, not hold, the head and shoulders as you lower them to your left knee. Then gently lower the head and shoulders to the blanket.
- Grasp the end of the blanket above the patient's head, roll it up a few inches, and drag the patient to safety.

**REAR APPROACH ASSIST – One Rescuer**

- Used for an ambulatory patient who may be confused.
- Approach from the rear, put both arms between the patient's arms and body, and grasp their wrists.
- Gently guide them to safety, tuck your head into their shoulder to protect you should they move their head to one side.

**SIDE BY SIDE ASSIST – One Rescuer**

- This carry is for patients who can stand and walk with support.
- Put the patient's left (right) arm over your shoulder, and grasp it with your left (right) arm.
- Place your right arm around their waist, and support them as you walk to safety.

## Appendix:

**TWO PERSON SLING CARRY – Two Rescuers**

- Use when the patient can sit up in bed, but not walk unaided.
- Each rescuer positions themselves on either side of the patient.
- Have the patient put his/her arms over each rescuers shoulders, and hold on.
- The rescuers should then grasp each other's arms under the patient's knees and back, lifting like a sling.
- Two people can carry non-ambulatory patients for long distances using this method.
- Lean the patient against a wall when you want to unload the patient.
- Bend the knee closest to the wall to control descent, letting patient's feet touch the floor, and gently lowering their body.
- (Not recommended for patients with back or cervical problems.)

**EXTREMITY CARRY – Two Rescuers**

- Can be used as long as the patient can sit up in bed.
- The first rescuer sits behind the patient, has them fold their hands in front of their body, and grasps the patient's forearms with their own.
- The second rescuer sits between the patients legs, and cradles each leg with their arms.
- Stand in unison using good body mechanics.
- (Not recommended for patients with back or cervical problems.)

**CHAIR CARRY – Two Rescuers**

- Place the patient in a sturdy, non-swivel chair.  Tilt the chair backwards as rescuers lift the patient.
- If possible, secure the victim to the chair.
- If the rescuers need to carry the patient over uneven surfaces or stairs, the rescuers must face each other.

**BLANKET CARRY – Four to Six Rescuers**

- **Do not use sheets for this procedure, they will not provide sufficient support.**
- Can be used if the patient is very heavy.
- Can be used to carry IVs, oxygen tubing, etc.
- Three rescuers are needed to roll the patient to their side, lift in unison, and place them on a blanket, along with IVs, etc.
- The rescuers crouch on each side, roll up the blanket until their hands touch the patient, and then lift in unison.

## Appendix:

### Transportation Resource Needs Matrix

Use this tool to determine transportation needs when requesting assistance through your usual transportation providers or the County EMS

| **Resident Census and Transportation Needs** | | |
|---|---|---|
| | **# of Pt** | **Calculation:** |
| Discharge within 3 hours | | Multiply your total inpatient census by 20% |
| Residents Needing Transport | | Multiply your census by 80% |
| | | |
| **Type of Transportation Resource** | **# of Pt** | **Calculation:** |
| NICU Transport | | Multiply Total Inpatients Needing Transport by 6% |
| Critical Care Transport | | Multiply Total Inpatients Needing Transport by 6% |
| ALS Transport | | Multiply Total Inpatients Needing Transport by 7% |
| BLS Transport | | Multiply Total Inpatients Needing Transport by 50% |
| Van/Bus Transport | | Multiply Total Inpatients Needing Transport by 31% |

## Appendix:

## Appendix: Evacuation Patient Medical Information Form

*Completed by the nurse providing care. The following information is the minimum provided when transporting a patient/resident to another care site. A copy of the medical record and advanced directives should be included, if possible. A copy of this form should be maintained by the Patient Tracking Manager.*

| SENDING FACILITY | DATE | |
|---|---|---|
| PATIENT NAME | DATE OF BIRTH | SEX |
| MEDICAL RECORD NUMBER | ADMISSION DATE | CONSENT OBTAINED FOR TRANSFER (circle) Yes No Unable to Obtain |
| EMERGENCY CONTACT | TELEPHONE NUMBER | NOTIFIED OF TRANSFER (circle) Yes No |
| PATIENT ACUITY | ATTENDING PHYSICIAN | NOTIFIED OF TRANSFER (circle) Yes No |
| ORIGINAL CHART SENT WITH PATIENT (circle) Yes No | ADVANCED DIRECTIVE (circle) Yes No | COPY SENT WITH PATIENT (circle) Yes No |
| PRIMARY DIAGNOSIS | SECONDARY DIAGNOSES | ALLERGIES |
| PRIMARY LANGUAGE: ENGLISH (circle) Yes No | IF NO, PRIMARY LANGUAGE: | IF NO, DOES PATIENT UNDERSTAND ENGLISH: Yes No |

| VITALS AT TIME OF TRANSFER | TEMPERTURE | PULSE | RESPIRATIONS | BLOOD PRESSURE |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| **ISOLATION STATUS** (circle) None Contact Droplet Airborne Other | **PRECAUTIONS** (circle) Aspiration Seizure Fall Elopement Other: |
| **OXYGEN** (circle) Mask Cannula Other:_________<br>Oxygen Requirement:<br>**INTRAVASCULAR DEVICE** (circle) Central Line PICC Line Arterial Line Saline Lock Medication Drip Other:<br>**FOLEY** (circle) Yes No<br>**INCONTINENT** (circle) Yes No<br>If yes, (circle) Bowel Bladder | **DIET** (circle)<br>NPO<br>Tube Feeding: Yes No Enteral Parenteral<br>Formula:____________________<br>Type: Regular Low Salt Diabetic Bland<br>Consistency: Regular Ground Puréed Thickened Liquids<br>Other: |
| **ASSISTIVE DEVICES** (circle all that apply)<br>None Cane Walker Wheelchair Glasses<br>Dentures: Upper Lower Hearing Aid<br>Prosthesis, Type: | **MENTAL STATUS** (circle) Oriented Alert Lethargic Mildly Confused Severely Confused<br>**BEHAVIOR** (circle) Cooperative Disruptive Belligerent Combative Wanders Withdrawn |
| **MEDICATION(S) MOSTLY RECENT ADMINISTERED** | **MEDICATION(S) SENT WITH PATIENT** (circle) Yes No *If yes, describe below:* |

## Appendix:

<table>
<tr><td colspan="3">EQUIPMENT OWNED BY SENDING FACILITY<br>ACCOMPANYING PATIENT DURING TRANSPORT</td><td colspan="3">COMMENTS</td></tr>
<tr><td colspan="2">RECEIVING CARE SITE</td><td colspan="2">METHOD OF TRANSPORT</td><td colspan="2">TRANSPORTING AGENCY</td></tr>
<tr><td colspan="2">DATE TRANSFERRED</td><td colspan="2">TIME TRANSPORT INITIATED</td><td colspan="2">TIME OF ARRIVAL<br>AT RECEIVING FACILITY</td></tr>
<tr><td colspan="3">NAME OF PERSON COMPLETING THIS FORM</td><td colspan="3">CREDENTIAL AND TITLE</td></tr>
</table>

*Note: Additional information can be written on back if needed and/or time permits.*

## Appendix:

### Patient Evacuation Tracking Form

*Completed by the nurse providing care. The Patient Tracking Manager should maintain a NHICS 255, Transfer Summary Form, or this form to track all patients that are transferred to an alternate care site or discharged.*

<table>
<tr><td colspan="2">PATIENT NAME</td><td>DATE OF BIRTH</td><td>SEX</td></tr>
<tr><td>MEDICAL RECORD NUMBER</td><td colspan="3">DISPOSITION (circle) Discharged or Transferred</td></tr>
<tr><td>EMERGENCY CONTACT</td><td>TELEPHONE NUMBER</td><td colspan="2">NOTIFIED OF TRANSFER<br>(circle) Yes No</td></tr>
<tr><td>ATTENDING PHYSICIAN</td><td>NOTIFIED OF TRANSFER<br>(circle) Yes No</td><td colspan="2"></td></tr>
<tr><td>RECEIVING CARE SITE</td><td>METHOD OF TRANSPORT</td><td colspan="2">TRANSPORTING AGENCY</td></tr>
<tr><td>DATE TRANSFERRED</td><td>TIME TRANSPORT INITIATED</td><td colspan="2">TIME OF ARRIVAL AT RECEIVING FACILITY</td></tr>
<tr><td>ORIGINAL CHART OR INFO SHEET SENT WITH PATIENT(circle) Yes No</td><td colspan="3">ADVANCED DIRECTIVE COPY SENT WITH PATIENT (circle) Yes No (circle) Yes No</td></tr>
<tr><td>PRIMARY DIAGNOSIS</td><td colspan="3">SECONDARY DIAGNOSES</td></tr>
<tr><td colspan="2">EQUIPMENT OWNED BY SENDING FACILITY ACCOMPANYING PATIENT DURING TRANSPORT</td><td colspan="2">MEDICATION SENT WITH PATIENT<br>(circle) Yes No If yes, describe below:</td></tr>
<tr><td colspan="2">BELONGINGS SENT WITH PATIENT<br>(circle) Yes No If no, describe below:</td><td colspan="2" rowspan="2">COMMENTS</td></tr>
<tr><td colspan="2">NAME AND TITLE OF PERSONNEL MEMBER(S) ACCOMPANYING PATIENT TO ALTERNATE CARE SITE</td></tr>
</table>

# HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM

| 1. INCIDENT NAME | 2. DATE/TIME PREPARED | 3. PATIENT TRACKING MANAGER |
|---|---|---|
| | | |

**4. PATIENT EVACUATION INFORMATION**

| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | Accepting Hospital | Time Hospital Contacted & Report given |
|---|---|---|---|---|---|
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | Accepting Hospital | Time Hospital Contacted & Report given |

| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
|---|---|---|---|---|---|---|

| 5. SUBMITTED BY | 6. AREA ASSIGNED TO | 7. DATE/TIME SUBMITTED |
|---|---|---|
| 8.FACILITY NAME | | |

**Purpose:** Record information concerning patient disposition during a hospital/facility evacuation **Origination**: Patient Tracking Manager
**Copies to:** Planning Section Chief and Documentation Unit Leader

## General Evacuation Supplies

Additional resources needed may be needed during evacuation such as flashlights, spotlights, electrical cords, water stations, personal protective equipment, work gloves, portable ventilators, and other non-patient related equipment.

| Resource | Storage Location | Purpose |
|---|---|---|
| | | |
| | | |
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## Appendix:

### Care Department Supplies

**Care Department Evacuation Supplies**

The following items are stored in each care department

| Resource | Storage Location | Purpose |
|---|---|---|
| Evacuation triage tags | | |
| Permanent medium markers | | |
| Labels and ball point pens | | |
| 'Room Clear' labels (pink fluorescent, 2x4 inches) | | To identify areas that have been checked and evacuated |
| Flashlights / headlamps (4) | | |
| Blankets / carrying canvas | | |
| Large envelopes | | For records / transfer documentation to accompany |
| Rubber Bands | | For medical records information |
| Clipboard | | |
| Patient Evacuation Tracking Form NHICS 260) | | |
| Master Patient Evacuation Tracking Tools NHICS 263) | | |
| Unit personnel/visitor tracking form | | |
| Extra footies | | For ambulatory without shoes |
| Fluorescent vest | | For department / evacuation lead |
| department supplies to be 'grabbed' if time allows | | |

**Patient Care Department Shelter in Place Supplies**

The following items are stored in each patient care department: (add additional

| Resource | Storage Location | Purpose |
|---|---|---|
| Bottled water | | |
| Food | | |
| Radio | | |
| | | |
| | | |
| | | |
| | | |

## Appendix:

### Pharmacy Evacuation Cache

*(Below is a sample; update to reflect your supplies)*

| Medication | Strength / concentration | Quantity |
|---|---|---|
| Acetaminophen | 375mg tab | 500 |
| ASA | 81mg chewable | 30 |
| Albuterol | MDI | 5 |
| Furosemide (lasix) | 40mg injectable | 5 |
| Furosemide (lasix) | 40mg tab | 20 |
| Oxycodone elixir | 10mg/5ml tubs | 20 |
| Ibuprofen | 200mg tabs | 100 |
| Acetaminophen | 160mg / 5ml | 1 bottle |
| Diphenhydramine | 50mg / 2ml injectable | 10 |
| Diphenhydramine | 25mg tab | 50 |
| Enoxaparin | 100mg / syringe | 15 |
| Droperidol | 5mg / 2ml | 15 |
| Haloperidol | 10mg tab | 25 |
| Olanzapine | 10mg tab | 25 |
| Lorazepam | 2mg/2ml injectable | 15 |
| Ativan | 1mg po | 25 |
| Insulin | Regular | 2 bottles |
| Insulin | 70/30 | 2 bottles |
| Marcaine | 0.25% with epi | 2 bottles |
| Hydromorphone | 1mg/2ml | 20 |
| Saline lock | 5ml | 50 |
| Syringe tuberculin with needle | | 20 |
| Syringe 12ml | Luer lock | 20 |
| Syringe | 3ml with 1 inch 23 ga. needle | 20 |
| Needle | 18 ga. 1.5 inch | 20 |
| Needle | 25 ga. 1.5 inch | 10 |

## Appendix:

### Assembly Point Supplies

(*Below is a sample; update to reflect your supplies*)

| Item | Storage Location | Destination | Deployment Method (e.g., automatic upon evac, upon instruction from the IC, etc.) |
|---|---|---|---|
| **Administrative Items** | | | |
| Permanent markers | | | |
| Rubber bands for medical records | | | |
| Sheet protectors for transfer documentation to accompany patient | | | |
| NHICS Forms | | | |
| Evacuation tags | | | |
| Additional 'room clear' labels (100) | | | |
| Chart pads | | | |
| **Food Items** | | | |
| Bottled water | | | |
| Energy bars | | | |
| **Medical Items** | | | |
| IV Solutions | | | |
| D5 0.45NS – x bags | | | |
| NS – x bags | | | |
| Wheel Chairs (WC) | | | |
| Walkers | | | |
| Crutches | | | |
| Gloves, exam M, L | | | |
| Crash cart | | | |
| Portable oxygen cylinders (D type) | | | |
| First aid kits | | | |

## Appendix:

| Personal Items | | | |
|---|---|---|---|
| Sani-wipes | | | |
| Hand sanitizer | | | |
| Diapers, adult | | | |
| Sheets | | | |

| Item | Storage Location | Destination | Deployment Method (e.g., automatic upon evac, upon instruction from the IC, etc.) |
|---|---|---|---|
| Blankets | | | |
| Emesis bags | | | |
| Non-skid socks for ambulatory patients without shoes | | | |
| Facial tissues | | | |
| **Janitorial Items** | | | |
| Paper towels | | | |
| Flashlight | | | |
| Garbage bags, plastic | | | |
| Zip close plastic bags, gallon | | | |
| **"Infrastructure"** | | | |
| Tents | | | |
| Chairs | | | |
| Generators | | | |

## Appendix:

### Facility Shut Down and "Stay Team" Member Checklist

| Task | Assigned To | Complete |
|---|---|---|
| Change facility status to closed | Liaison Officer | |
| Identify the lockdown plan and how to harden exterior & critical infrastructure | Operations/Security Branch Director | |
| Define procedures for coordinating local public safety to determine inner and outer perimeters | Operations/Security Branch Director | |
| Procedure to account for safe evacuation of assigned "stay team" personnel | Logistics Section | |
| Define departmental procedures for securing and shutting down equipment and identifying personnel assigned to perform shutdown functions: (critical operations responsibilities) | | |
| Central / sterile supply | | |
| Dietary & foodservices | | |
| Hazardous waste (satellite and waste sites) | Safety Officer | |
| Hazardous materials storage locations | Safety Officer | |
| Information Technology (IT, telecomm, radio) | | |
| Finance | | |
| Lab | | |
| Morgue | | |
| Pharmacy (defined procedures for security and/or management of controlled substances) | | |
| Records | | |
| Utilities (see next chart for procedures) | | |

## Appendix:

### Utility Shutdown Procedures

| Utility | Location of Shut Off | Responsible Party Performing Shut Off | Procedure |
|---|---|---|---|
| Electricity | | | |
| HVAC | | | |
| Medical Gas - Oxygen | | | |
| Medical Vacuum | | | |
| Natural Gas | | | |
| Sewer | | | |
| Steam | | | |
| Telephone | | | |
| Water – Potable | | | |
| Water – Fire Sprinkler | | | |

## Appendix:

Incident Management Team Recovery Responsibilities

### COMMAND

- ❑ Incident Commander
    - ○ Assess if criteria for partial or complete reopening of the facility is met, and order reopening and repatriation of patients
    - ○ Oversee restoration of normal hospital operations
- ❑ PIO: Conduct final media briefing providing situation status, appropriate patient information and termination of the incident
- ❑ Liaison Officer: Notify local emergency management, fire, EMS and Licensing & Certification of termination of the incident and reopening of the facility
- ❑ Safety Officer: Oversee the safe return to normal operations and repatriation of patients

### OPERATIONS

- ❑ Restore patient care and management activities
- ❑ Repatriate evacuated patients
- ❑ Re-establish visitation and non-essential services

### PLANNING

- ❑ Finalize the Incident Action Plan and demobilization plan
- ❑ Compile a final report of the incident and hospital response and recovery operations
- ❑ Ensure appropriate archiving of incident documentation
- ❑ Write after-action report and corrective action plan to include the following:
    - Summary of actions taken
    - Summary of the incident
    - Actions that went well  Area for improvement
    - Recommendations for future response actions

### LOGISTICS

- ❑ Implement and confirm facility cleaning and restoration, including:
    - Structure
    - Medical equipment certification
- ❑ Provide debriefing and mental health support services for personnel and patients
- ❑ Inventory supplies, equipment, food, and water, and return to normal levels

### FINANCE/ADMINISTRATION

- ❑ Compile final response and recovery cost and expenditure and estimated lost revenues summary and submit to the Incident Commander for approval
- ❑ Contact insurance carriers to assist in documentation of structural and infrastructure damage and initiate

## Appendix:

### Hierarchy of Repopulation Approval(s)

Dependent upon circumstances, the following sequential steps should be expected prior to the repopulation of evacuated hospital facilities.

| Steps | Date Completed |
|---|---|
| A. Local government agencies have removed restrictions, if any, related to the environmental quality in the area or facility for the types of patients to be moved back into the facility. | |
| B. Local fire department and/or law enforcement agency representative allows re-entry to the specific evacuated neighborhood in which the facility is located and/or allows re-entry to evacuated facilities, as applicable. | |
| C. If structural integrity or any major building system is compromised, DOB inspects and repopulation cannot occur until any red and yellow building tags are removed from the impacted building by DOB. | |
| D. If required, due to prolonged loss of power and refrigeration or breach of pharmaceutical security, State Pharmacy Board may conduct a site visit to approve measures taken to restore Pharmacy capacity and safety. | |
| E. The CEO/IC oversees an assessment of environmental safety, facilities, operations and resources, including the factors identified in the General All Hazards Repopulation Factors checklist below, and prepare the facility for repopulation. | |
| F. The CEO/IC maintains communication with the District Office regarding facility status, progress and estimated timeframes for reopening of facility (ies). Depending upon the circumstancesDOH may schedule a reportable event visit. | |
| G. Once the CEO/IC makes a determination, based on best judgment, that the facility is ready to repopulate, DOH is notified and:<br>1. If necessary, an DOH repopulation inspection is scheduled, or 2. Repopulation is initiated. | |

## Appendix:

### General All-Hazards Re-Population Factors / Steps

*The following factors / steps should be considered as appropriate to the type of evacuation.*

| Factors / Steps | Status/Date |
|---|---|
| A. Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by DOB, fire marshal and Licensing & Certification (L&C). | |
| B. Air particulate exposure levels (e.g., smoke, chemicals) in buildings are documented to be reduced to acceptable/safe levels as defined by NYS/OSHA permissible exposure limits (PELS) and local Air Quality Management District standards using available methods (e.g., air scrubbers, open windows, blowers, HAZWOPER response, etc), if needed. Only test equipment appropriate to the hazard should be used to determine safe levels of habitability and may require an outside testing laboratory service. | |
| C. All interior and exterior surfaces/areas are clean and free of debris (e.g., counters, walls, drawers, closets, roof, parking facilities, etc). | |
| D. All filters in the facility, HVAC systems, and generators, etc. should be cleaned/replaced, if needed. | |
| E. Replace or clean linens, drapes, and upholstery, if needed. | |
| F. All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/ quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.). | |
| G. Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are returned to operational status. The facility's ability to provide essential services should be sustainable for the long term. | |
| H. Vandalism and/or looting damage, if applicable, is repaired and alleviated. | |
| I. Full and non-abbreviated generator and smoke detector tests are completed, if needed. | |
| J. HVAC systems are tested and operational, if needed. | |
| K. Utilities are tested and operational (electricity, water supply and quality, plumbing, etc.). | |
| L. Dietary services are operational and sustainable for the long term; in the case of damage to kitchens/equipment, program flex approval from L&C may be requested for contract services during repairs. | |

## Appendix:

Blank

## UNION PLAZA CARE CENTER

**TITLE:** Missing Resident

**POLICY:** It is the policy of UNION PLAZA CARE CENTER to secure the safety and well-being of our residents.

**PROCEDURE:**

1. Upon admission each resident will be photographed and a copy of this photograph will be maintained in the residents chart.
2. Residents on all units will be accounted for on an hourly basis.
3. In the event that a resident is identified as a wanderer, a copy of the residents photo will be maintained at the security/reception desk.
4. Identified wanderers will be issued an Alarm Activated Identification Band.

In the event the above procedures prove insufficient, and a resident is found to be missing from a unit, the following procedures will be initiated:

1. The RN Supervisor/LPN charge nurse will initiate an immediate search of all areas of the residents unit, including bathrooms and storage areas
2. If the resident is not located on the unit, the DNS / Designee will be immediately informed.
3. Security guard shall be informed to announce "Dr. Find is in the building", indicating that the missing resident procedure should now be put into effect.
   a. In the event the Administrator /Designee is not in the facility, security shall call the Administrator to inform her/him of the search status.
   b. The security guard will be responsible to monitor security cameras at the front desk and try to locate the last known whereabouts
4. Each RN Supervisor /LPN Charge nurse will immediately initiate a search of the unit to identify any resident not belonging to their unit.
   a. The results of each unit search will be reported to the DNS/ Designee
5. A facility wide search will be instituted including all resident areas.
   a. Basement
   b. Parking Levels
   c. Recreation areas and Rooftop areas
6. If there are community locations that the resident has been known to frequent, these areas will be thoroughly searched.
7. If the resident is not found within two (2) hours, the facility will notify the following:
   a Local Law Enforcement Agencies
   b Local Hospital's Emergency Rooms
   c Resident's responsible party of record

8. The Nursing Supervisor shall document all information in the nurses note and (24) twenty-four hour report.

9. In the event that the resident has been found to be alert and oriented and has left the facility of his or her own volition, the resident will be discharged Against Medical Advice (AMA) after forty -eight (48) hours.

10. In the event that the resident is found to be demented or incompetent, the New York State Department of Health will be notified after twenty-four (24) hours.

11. In the event that the resident is located, the Nursing Supervisor shall document date, time and location where resident was found. Upon resident's return to the unit, nursing shall assess the resident's condition. Nursing Supervisor shall document any pertinent data regarding the resident condition (i.e.: bruises, cuts, marks, changing condition, etc.) The attending physician or alternate shall be contacted, and a complete physical examination of the resident shall be performed

12. A full investigation of the event will be conducted, and the NYS Department of Health will be notified.

UNION PLAZA CARE CENTER

# Evacuation and Shelter

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## Overview

**Purpose:**

The purpose of this plan is:

- To direct the activities required to implement sheltering-in-place, partial evacuation/internal relocation or full evacuation
- To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation
- To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the NHICS

**General Plan/Policy Guidelines:**

  - Sheltering-in-place, relocation, and evacuation activities:
  - May occur as standalone response or may be implemented in a progression, if necessary, as the incident evolves
  - May be implemented in a proactive response to impending hazards
  - May be implemented in response to an acute incident
- The following are examples of factors that could lead to activation of the shelter-inplace / relocation / evacuation plan:
  - Loss of environmental support services including heating, water, air conditioning, electrical power, and medical gases.
  - Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.
  - External emergencies including natural and man-made disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminated victims/toxic agents, radiation exposure, explosions and police actions.
- The evacuation of the facility shall only be initiated as a last resort in response to disruption of services caused by an internal or external disaster.
- The responsible individual for the activation and implementation of this plan is the Incident commander, Administrator or

**Supporting Plans**

If necessary, based on the incident, any or all the following plans may also be activated in support of the evacuation / shelter in place plan:

- Emergency operations plan (EOP)
- Command center operations
- Department-specific evacuation plans
- Lockdown procedures
- Active shooter/threat
- Facility closure, restoration and start up and Business continuity

## Operational Definitions

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP.

- When SIP is done in an active shooter or active threat situation, it can be called Defend in Place. Refer to Active Shooter/Threat Plan

**Evacuation:** The movement of patients, personnel and visitors from a dangerous location to one of relative safety.

- **Partial Evacuation or Relocation:** Movement within the facility.
- **Horizontal Evacuation:** Evacuation on the same floor, often to the other side of a set of fire barrier doors.
- **Vertical Evacuation:** Evacuation to a safe place on another floor, can be upward or downward.
- **Total or Complete Evacuation:** The full evacuation of a facility to an outside area which may also require transfer of patients (and possibly personnel) to another healthcare facility or alternate site.

**Emergent Evacuation:** An evacuation that is conducted in quick response to an acute emergency.

**Planned or Phased Evacuation:** An evacuation that is conducted in a planned or phased manner in response to an impending emergency such as hurricane or flood.

**Refuge Area**: A location within a building that is identified as having relative safety. May be used in SIP situations or partial evacuation/relocation.

**Assembly Point or Collection Area:** A pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

## Plan Activation

The responsible individual for the activation and implementation of this plan is the Senior staff member on duty.

The decision to implement whole or parts of the evacuation plan should be determined based on the incident assessment, information and/or recommendations from other facility personnel or community response partners such as the local fire or police department. Decision making resources available are:

- Decision Tree - Appendix, page 23
- Decision Matrix - Appendix, page 24
- Incident Assessment Worksheet, Incident Management

**Establish Command and Control**

- The overall management of incident response and recovery is the responsibility of the Incident Commander as designated in the Emergency Management Plan.
  - All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
  - Every department is responsible for implementing their activities within the evacuation plan.
- The Incident Commander will notify and activate:
  - Activate Code [Code phrase] .
- Activate NHICS Incident Management Team members as needed by the incident.

  The NHICS Incident Response Guide for Evacuation may serve as a guide
  - Activate the Command Center. If the primary location is not available, notification must include the new alternate location.

  ICS and Command Center operations shall be guided by:
  - This plan, and other plans activated in support of this incident.
  - ICS Job Action Sheets.

- All information related to the incident shall be coordinated and released through the Command Center.
- The Command Center will coordinate with outside agencies, other healthcare facilities and facility administration regarding facility status, evolving situational needs, and overall status of the evacuation/shelter in place process.

**Roles and Responsibilities**

In addition to the use of the position Job Action Sheets, the following identifies some key activities and responsibilities for certain NHICS IMT members and all personnel. Additional resources available:

- Initial Critical Action Sheet for an Emergency Evacuation - Appendix, page 25
- Initial Critical Action Sheet for Emergent Shelter in Place - Appendix, page 26
- Defend in Place for Active Threat/Shooter - Appendix, page 27
- Command Personnel Checklist for Shelter, Relocation, & Evacuation - Appendix, page 30

- HICS Evacuation Incident Response Guide

*Incident Commander*

Has the full authority and responsibility for the decision-making processes for this response.

*Public Information Officer*

- Coordinate media communications regarding the status of the facility, including the need to evacuate.
- Establish a family information center to notify and respond to queries from family members regarding the status and location of patients who have been evacuated. Utilize the tracking information provided to the Command Center by the Planning Section Chief.
- Assign personnel to notify the patients/residents emergency contact person.

*Liaison Officer*

- Notify local agencies to notify that you are experiencing an adverse incident that requires sheltering or evacuation and update your operational status (capabilities, resources needs, etc.).
- Ensure the facility is placed on ambulance diversion
- All Facilities: Notify DOH
    - Notify community response partners, including:
      ○ Local fire department (may be able to assist with evacuation; provide information on the incident, etc)
      Local police department (may be able to assist with securing the facility / area; provide information on the incident, etc)

*Safety Officer*

- Oversee the immediate stabilization of the facility
- Recommend areas for immediate evacuation to protect life
- Ensure the safe evacuation of patients, staff and visitors
- Conduct initial and ongoing analysis of existing evacuation practices for health and safety issues related to personnel, patients, and facility, and implement corrective actions to address

*Operations Section Chief*

- Coordinate the processes necessary to safely evacuate a portion or all of the facility.
- Identify appropriate staging areas for the receipt and movement of patients/residents, personnel and visitors.
- Work with the Medical Care Branch Director to identify (number and acuity levels), prioritize, and evacuate patients in a systematic and orderly manner.

Communicate with the Infrastructure Branch Director to determine the need for — and orderly implementation of — the operational reliability and/or shut down of utilities and structural support systems.

- Coordinate with the Infrastructure Branch Director to determine and supply necessary utilities and medical gases to the sheltering or evacuation assembly points.
- Coordinate with the Liaison Officer to determine the number and type of transportation vehicles that will be necessary to evacuate patients to alternate care sites.
- Work with the Security Branch Director to establish access and control of key areas of the facility and campus during the evacuation.
- Interface with the Business Continuity Branch Director to assure that the security and availability of vital patient/resident health record, and other key information is maintained.

*Planning Section Chief*

- Establish and implement processes to track the location of patients/residents, personnel and resources who have been moved from one location to another — including evacuation to alternate sites of care.

*Logistics Section Chief*

- Work with the Operations Section Chief to provide the necessary medical equipment, beds, medications, and supplies to safely relocate patients to alternate locations. Caches of equipment, supplies, and medications pre- positioned to manage an influx of casualties can be used if they are not required for their intended purpose.
- Assure an adequate supply of personnel and other human resources to safely evacuate patients/residents and visitors to alternate locations.
- Ensure that potable water and basic food supplies are brought to the sheltering area or assembly points.
- Collaborate with the Operations and Planning Section Chiefs to identify and address both internal and external transportation needs.
- Establishing a family information center to notify and respond to queries from family members of personnel regarding the status and location of personnel who have been evacuated.

*All Personnel*

- All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
- Assist patients/residents with sheltering or evacuating as indicated

Communication

Internal notification and external communications should be conducted according to the Emergency Operations Plan. Key communications for facility evacuations include, but are not limited to:

- **Personnel, on duty**: Notification of potentially unsafe situation(s) at the facility. If evacuation activities are possible, an 'evacuation standby' notification should be made as soon as possible so that units may begin accessing appropriate supplies and collecting belongings and records.
- **Personnel, off duty**: Notification of potentially unsafe situation(s) at the facility. Provide guidance on whether personnel should report to duty as usual or not.
- **Patient families**: Notification of patient/resident families of evacuation destinations
- **Medical providers**: Notification of evacuation destinations
- **Personnel families**: Notification of incident status and evacuation destinations
- **Public safety**: Communication links to facilitate coordination with public safety agencies (security and traffic control), EMS and other transport providers (buses, etc), and fire agencies (lifting assistance)
- **Media**: Public information reflecting the capabilities of the facility

## Initial Notification Chart

See Appendix, page 43.

## Estimate How Many Will Need to Be Evacuated or Need Sheltering Resources

See Appendix, page 44, to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

## Sheltering in Place Procedures

When the threat does not permit safe relocation or evacuation, the following actions may be taken. **Patient care and administrative departments are authorized to initiate these actions upon recognition/notification of threat** (in conjunction with notification of supervisors or other actions under the emergency management plan):

*Weather* – wind, hail, or other weather threat.
Remain calm.
Move patients/residents and personnel away windows as possible.
Close drapes/blinds and exterior doors/windows.
Ensure personnel and visitors also advised of weather situation.
Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
Personnel will remain with patients/residents

- *Security emergency – bomb threat, individual posing security threat, external civil unrest* o Remain calm.
    - Refer to Active Shooter/Bomb Threat policy. o Implement department-specific access controls.
    - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed. o Ensure personnel and visitors are aware of the situation.
    - Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
    - Personnel will remain with patients/residents.

- *Hazardous materials (HAZMAT) incident* o Remain calm.
    - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
    - Ensure visitors and personnel aware of threat – location and actions to take. o Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
    - Personnel will remain with patients/residents.

## Evacuation - General Guidelines

**Authority and Decision Making**

- All personnel are authorized to take immediate patient/resident relocation actions in response to an immediate life safety emergency.
- Initiation of a vertical or complete evacuation, with the exception of persons in immediate danger, will be coordinated by the Incident Commander/Command Center.

**Evacuation Priorities**

In an emergency:

1. Persons in immediate danger, If persons are not in immediate danger, personnel shall WAIT for evacuation orders.
2. Ambulatory persons
3. Non-ambulatory persons
4. Critical patients will be moved last when the maximum number of personnel and equipment is available.
5. Personnel will remain with patients/residents.
6. Evacuation shall be completed in a calm and orderly fashion.

**Evacuation Routes**

Evacuation and specific guidance for travel route and in-house transportation must be a systematic, coordinated effort in order to remove all patients/residents, visitors, and personnel from affected areas in a safe and timely manner.

- Evacuation shall be completed in a calm and orderly fashion.
- When possible, horizontal evacuation is preferred over vertical evacuation.
- Departments should have pre-identified evacuation routes.
- Incident specific evacuation routes may be necessary and must be communicated by the Command Center quickly to affected areas.
- Only when absolutely necessary should evacuation result in patient/resident leaving the interior of the facility.
- Visitors, personnel, and ambulatory patients should walk to the designated assembly point. If vertical evacuation is necessary, stairs — not elevators — should be used for these individuals. Personnel should be assigned at key points along the evacuation route to direct individuals to the assembly points.
- Elevators — if operational — are reserved for transporting non-ambulatory patients. Engineering / maintenance personnel should be assigned to take operational control of the elevators using the bypass key to take elevators directly to / from the affected areas. Do not use elevators in a fire or earthquake.
- If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down stairwells using assist devices, blanket carry, or two-man carry techniques.
- Human Chain - can be used if you have large numbers of ambulatory patients. Two personnel members are needed, one in the front and one in the rear. Have the first patient put his/her hand on the shoulder of the first personnel member, and everyone

else do the same to the person in front. The last person in the chain should be the second personnel member.

**Return to Facility**

Do not re-enter the facility for any reason unless:

- Assisting with evacuation of patients/residents, visitors or other personnel/equipment
- Authorized by the Incident Commander/Command Center
- An order to repopulate / reopen the facility has been approved by Licensing and Certification

## Moving to a Safe Refuge - Horizontal Evacuation

Refuge areas are used for internal evacuation or relocation. They are internal locations that will receive and hold patients/residents, personnel and visitors for a period of time until they can return to their original location or are evacuated.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor.
3. Identify the next functional smoke compartment (i.e., beyond the next set of double fire doors).
4. Movement shall be completed in a calm and orderly fashion.
5. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
6. Move patients/residents, personnel and visitors who are closest to the hazard to the next functional smoke compartment or identified refuge area. If you are moving patients to another floor, follow instructions for vertical evacuation.
7. Ambulatory patients should be assisted to the new location, and non-ambulatory patients moved on beds, carts, wheelchairs, or via blanket carry.
8. If possible, take with you the necessary patient/resident care equipment and supplies from the hazardous area.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated ( How marked ?)
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*Planning Note: pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc*).
13. The area supervisor will identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And

marked as clear (*Planning Note: pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).

14. Relocation does not involve formal gathering of medical records, unless this relocation is part of a phased evacuation, then gather patient records.
15. Continue to care for all patients/residents during transport and relocation.
16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.
17. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command Center.
18. Ensure personnel and visitors are aware of the situation.
19. Personnel will remain with patients/residents.

**Safe Refuge Areas and Horizontal Evacuation Area Chart** - see Appendix, page 41

**Horizontal Evacuation: Personnel Responsibilities**

- Affected area personnel – assist with patient care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

## Vertical Evacuation Procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and relocation area.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Evacuate patients/residents, personnel and visitors from the hazard
7. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
8. Elevators — if operational — are reserved for transporting non-ambulatory patients. o Do not use elevators in a fire or earthquake.
    - o If elevators are non-operational, and vertical evacuation is required, nonambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc*).
13. The area supervisor will identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etcr*).
14. Continue care for all patients/residents during transport and at the assembly point.
15. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. NHICS Form 255 may be used.
16. Keep patient/resident files and records with the patient.
17. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.

18. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command Center.
19. Ensure personnel and visitors are aware of the situation.
20. Personnel will remain with patients/residents.

**Vertical Evacuation Route Chart** - see Appendix, page 48

**Vertical Evacuation: Personnel Responsibilities**

- Affected area personnel – assist with patient/resident care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

## Complete Evacuation Procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

**Procedures**

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and external assembly point.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Each patient who is evacuated should have the following accompany them: o Their medical record – which should remain in their possession during the entire evacuation process
   - Necessary medications along with their medication administration record o Their addressograph plate or name labels o Personal belongings (if time permits)
   - Ideally, these items should be placed in a large plastic belongings bag and the bag marked with the patient's name and medical record number with indelible ink.
7. Evacuate patients/residents, personnel and visitors from the hazard
8. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
9. Elevators — if operational — are reserved for transporting non-ambulatory patients. o Do not use elevators in a fire or earthquake.
   - If elevators are non-operational, and vertical evacuation is required, nonambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
10. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
11. Each room should be marked as evacuated (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
13. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. *pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*
14. The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator.*
15. Continue care for all patients/residents during transport and at the assembly point.

16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. HICS Form 255 may be used.
17. Keep patient/resident files and records with the patient.
18. Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources to manage your patients/residents.
19. Ensure personnel and visitors are aware of the situation.
20. Personnel will remain with patients/residents.

**Guidelines for Evacuating Specific Patient Care Areas**

*Hemodialysis*

The following personnel are responsible for ensuring the safety of the patients:

- Operating Suite - the surgeon in charge of each case.
- Hemodialysis - The Nurse Manager or designee and physician will direct activities of the personnel.
- Obtain equipment and services required for completion of the procedure.
- Keep list of anticipated supplies and prepare to procure additional supplies as needed.
- Patients on ventilators: when central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
- Patients with IVs, arterial lines and Swan-Ganz: Disconnect transducer from patient cable-take pressure bag with patient. Saline lock all non-critical IV lines.

*Ventilator Unit*

- The Nurse Manager or designee shall evaluate the ICU patients with the house officer to determine possible transfers and/or discharge.
- Patients on ventilators: when central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
- Transfer as many patients as possible to medical surgical or step-down units, if safe to do so.
- Use gurneys, beds and evacuation equipment to move patients to refuge areas.
- Collaborate with house officer and respiratory therapists to evaluate appropriate shutoff of oxygen, ventilation equipment and other gases to preserve resources.

**Evacuation of Non-Patient Care Areas**

Overall, the evacuation of non-patient care areas will follow the same general guidelines.

1. Remain calm.

2. Recognize local threat or receive evacuation instructions from the Command Center or authorized personnel according to facility plan and move personnel to the pre-identified assembly point.
3. Persons in immediate danger should evacuate first.
4. In areas where there are visitors, escort the visitors to your department's assembly point.
5. Unless otherwise indicated, evacuation should proceed from offices farthest from the evacuation route to closest.
6. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
7. Each room should be marked as evacuated (*your facility should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
8. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate.
9. The department head should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear
10. Personnel/visitors with disabilities may require assistance. Each department head must identify which of their personnel may have difficulty during an evacuation and pre-plan the best way to aid their movement to a safe location.
11. Visitors should remain at the assembly point until the Command Center declares an "all clear" or other directions are given.
12. Account for personnel at assembly point (conduct roll call). If you have time, conduct roll call prior to evacuation, and again at the assembly point.
13. Initiate continuity of operations plan actions.
14. Update the Command Center on your operational status and impact on personnel and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources. Send personnel to the labor pool is requested.
15. Ensure personnel and visitors are aware of the situation.

**Complete Evacuation: Personnel Responsibilities**

- Since all areas will be affected, all personnel will assist with patient care and evacuation of current patients from their units, and perform follow up care at the assembly point.
- Non-clinical personnel – all functions will cease, and personnel will evacuate to their designated assembly point, and assign personnel to the labor pool for further instructions.

**Vertical/Complete Evacuation Transport Devices**

If there is a need to relocate patients horizontally, residents shall be moved using normal patient transportation equipment and routes of travel.

The following resources can be used in patient evacuation:

- Wheelchairs can be used to move ambulatory, minimally ambulatory patients and non-ambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then it can be used to move the patient/resident/personnel to the assembly point.
- Beds/gurneys: can be used to move non-ambulatory patients, but very difficult for vertical movement.
- Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

Additional resources may be needed during evacuation flashlights, spotlights, electrical cords, water stations, personal protective equipment, work gloves, portable ventilators, and other non-patient related equipment may be needed.

Specialized evacuation transport devices (chairs, stair stretchers, sleds, infant carry slings, motorized gurneys, blankets) are located within the facility and are intended for use in vertical and complete evacuations.

See Appendix, page 50, for a complete list of devices and location.

## Evacuation Assembly Points

In the event of a complete or total evacuation, residents, personnel and visitors will evacuate to external assembly points. Each department is pre-identified to evacuate to a specific assembly point.

**Determining Assembly Points**

Assembly points are assigned based on the care provided in the department. Departments with the most acute patients will assemble together near the emergency department where additional resources and ground transportation will be the most available. Departments without patients will evacuate to the remotest locations.

Non-department based assembly points are identified for the Command Center, Labor Pool, Communications Center, and Personnel First Aid.

**Assembly Point Key Activities**

- Roll call of all patients/residents, personnel and visitors
- Patient assessment and care

**Assembly Point Resource Needs**

Resources may be brought with personnel as they evacuate. Other resource needs shall be filled by the Command Center from external disaster caches.

- Food and water
- Communication devices for personnel to keep updated
- Environmental protection (tents, umbrellas, blankets, sheets, etc.)
- Chairs, flashlights/light sticks, basic first aid kits
- Medical supplies - depending on the care provided

**Evacuation Assembly Point Chart - see Appendix, page 49**

## Resident Transfer to Alternate Facilities

**Internal Coordination**

Internal organization of residents should be implemented concurrently with the External Coordination procedures.

*Organizing Residents*

Categorize and physically organize patients/residents as follows:

- Those who have their own transportation and are being discharged to home
- Those who need to be evacuated to an alternate acute care facility
- Those who need to be evacuated to a skilled nursing facility
- Those who are being discharged home but require transportation

Once the resident's evacuation status has been determined, it should be noted on a sign, sticker, or other mechanism and placed prominently on the resident. This tag should remain on the resident always until the evacuation destination is reached.

*Resident Information*

As each patient/resident is placed in their appropriate category, their medical record (which should have accompanied them) should be reviewed to collect information necessary to track and discharge / transfer the resident.

See Appendix, page 54 and 55, for forms.

*Patient/Resident Tracking*

- Patient tracking information is to be maintained in the area with copies forwarded to the Command Center and kept with the Patient Tracking Manager.
- Standard inter-facility transfer forms are to be completed on each patient/resident sent to an alternate care site, along with a copy of the medication administration record, and other pertinent medical record information.
- Patients/residents discharged to home should be provided with standard discharge instructions.
- If home health follow-up is necessary, send pertinent medical information home with the patient as well.
- Patient Tracking Manager and/or deputies will contact alternate care sites to ensure patient arrival until all patients have been verified as arriving and HICS form 255 is completed.

*Personnel Tracking*

- Facility shall coordinate personnel who may accompany patients/residents being transferred to alternate care sites.
- If personnel are to remain at these sites, then implement the mutual aid agreements established with these facilities.

- The record will be maintained of the name, title, and the facility that they were assigned to with the transfer log.

**External Coordination**

- If residents need to be transferred to another facility for ongoing medical care, **identify available beds** by the following procedures:
    1. Coordinate with other facilities in the same healthcare system
        - 
    2. Skilled Nursing Facilities: If the above resources are unavailable or inadequate, request assistance from Licensing and Certification:
        - Contact Licensing and Certification: 800-228-1019
        - Provide the number of residents by type of acuity that require evacuation Provide the number of patients by type of bed (critical care, medical/surgical, etc) that require evacuation
- **Obtain transportation resources** by contacting your contracted ambulance providers If not feasible or additional resources are needed from the County, contact the EMS Agency
- Transferred patients should have **medical records and medications** sent with them

**Transportation Resource Needs Matrix**

Estimate the type and quantity of transportation resources needed using the tool in Appendix, page 53. Use this information when requesting assistance through your usual transportation providers or the County EMS Agency.

**Evacuation Triaging and Transportation Tag**

An Evacuation Transportation Tag System shall be used to track patients who are evacuated from the facility.

- Clinical personnel are responsible for patient assessment/triage which will dictate mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement of patients from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

See Appendix, page 46, for the evacuation triage system color code.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of the evacuation tags at each patient care unit.
- Coordinating the distribution of evacuation tags during the incident.
- Tracking patients who are evacuated from the facility.

## Closure of a Portion or All of the Facility Following Evacuation

The decision to close all or a portion of the facility is made by the Incident Commander in collaboration with senior Command Center personnel. Closure of the facility (all or in part) is indicated if:

- The facility ceases the operational capability to provide safe and adequate care.
- The environment of care is no longer capable of supporting safe and adequate care.
- Closure has been directed by an external agency having legal authority to do so.

Facility operations during an evacuation will be under the direction of the Infrastructure Branch Director. This position will coordinate all facility control operations as needed during an evacuation. The first step in this process is to have the current status of all facility systems evaluated and documented using the NHICS 251 Facility System Status Report. From this status report, the Infrastructure Branch Director may call for additional support (e.g., local utilities companies/vendors).

**General Guidelines**

- Whenever possible, operationally capable areas should continue to provide care, treatment, and service as long as possible.
- Affected / hazardous areas will be closed first. Once cleared, these areas will be locked and utilities to the area shut down.
- Non-essential areas should be closed next. Once cleared, these areas should be locked and utilities to the area shut down.
- Resident care areas should be closed based on operational and environmental conditions. Closure should proceed from the most at-risk to the least at-risk areas. Once cleared, these areas should be locked and utilities to the area shut down.
- If time and circumstance permit, patient care areas should be scavenged for available supplies, equipment, medication, beds, transport devices, etc. These material resources should be brought to appropriate assembly points or as otherwise directed by the Command Center.
- Information Services should conduct a full backup of all information systems prior to shutting down mainframe computers and network systems. Individual proprietary systems should be backed up to external hard drives for removal from the facility.
- If time and circumstances permit, medical records should be boxed and removed and transported to an off-site storage location. Records should be removed — if possible — from most recent admissions going backward.
- If time and circumstances permit, personnel records should be boxed and removed from human resources and transported to an off-site storage location.
- Unless safety issues are present, utilities should be maintained until the affected areas are fully cleared and ready for closure. At that point, Engineering should implement

standard and/or emergency shut-down procedures as warranted. Once utilities are shut down, they should be locked out / tagged out and the area secured as able.

- Controlled substances are secured at all times except during administration. If the facility were to close, these items would be secured by default. o If medications are to be moved or evacuated with patients, they must be secured with licensed personnel.
- Process to secure diagnostic radiology areas / medications / isotopes in accordance with state law.

**Securing the Facility**

Usual procedures to secure the facility will be implemented. Focus areas include:

- Maintaining general security, especially during prolong incidents or when resources are scarce
- Establishing a perimeter around the facility, especially patient care areas OR establishing a perimeter around affected high risk area areas within the facility
- Controlling access and movement in and between facilities
- Maintaining traffic control on grounds
- Ensuring only authorized persons re-enter the facility after evacuation
- Coordination with local public safety, as needed

**Stay Team**

If the facility has been evacuated, but personnel need to remain to stabilize the incident and restore functionality, designate a Stay Team. This may include members of the Incident Management Team including the Safety Officer, emergency management personnel, facilities/engineering, risk management, human resources, etc.

See Facility Shut Down and "Stay Team" Member Check List - Appendix, page 62.

## Recovery: Restoring the Facility after Evacuation

Recovery - Assure that restoration and reimbursement issues and planning for facility start-up are addressed through the facility continuity of operations plan or business continuity plan.

**General Guidelines**

- Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by DOB , fire marshal and Licensing & Certification.
- Prioritize which departments and personnel to repatriate
- Restoration and testing of infrastructure – water, electricity, HVAC, medical gases

- All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.).
- Procedures to assess the need for and implementing cleaning and decontamination
- Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are reestablished
- Notification of reopening to other hospitals/healthcare facilities, EMS Agency, Resident families, media
- Procedures for repatriation of resident including:
  - o Patient transportation coordination with sending hospital/healthcare facility
  - o Medical records management
  - o Transportation coordination
  - o Attending assignments
  - o Room assignments

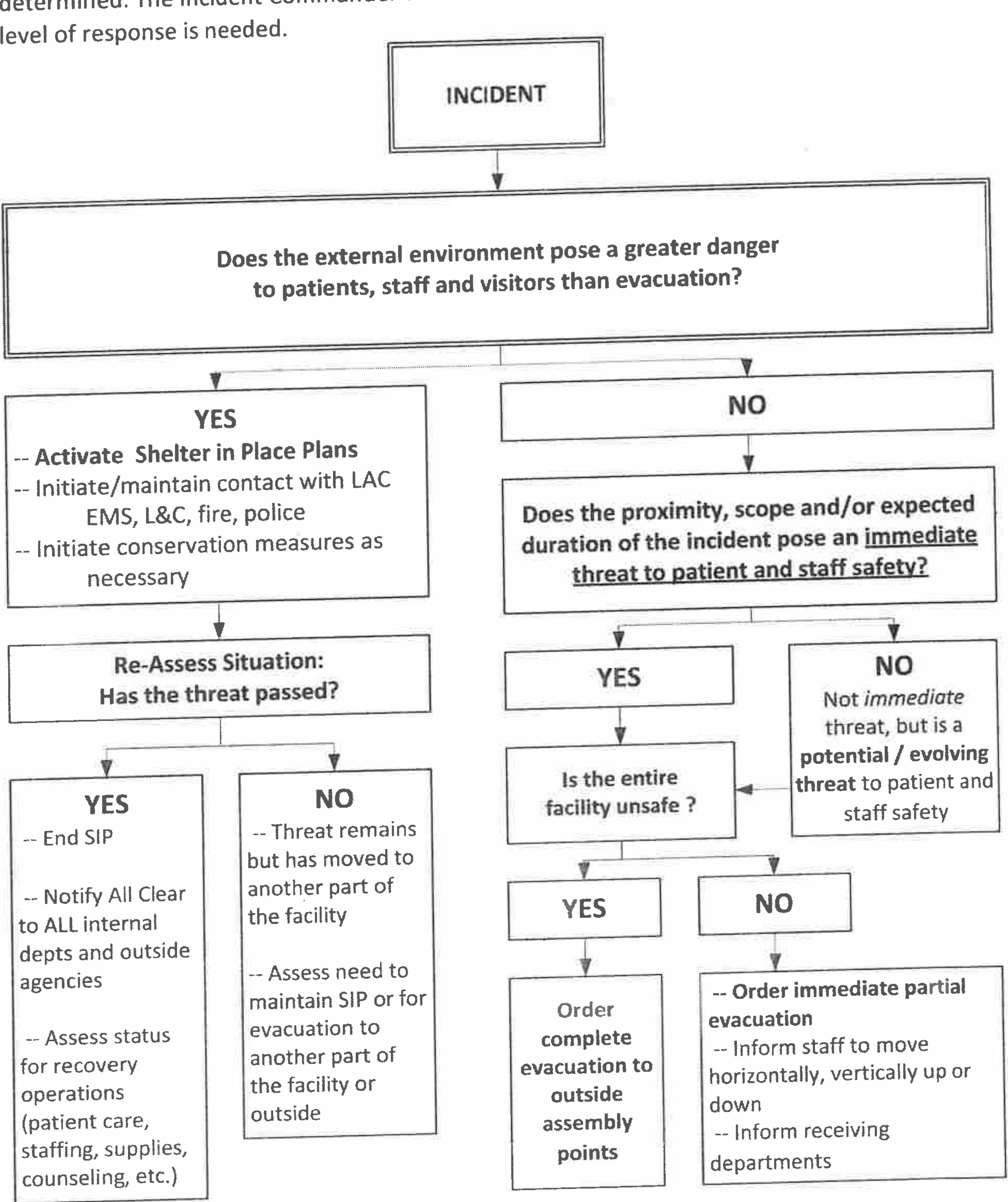
For additional resources, see

- Incident Management Team Recovery Responsibilities - Appendix, page 63
- Hierarchy of Repopulation Approval(s) - Appendix, page 64
- General All-Hazards Re-Population Factors / Steps - Appendix, page 65

## Appendix:

### Decision Tree

When the decision is made to activate, the magnitude of the emergency response must be determined. The Incident Commander will utilize the Decision Tree to determine what type and level of response is needed.



## Appendix:

### Decision Matrix

When the decision is made to activate, the magnitude of the emergency response must be determined. The Incident Commander will utilize the Decision Matrix to determine what type and level or response is needed add triggers for facility if needed.

| **Incident requiring facility to consider whether an evacuation plan or shelter in place plan should be activated.** | |
|---|---|
| **SCENARIO #1**<br>**The external environment* would pose a greater danger** to residents, personnel, and visitors than evacuation.<br>* External may mean inside - but outside of the affected area; or external - outside the facility | **YES**<br>• **Activate Shelter in Place Plans**<br>• Initiate/maintain contact with OEM, or L&C, local fire, local police<br>• Initiate conservation measures as necessary |
| **Assess situation: Threat has passed.** | **YES**<br>• End SIP<br>• Notify All Clear to ALL internal depts & outside agencies<br>• Assess status for recovery operations (patient care, supplies, counseling, staffing, etc.) |
| | **NO**<br>Threat remains but has moved to another part of the facility. Assess need to maintain SIP or for evacuation to another part of the facility or outside. |
| | |
| **SCENARIO #2**<br>The proximity, scope and/or expected duration of the incident pose an **immediate threat to resident and personnel safety.** | **YES**<br>• **Order immediate partial evacuation**<br>• Inform personnel to move horizontally, vertically up or down<br>• Internal Relocation: Inform receiving departments<br>• **OR Order complete evacuation to pre-identified assembly points** |
| | **NO** – not immediate threat, but threat exists, follow steps for Scenario #3 |
| | |
| **SCENARIO #3**<br>**Potential / evolving threat** to resident and personnel safety | **YES**<br>Decision to make: Partial or Total Evacuation? |
| **Assess situation: Is the entire facility unsafe for patients/residents or personnel?** | **YES**<br>• Activate Complete Evacuation Plan<br>• Determine evacuation sequence of departments |
| | **NO**<br>Activate Partial Evacuation or Relocation Plan<br>• Inform personnel to move horizontally, vertically up or down<br>• Internal Relocation: Inform receiving departments |

Appendix:

## Initial Critical Action Sheet for an Emergent Evacuation

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

**Upon initial notification that an incident has occurred:**

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

**If the decision is made by the AOD to evacuate:**

- ❑ Activate the Evacuation Plan
- ❑ Contact the operator to overhead page "Code xx"
- ❑ Notify and activate the NHICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Determine type of evacuation needed: vertical, horizontal, complete ○ Will patients and personnel stay in the building, or will they need to evacuate to the outside?
- ❑ Order the organized and timely evacuation of the facility. Prioritize departments to be evacuated, based on:
    - ▪ Danger / risk level - high danger, evacuate first
    - ▪ Ease of movement - more ambulatory, evacuate first ○ Instruct departments to gather as much medical information, medications, medical supplies and equipment as possible
  - ○ Instruct departments to follow the designated evacuation route
  - ○ Instruct department to evacuate to their designated assembly point and conduct roll call of personnel, patients, and visitors
- ❑ Notify fire, EMS, L&C, and law enforcement, local emergency management agency
  ○ Establish Unified Command with first responder agency, if applicable
- ❑ Establish the external Command Center, if doing a complete evacuation
  - ○ Have Operations / Infrastructure Branch assess the status of the facility
    ○ Try to maintain life support operations (power, water, communications) until all are evacuated
    Determine if any of the assembly point areas are unsafe
- ❑ Have Operations / Medical Care Branch assess if resident care is being compromised and if transfer will be required
- ❑ Have Logistics establish a Labor Pool
- ❑ Have Logistics deploy the evacuation disaster supplies cache ○ Deploy radios to assembly points
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of nonessential personnel

## Appendix:

### Initial Critical Action Sheet for Emergent Shelter in Place

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

**Upon initial notification that an incident has occurred:**

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ For an active threat, contact law enforcement immediately o Upon arrival, establish Unified Command with first responder agency
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

**If the decision is made by the AHJ to shelter in place:**

- ❑ Activate the Shelter in Place Plan
- ❑ Contact the operator to overhead page "Code xx" or page instructions (sample message: "May I have your attention, please. Authorities have advised us of an emergency nearby. For your safety, everyone is requested to stay inside and shelter in place until we are notified that the emergency is over.")
- ❑ Notify and activate the NHICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Order the organized and timely shelter in place of the affected area
  - o HazMat or severe weather instructions for the affected area
    - ▪ Shelter in a location with few windows and doors, and with access to restrooms and drinking water
    - ▪ Close and lock windows. Secure doors; lock if possible
    - ▪ Seal cracks around doors and windows (and any vents that do not close) with damp towels, duct tape, plastic sheeting, etc.
  - o Active threat (e.g., shooter) instructions for the affected area
    - ▪ Hide out of the active shooter/threat's view
    - ▪ Lock the door and blockade with heavy furniture
    - ▪ Silence cell phones and pagers
    - ▪ Turn off any source of noise (e.g., biomedical equipment, radios, TVs) ▪ Hide behind large items
    - ▪ Remain quiet
    - ▪ If have access to a phone, call security. If you cannot speak, leave the line open allow security to listen
- ❑ Notify fire, EMS, and Police
- ❑ HazMat: Have Operations / Infrastructure Branch assess the status of the facility o Shut off heating, air conditioning or other ventilation system so outside air is not drawn indoors, or prevent circulation throughout the facility if the source is internal
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of nonessential personnel

Appendix:

## Defend in Place for Active Threat/Shooter

**Characteristics of an Active Threat/Shooter Situation**

- An active threat/shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area
- Typically use firearms, but may also use knives, or other weapons
- Most commonly, victims are selected at random, however a disgruntled patient/family member or staff member may target their victim
- Unpredictable and evolve quickly
- Law enforcement is usually required to end an active shooter situation
- Because active threat/shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active threat/shooter situation

**How to Respond When an Active Threat/Shooter is in Your Vicinity**

Quickly determine the most reasonable way to protect your own life. Remember that patients are likely to follow the lead of employees and managers during an active threat/shooter situation.

*Option 1. Evacuate*

If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

 Remain calm

- Have an escape route and plan in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active threat may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe

*Option 2. Hide out or Defend in Place*

If evacuation is not possible, find a place to hide where the active threat is less likely to find you. Your hiding place should:

- Be out of the active threat's view
- Provide protection if shots are fired in your direction (i.e., a room or office with a closed and locked door)
- Not trap you or restrict your options for movement
- To prevent an active threat from entering your hiding place: ○ Lock the door
    - Blockade the door with heavy furniture ○ Call 911 when safe to do so

- If the active threat is nearby: o Lock the door
    - Silence your cell phone and/or pager
    - Turn off any source of noise (i.e., biomedical equipment, radios, televisions) o Hide behind large items (i.e., cabinets, desks)
    - Remain quiet

*Option 3. If evacuation and hiding out are not possible*

- Remain calm
- Dial 911, if possible, to alert police to the active threat's location
- If you cannot speak, leave the line open and allow the dispatcher to listen

*Option 4. Take action against the active shooter*

As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Act as aggressively as possible against him/her
- Throw items and improvising weapons
- Yell
- Commit to your actions

**How to Respond When Law Enforcement Arrives**

Law enforcement's purpose is to stop the active shooter as soon as possible.

*What to Expect from Officers' Actions*

- Officers will proceed directly to the area in which the last shots were heard or threat is identified to be
- Officers usually arrive in teams of four (4)
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment
- Officers may be armed with rifles, shotguns, and/or handguns
- Officers may use pepper spray or tear gas to control the situation
- Officers may shout commands, and may push individuals to the ground for their safety

*How to React When Law Enforcement Arrives*

- Remain calm, and follow officers' instructions
- Put down any items in your hands (i.e., bags, jackets)
- Immediately raise hands and spread fingers
- Keep hands visible at all times
- Avoid making quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming and/or yelling
- Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises

- The first officers to arrive to the scene will not stop to help injured persons
- Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

*Information to Provide to Law Enforcement or 911 Operator*

- Location of the active shooter/threat
- Number of shooters, if more than one
- Physical description of person making the threat
- Number and type of weapons held by the person making the threat
- Number of potential victims at the location

**Managing the Consequences of an Active Threat/Shooter Situation**

After the active shooter has been incapacitated and is no longer a threat, facility Incident Command should engage in post-incident assessments and activities, including:

- Account for all individuals at a designated assembly point to determine who, if anyone, is missing and potentially injured
- Determine a method for notifying families of individuals affected by the active threat/shooter, including notification of any casualties
- Assess the psychological state of individuals at the scene, and refer them to health care specialists accordingly
- Identify and fill any critical personnel or operational gaps left in the organization as a result of the active threat/shooter

## Appendix: Command Personnel Checklist for Shelter, Relocation, & Evacuation

*Does not replace N HICS Job Action Sheet – Use as an Incident-Specific Supplement*

The Incident Commander can use this checklist to assign tasks to Command and General Personnel.

| Task | Assigned | Complete |
|---|---|---|
| **Initial assessment** | | |
| Review threat intensity and likely duration | | |
| Review any department-based relocations that are occurring and anticipate needs in those areas | | |
| Determine, based on the department-based impacts, the need for sheltering vs. relocation of displaced patients vs. partial or full evacuation to other institutions (*see relevant sections below*) | | |
| Assure damage and utilities impact assessment being conducted by Infrastructure Branch Director | | |
| **Shelter in place** | | |
| Instruct Infrastructure Branch Director to shut down air intakes if there is a plume threat or shut down internal ventilation | | |
| Implement necessary access controls and monitoring in response to threats (Security Branch Director) | | |
| Communicate protective actions (door and drape closings, etc) to affected departments as well as any incident details | | |
| **Relocation - Movement within the Facility** | | |
| Determine affected departments and actions taken | | |
| Determine facility capacity for relocated patients – if insufficient see evacuation, below | | |
| Assure resources (personnel and supplies) transferred to departments absorbing relocated patients | | |
| Assure all residents accounted for and information transferred to receiving departments | | |
| Determine timeframe to recover affected departments and any effects on admissions, | | |
| **Evacuation** | | |
| Determine scope of evacuation (partial for subset of residents/ areas complete for total facility evacuation) based on threat | | |

| | | |
|---|---|---|
| Consider appointment of Evacuation Branch Director under Operations if Operations has multiple other issues (fire, etc) to address | | |
| Activate any appropriate facility response plan alerts | | |
| Announce evacuation order to affected units / facility | | |
| **Task** | **Assigned** | **Complete** |
| Determine whether usual assembly points can be used and announce alternatives if needed | | |
| Assign Staging Manager and Transportation Officer (NHICS positions) to coordinate patient and vehicle staging according to evacuation plans | | |
| Initiate coordination between Planning Chief and Resource Unit on transportation and facilities to accept residents and report back to IC | | |
| Contact County OEM/DOH Agency for coordination assistance; | | |
| Security to implement appropriate access controls – no family or visitors inside during evacuation | | |
| Security coordinates with local law enforcement regarding traffic controls external to facility | | |
| Logistics Chief to assure pharmaceuticals and supplies to staging areas | | |
| Distribute personnel and resources to affected areas to facilitate movement to staging areas | | |
| PIO to communicate facility status to media and families | | |
| Assure matching of residentss to appropriate transfer facility | | |
| Assure resident tracking by transportation officer at time of loading | | |
| Assure prioritized movement of residents to and through staging (in non-emergency evacuation Staging Manager should call units to sequentially evacuate them) | | |
| Determine if any personnel need to accompany residents to receiving facilities | | |
| In case of complete evacuation – appoint Stay Team Unit Leader | | |

## Appendix: Incident Assessment Worksheet

Use this worksheet to assess the impact that the incident will have on the facility. Sources of this information may come from the affected departments, Liaison Officer, other community response partners / facilities/ or engineering department, news media, etc.

| INCIDENT CHARACTERISTICS | |
|---|---|
| **Arrival** | |
| *Note: The amount of time until the event combined with the anticipated time to evacuate determines how long an evacuation decision can be deferred* | |
| **When is the incident expected to impact the facility?** | |
| **How variable is the impact timeframe?** | |
| **Magnitude** | |
| *Note: The magnitude of the event predicts potential damage to a facility and utilities, which could cut off the supply of key resources, or otherwise limit the ability to shelter-in-place and care for patients.* | |
| **What are the expected effects on the facility?** | |
| **What are the expected effects on the community?** | |
| **How likely is the event to be more or less severe than predicted – what are the impacts?** | |
| **Area Impacted** | |
| *Note: Competition for resources needed to evacuate patients (especially vehicles) increases when more facilities evacuate simultaneously.* | |
| **How large is the geographic area affected?** | |
| **How many vulnerable healthcare facilities are in this geographic area (LTC, hospitals, others)?** | |
| **Duration** | |
| *Note: The duration of the incident affects how long facilities have to operate on backup, alternative, or less predictable resources.* | |
| **How long is the incident expected to last?** | |
| **How variable is the expected duration?** | |

| ANTICIPATED EFFECT OF THE INCIDENT ON KEY RESOURCES | |
|---|---|
| **Water** | |
| *Note: Water loss of unknown duration (more than 1-2 days) is almost always cause for evacuation.* | |
| **Is the facility or main city water supply in jeopardy? Already non-functional?** | |
| **Is there a backup water supply (well, nearby building with intact water mains)?** | |
| **If not, how soon will city water return?** | |
| **Heat / Air Conditioning** | |
| *Note: Loss of heat especially during a northern winter, or loss of air conditioning in summer, is often a cause for evacuation—often within 12 hours.* | |
| **Is the HVAC system in jeopardy (steam, water for boilers, etc.)? Already non-functional?** | |
| **Is there a backup (intact nearby building that still has power/HVAC)?** | |
| **If not, will the building be too cold/hot for patient safety before adequate temperature stabilizes?** | |
| **Electricity** | |
| *Note: Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.* | |
| **Is power at risk? Just for the facility or a wider area?** | |
| **Are backup generators functional?** | |
| **How long can they run without refueling?** | |
| **Is refueling possible given the situation?** | |
| **Can some sections/wings be shut down to reduce fuel consumption and stretch fuel supplies?** | |
| **Facility Structural Integrity** | |
| *Notes: Structural damage may cause rooftop water tanks to fail, flooding the building. Safety/ integrity may not be obvious to untrained occupants.* | |
| **Is the building obviously/visibly unsafe? All of it or only portions (e.g., can people be consolidated in safer sections)?** | |

| | |
|---|---|
| **Is there a water tank on the roof, and is it intact?** | |
| **Is a structural engineer needed to make an assessment?** | |
| **ANTICIPATED EFFECT OF THE INCIDENT ON THE COMMUNITY** | |
| **Road Conditions** | |
| *Notes: There may be a limited window of opportunity to carry out a ground-based evacuation. Increased use of helicopters to evacuate patients may be required. Personnel may not be able to get to the facility to relieve existing personnel or assist in the evacuation.* | |
| **Are any major routes from the hospital to potential receiving care sites closed or threatened?** | |
| **Will evacuation traffic clog major routes from the hospital to potential receiving care sites?** | |
| **Are access routes to the hospital cut off or threatened?** | |
| **Community/Building Security** | |
| *Note: If patient and personnel safety cannot be assured, the decision needs to be made whether sheltering in place is safer or if evacuation will be necessary.* | |
| **Have any nearby areas experienced increases in civil disorder or looting?** | |
| **Are local law enforcement agencies understaffed due to self-evacuations or significant additional responsibilities?** | |
| **Are additional private security officers available to secure the hospital?** | |
| **Evacuation Status of Other Nearby Health Care Facilities** | |
| *Notes: If other healthcare facilities are evacuating: the competition for ambulances, wheelchair vans, and buses may be substantially increased; you may be asked to accept additional patient; patients may have to be relocated to facilities further away than anticipated.* | |
| **Are other healthcare facilities already evacuating or planning to evacuate, or have they decided to shelter-in-place?** | |
| **State/County/Local Evacuation Order** | |
| *Note: You may have no choice but to evacuate.* | |
| **Have evacuation orders been issued in areas closer to the incident?** | |

| | |
|---|---|
| Have any public or private statements been issued regarding the possibility of an evacuation order? | |
| Have any other incidents occurred that increase the likelihood that an evacuation order will be issued? | |
| **Availability of Local Emergency Response Agencies** | |
| Unavailability of local fire agencies increases the risk of sheltering-in-place. | |
| Are local emergency response agencies understaffed or less available due to other responsibilities? | |

## Triage Officer Checklist - Evacuation

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that patients/residents are properly triaged to determine their most appropriate disposition for the most optimal care, and prepare for transfer if applicable.

| Task | Assigned | Complete |
|---|---|---|
| **Initial tasks** | | |
| Ensure basic medications, any needed IV fluids or resident care supplies are available or requested via the Staging Manager | | |
| Assist in identifying and clearing space for Green/Yellow/Red patients/residents | | |
| Assess residents arriving to the Staging Area for:<br>• Discharge home – (depending on situation may be held for discharge or transferred to another safer location nearby for discharge)<br>• Transfer to other facility: ○ Green – ambulatory, low acuity (bus, etc.)<br>○ Yellow – non-ambulatory, non-critical care (WC or BLS vehicle) ○ Red – critical care (ALS / critical care) | | |
| Assure evacuation tag applied and reflects priority for transfer accurately | | |
| **Subsequent tasks** | | |
| Group patients for transport loading by acuity | | |
| Direct personnel to provide necessary resident care during staging period | | |
| Coordinate with Staging Manager (or Officer, if several staging sites) and Transport Officer regarding supplies, patient loading priority, appropriate vehicle for transport, and flow issues | | |
| **Demobilization** | | |
| Ensure equipment and supplies are retrieved/returned | | |

## Evacuation Staging Manager Checklist

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

| Task | Assigned | Complete |
|---|---|---|
| **Immediate (Operational Period 0-2 Hours)** | | |
| Determine need for and appropriately appoint Evacuation Staging Team Leaders, distribute any corresponding Job Action Sheets and position identification. | | |
| Brief the Evacuation Staging Team Leaders on current situation; outline branch action plan and designate time for next briefing. | | |
| Identify appropriate area(s) to serve as Staging Area(s) based on resident acuity for the preparation of transporting residents and their equipment from facility to an accepting facility. | | |
| Coordinate staging needs of residents and their equipment and all evacuation staging team members. Requesting additional or rotation of personnel to evacuation staging areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader | | |
| Instruct all Evacuation Staging Team Leaders to evaluate situation, including, equipment, supplies, and medication inventories and personnel needs in collaboration with Logistics Section Supply Unit Leader; report status to Operations Section Chief and Supply Unit. | | |
| Continue coordinating transport of residents and their equipment from staging to the transport area, working with the Transport Manager as needed. | | |
| **Extended (Operational Period Beyond 12 Hours)** | | |
| Continue to monitor the Evacuation Staging Team's ability to meet workload demands, personnel health and safety, resource needs, and documentation practices. | | |
| Coordinate assignment and orientation of personnel sent to assist patient/resident | | |
| Rotate personnel on a regular basis. | | |
| **Demobilization/System Recovery** | | |
| As needs for Evacuation Staging Area decrease, return personnel to their normal jobs or release and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader. | | |

## Evacuation Staging Team Member Checklist

*Does not replace NHICS Job Action Sheet – Use as an Incident-Specific*

Mission: To ensure that patients/residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

| Task | Assigned To | Completed |
|---|---|---|
| **Initial tasks** | | |
| Receive patieresidents into Staging Area and | | |
| Confirm transfer information is complete and accurate for each resident (including: evacuation tag, Patient Medical Information Form, and Patient Evacuation Tracking Form NHICS 260) | | |
| Assure resident comfort and medical needs are met (personnel, medication, water, blankets) | | |
| Communicate any care needs to Staging Team Leader | | |
| Communicate any resource needs to Staging Team Leader | | |
| **Subsequent tasks** | | |
| Group residents for transport loading by acuity or destination (dependent upon size of event and number of staging locations) | | |
| At the end of shift, brief Evacuation Staging Team Leader on any current problems or any outstanding issues | | |
| Complete and submit any documentation to Evacuation Staging Team Leader | | |
| **Demobilization** | | |
| Ensure equipment and supplies are retrieved/returned | | |
| Upon deactivation of your position brief, Evacuation Staging Team Leader on any current problems or any outstanding issues | | |
| Complete and submit any documentation to Evacuation Staging Team Leader | | |

## Department Shelter in Place and Evacuation Plan

| | |
|---|---|
| Relocation: Horizontal (first option) to: | ADJACent WinG |
| Vertical (second option) to: | Floor Below |
| Vertical evacuation route/path: | Stair A North B South |
| Evacuation assembly point: | |
| Department shelter in place supplies/equipment location: Central Supply | |
| Department evacuation supplies/equipment location: | Stairs |
| Estimated number of patients/residents at peak: | 200 |
| Estimated number of personnel at peak: | 160 |
| Estimated number of visitors at peak: | 75 |

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
  - o Move patients/residents and personnel away from windows as possible.
  - o Close drapes/blinds and exterior doors/windows.
    - *Security emergency – bomb threat, individual posing security threat, external civil unrest*
      - o Refer to Active Shooter/Bomb Threat policy.
      - o Implement department-specific access controls.
      - o Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
  - o If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

**Evacuation:** The movement of residents, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement from the facility to another institution. Complete facility evacuation is undertaken as a last resort. Each department has an Assembly Point, a pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

**Anyone recognizing an imminent danger to residents or others shall take immediate steps to safeguard those in danger including patient movement.**

**Charge Nurse/Administrator Responsibilities upon notice of evacuation decision:**

- □ Remain calm.
- □ Receive instruction from the Command Center.
- □ Notify department personnel and reassign personnel as needed.
- □ Compile a list of patients and all facility personnel currently working in your area.
- □ residents, personnel, and visitors in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third.
- □ Confirm assembly point destination is available
- □ Triage residents for movement / transport using evacuation tags (with equipment)
    - o Tag color reflects priority: green patients are ambulatory (move first), yellow non-ambulatory, red unstable/critical care (move last)
    - o Tag all residents and attach tear-off band from tag to belongings
    - o Determine ambulatory status of patients and assign personnel to move them. All patients capable of ambulating should form a chain by holding hands (if capable) and be lead to the new location by personnel member(s).
    - o Assess acuity and resource needed to LOAD, MOVE, and CARRY non-ambulatory residents. Will depend on elevator status, etc. In non-emergency assure that staging is ready for yellow/red residents prior to moving.
- □ Assign a person to check all rooms to assure:
    - oNo occupants remain and no safety issues
    - o Evacuated rooms are marked with *(pre-determined room clear indicator)*
- □ If time and resources allow, assign person(s) to transport your area's medications.
- □ Documentation: o Emergency: Take patient summary sheet with demographics, allergies, medications, problem list, emergency contact information. Bring full chart if possible.
    - o Non-emergency: Above plus medication administration record and facility chart.

- □ Upon arriving at assembly point, complete resident and personnel head count. Personnel shall remain at safe location until reassigned or dismissed. residents shall be directed to remain at staging location until further instructions are given for discharge or transportation.
- □ Special Considerations:
    - o Patients on ventilators: When central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.
    - o Patients with IVs
        - ▪ Saline lock all non-critical IV lines

- Nasogastric or gastrostomy tubes should be disconnected from suction, or collection system and kept open to drain by gravity.
- Evacuate tracheostomy patients with an obturator and a spare tracheal tube, as well as a bulb syringe for suction.
- Clamp peritoneal dialysis tubing, disconnect from solution, and cap the tubing end. (Do not evacuate bottles, bags, or octopus attachments).
- Remove cardiac monitors, leaving leads in place.
- Disconnect oxygen prior to evacuation.

| **Shelter In Place Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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| **Evacuation Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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## Support and Administrative Department Shelter in Place and Evacuation Plan Template

| | |
|---|---|
| Relocation: Horizontal (first option) to: | DAY ROOM |
| Vertical (second option) to: | N/A |
| Vertical evacuation route/path: | N/A |
| Evacuation assembly point: | 33RD + UNION ST |
| Department shelter in place supplies/equipment location: | NURSING OFFICE |
| Department evacuation supplies/equipment location: | " |
| Estimated number of patients/residents at peak: | 0 |
| Estimated number of personnel at peak: | 20 |
| Estimated number of visitors at peak: | 5 |

**Shelter in Place:** A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
  - Move patients/residents and personnel away from windows as possible.
  - Close drapes/blinds and exterior doors/windows.
    - *Security emergency – bomb threat, individual posing security threat, external civil unrest*
      - Refer to Active Shooter/Bomb Threat policy.
      - Implement department-specific access controls.
      - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
  - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

**Evacuation:** The movement of residents, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement

from the facility to another institution. Complete facility evacuation is undertaken as a last resort.

**Anyone recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement.**

**Supervisor Responsibilities upon notice of evacuation decision:**

- □ Remain calm.
- □ Receive instruction from the Command Center.
- □ Notify department personnel and reassign personnel as needed.
- □ Compile a list of all facility personnel currently working in your area.
- □ Patient/residents, personnel, and visitors in imminent danger should be moved first, ambulatory persons second and non-ambulatory persons third.
- □ Confirm assembly point destination is available.
- □ Prior to leaving work area secure any hazardous chemicals, safes, and other potential hazards.
- □ Take any 'go-kits' or continuity supplies for your unit.
- □ Assign a person to check all rooms to assure: o
    No occupants remain and no safety issues
    - o Evacuated rooms are marked with (*pre-determined room clear indicator)*
- □ Upon arriving at assembly point, complete head count. Personnel shall remain at safe location until reassigned or dismissed.

| **Shelter In Place Supplies and Equipment Stored in this Department** | |
|---|---|
| **Resource** | **Purpose** |
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| Evacuation Supplies and Equipment Stored in this Department | |
|---|---|
| **Resource** | **Purpose** |
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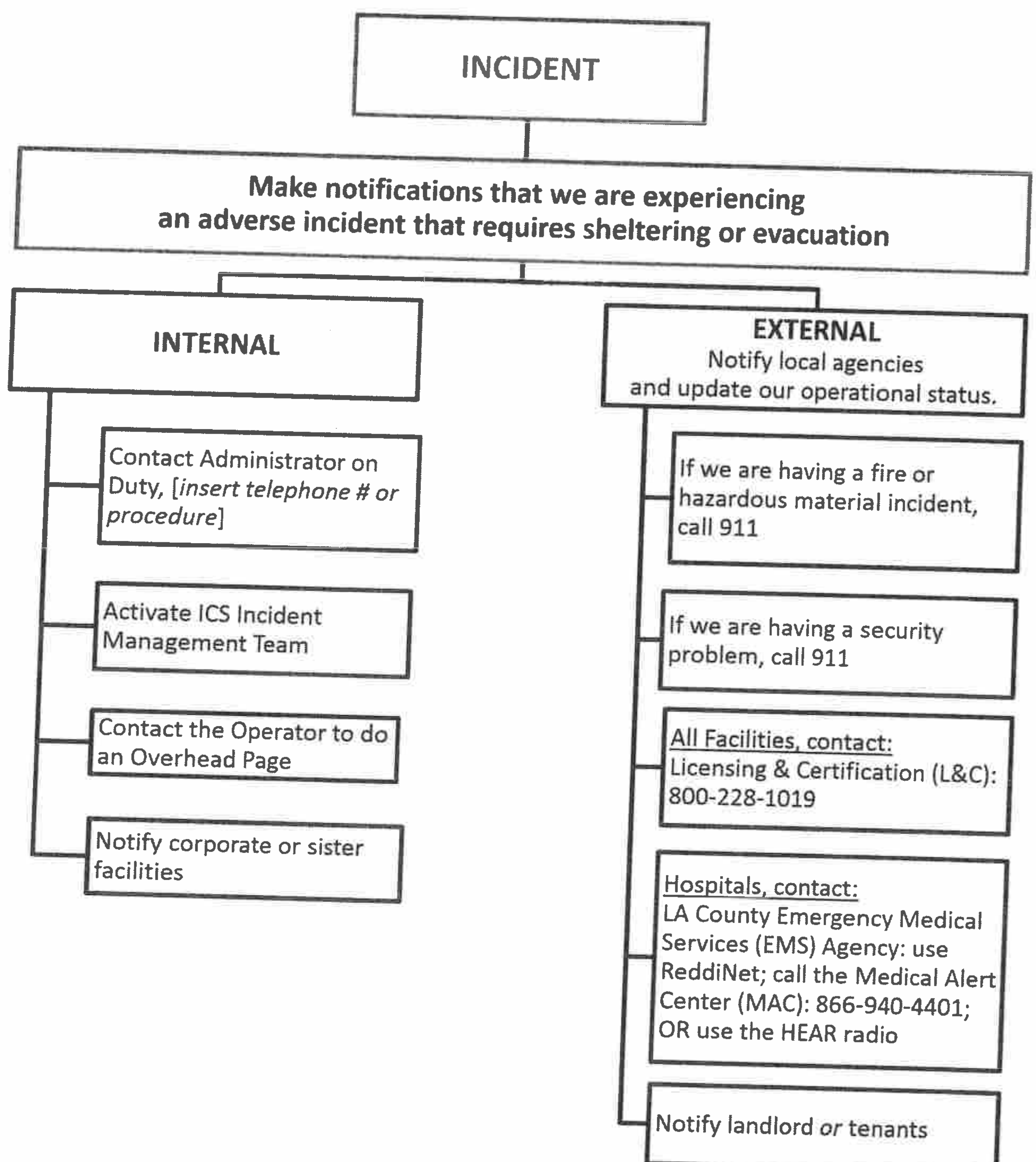
Appendix: Initial Notification Chart



## Estimate of How Many Will Need to Be Evacuated or Need Sheltering Resources

Use this table to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

| **Personnel, Patient/Resident and Visitor Census at Its Lowest** | | | | | |
|---|---|---|---|---|---|
| **Day of the Week:** | | | **Time of Day:** | | |
| **Department or Area** | **Location** (Floor, etc.) | **# of All Personnel*** | **# of Ambulatory Patients** | **# of Nonambulatory Patients** | **# of Visitors** |
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* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

## Evacuation Triage and Transportation Tag

An evacuation triage and transportation tag system shall be used to track residents who are evacuated from the facility.

- Clinical personnel are responsible for assessment/triage which will dictate priority and mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of and coordinating the distribution the evacuation tags at each patient care department. o If tags are not available or you run out, use any piece of

| EVACUATION TRIAGE LEVEL | PRIORITY FOR EVACUATION FROM PATIENT CARE UNIT (Reversed START Triage) | PRIORITY FOR TRANSFER FROM THE TRANSPORT STAGING AREA TO ANOTHER HEALTHCARE FACILITY (Traditional START Triage) |
|---|---|---|
| RED | ▯ These are evacuated LAST from the unit because they require maximum assistance to move. These may<br>▯ require 2-3 personnel members to transport | • These are transported FIRST as transfers from your staging area to an alternate healthcare site.<br>• These require maximum support to sustain life in an evacuation. |
| YELLOW | ▯ These require some assistance and should be evacuated SECOND in priority. may require wheelchairs or<br>▯ stretchers and 1-2 personnel members to transport. | ▯ These will be transported SECOND in priority as transfers from your staging area to an alternate healthcare site. |
| GREEN | ▯ These equire minimal assistance and can be evacuated FIRST from the unit.<br>▯ are ambulatory and 1 personnel member can safely lead several patients who fall into this category to the assembly point. | ▯ These will be transported LAST as transfers from your staging area to an alternate healthcare site or released to home. |

## Safe Refuge Areas and Horizontal Evacuation Area Chart

| Department | Floor | Primary Horizontal Evacuation Area | Secondary Horizontal Evacuation Area |
|---|---|---|---|
| Rereation | 9 | Roof top | Solarium |
| Nursing | 8 | North or South | Non Available |
| " | 7 | " | " |
| " | 6 | " | " |
| " | 5 | " | " |
| " | 4 | " | " |
| " | 3 | " | " |
| " | 2 | " | " |
| ADmin | 1 | " | outside |
| HK + Diet | LL | " | PT |

Vertical Evacuation Route Chart

| Department | Floor | Designated Stairwell | Designated Elevator (for non-ambulatory residents; if operational) |
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## Evacuation Assembly Point Chart

This chart identifies each department with their primary exit stairwell and external assembly point.

| Department | Location | Exit Stairwell # | Assembly Point |
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>> Insert Map of Assembly Points

## Vertical/Complete Evacuation Transport Devices

The following specialized evacuation transport devices (chairs, stair stretchers, sleds, motorized gurneys, blankets) are located within the facility and are intended for use in vertical and complete evacuations. Just in time training may be done by personnel already trained in use of the equipment.

| Device | Location | Purpose |
|---|---|---|
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The following existing resources can be used in vertical evacuation but are more difficult to use:

- Wheelchairs can be used to move ambulatory, minimally ambulatory patients and nonambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then it can be used to move the evacuee to the assembly point.
- Beds/gurneys can be used to move non-ambulatory patients, but very difficult for vertical movement.
- Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

## Carry Evacuation Techniques

Below are emergency carry techniques for evacuation of non-ambulatory patients/residents, personnel or visitors. These techniques would be used as a last resort.

**PACK STRAP CARRY – One Rescuer**

- This method should be used when the patient can stand, but not walk, and limited personnel are available.
- Have the patient stand at the side of the bed directly behind you.
- Have them place their arms over your shoulders and cross them in front.
   Grasp the opposite arm, bend your knees, lean forward and lift.
- This method can be used for short distances, or if the patient is very light.

**ONE-PERSON ARM CARRY – One Rescuer**

- Hold the patient around the patient's back and under the knees.
- This method can be used for short distances, or if the patient is very light.

**BLANKET DRAG – One Rescuer**

- Lower the bed as much as possible, and put blanket along the side of the bed, make sure some of the blanket is under the bed. Leaving two to three feet extra at the top.
- Kneel on your left knee, and put your left arm under the their shoulders. Place your right arm under their knees, and pull their legs and hips off the bed, allowing the head and torso to follow.
- Use your left arm to support, not hold, the head and shoulders as you lower them to your left knee. Then gently lower the head and shoulders to the blanket.
- Grasp the end of the blanket above the patient's head, roll it up a few inches, and drag the patient to safety.

**REAR APPROACH ASSIST – One Rescuer**

- Used for an ambulatory patient who may be confused.
- Approach from the rear, put both arms between the patient's arms and body, and grasp their wrists.
- Gently guide them to safety, tuck your head into their shoulder to protect you should they move their head to one side.

**SIDE BY SIDE ASSIST – One Rescuer**

- This carry is for patients who can stand and walk with support.
- Put the patient's left (right) arm over your shoulder, and grasp it with your left (right) arm.
- Place your right arm around their waist, and support them as you walk to safety.

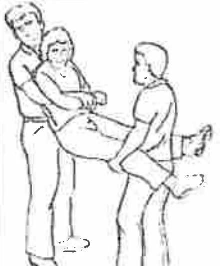
## Appendix:

**TWO PERSON SLING CARRY – Two Rescuers**

- Use when the patient can sit up in bed, but not walk unaided.
- Each rescuer positions themselves on either side of the patient.
- Have the patient put his/her arms over each rescuers shoulders, and hold on.
- The rescuers should then grasp each other's arms under the patient's knees and back, lifting like a sling.
- Two people can carry non-ambulatory patients for long distances using this method.
- Lean the patient against a wall when you want to unload the patient.
- Bend the knee closest to the wall to control descent, letting patient's feet touch the floor, and gently lowering their body.
- (Not recommended for patients with back or cervical problems.)

**EXTREMITY CARRY – Two Rescuers**

- Can be used as long as the patient can sit up in bed.
- The first rescuer sits behind the patient, has them fold their hands in front of their body, and grasps the patient's forearms with their own.
- The second rescuer sits between the patients legs, and cradles each leg with their arms.
- Stand in unison using good body mechanics.
- (Not recommended for patients with back or cervical problems.)



**CHAIR CARRY – Two Rescuers**

- Place the patient in a sturdy, non-swivel chair.  Tilt the chair backwards as rescuers lift the patient.
- If possible, secure the victim to the chair.
- If the rescuers need to carry the patient over uneven surfaces or stairs, the rescuers must face each other.

**BLANKET CARRY – Four to Six Rescuers**

- **Do not use sheets for this procedure, they will not provide sufficient support.**
- Can be used if the patient is very heavy.
- Can be used to carry IVs, oxygen tubing, etc.
- Three rescuers are needed to roll the patient to their side, lift in unison, and place them on a blanket, along with IVs, etc.
- The rescuers crouch on each side, roll up the blanket until their hands touch the patient, and then lift in unison.

## Appendix:

### Transportation Resource Needs Matrix

Use this tool to determine transportation needs when requesting assistance through your usual transportation providers or the County EMS

| **Resident Census and Transportation Needs** | | |
|---|---|---|
| | **# of Pt** | **Calculation:** |
| Discharge within 3 hours | | Multiply your total inpatient census by 20% |
| Residents Needing Transport | | Multiply your census by 80% |
| | | |
| **Type of Transportation Resource** | **# of Pt** | **Calculation:** |
| NICU Transport | | Multiply Total Inpatients Needing Transport by 6% |
| Critical Care Transport | | Multiply Total Inpatients Needing Transport by 6% |
| ALS Transport | | Multiply Total Inpatients Needing Transport by 7% |
| BLS Transport | | Multiply Total Inpatients Needing Transport by 50% |
| Van/Bus Transport | | Multiply Total Inpatients Needing Transport by 31% |

Appendix:

## Appendix: Evacuation Patient Medical Information Form

*Completed by the nurse providing care. The following information is the minimum provided when transporting a patient/resident to another care site. A copy of the medical record and advanced directives should be included, if possible. A copy of this form should be maintained by the Patient Tracking Manager.*

| | | | | |
|---|---|---|---|---|
| **SENDING FACILITY** | | **DATE** | | |
| **PATIENT NAME** | | **DATE OF BIRTH** | | **SEX** |
| **MEDICAL RECORD NUMBER** | **ADMISSION DATE** | **CONSENT OBTAINED FOR TRANSFER** (circle) Yes No Unable to Obtain | | |
| **EMERGENCY CONTACT** | **TELEPHONE NUMBER** | **NOTIFIED OF TRANSFER** (circle) Yes No | | |
| **PATIENT ACUITY** | **ATTENDING PHYSICIAN** | **NOTIFIED OF TRANSFER** (circle) Yes No | | |
| **ORIGINAL CHART SENT WITH PATIENT** (circle) Yes No | **ADVANCED DIRECTIVE** (circle) Yes No | **COPY SENT WITH PATIENT** (circle) Yes No | | |
| **PRIMARY DIAGNOSIS** | **SECONDARY DIAGNOSES** | **ALLERGIES** | | |
| **PRIMARY LANGUAGE: ENGLISH** (circle) Yes No | **IF NO, PRIMARY LANGUAGE:** | **IF NO, DOES PATIENT UNDERSTAND ENGLISH:** Yes No | | |

| **VITALS AT TIME OF TRANSFER** | **TEMPERTURE** | **PULSE** | **RESPIRATIONS** | **BLOOD PRESSURE** |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| **ISOLATION STATUS** (circle)<br>None Contact Droplet Airborne Other | **PRECAUTIONS** (circle)<br>Aspiration Seizure Fall Elopement Other: |
| **OXYGEN** (circle) Mask Cannula Other:_________<br>Oxygen Requirement: | **DIET** (circle)<br>NPO<br>Tube Feeding: Yes No Enteral Parenteral<br>Formula:____________________<br>Type: Regular Low Salt Diabetic Bland<br>Consistency: Regular Ground Puréed Thickened Liquids<br>Other: |
| **INTRAVASCULAR DEVICE** (circle)<br>Central Line PICC Line Arterial Line Saline Lock<br>Medication Drip Other: | |
| **FOLEY** (circle) Yes No | |
| **INCONTINENT** (circle) Yes No<br>If yes, (circle) Bowel Bladder | |
| **ASSISTIVE DEVICES** (circle all that apply)<br>None Cane Walker Wheelchair Glasses<br>Dentures: Upper Lower Hearing Aid<br>Prosthesis, Type: | **MENTAL STATUS** (circle) Oriented Alert Lethargic<br>Mildly Confused Severely Confused<br>**BEHAVIOR** (circle) Cooperative Disruptive<br>Belligerent Combative Wanders Withdrawn |
| **MEDICATION(S) MOSTLY RECENT ADMINISTERED** | **MEDICATION(S) SENT WITH PATIENT**<br>(circle) Yes No *If yes, describe below:* |

Appendix:

| EQUIPMENT OWNED BY SENDING FACILITY ACCOMPANYING PATIENT DURING TRANSPORT | | COMMENTS |
|---|---|---|
| RECEIVING CARE SITE | METHOD OF TRANSPORT | TRANSPORTING AGENCY |
| DATE TRANSFERRED | TIME TRANSPORT INITIATED | TIME OF ARRIVAL AT RECEIVING FACILITY |
| NAME OF PERSON COMPLETING THIS FORM | | CREDENTIAL AND TITLE |

*Note: Additional information can be written on back if needed and/or time permits.*

Appendix:

## Patient Evacuation Tracking Form

*Completed by the nurse providing care. The Patient Tracking Manager should maintain a NHICS 255, Transfer Summary Form, or this form to track all patients that are transferred to an alternate care site or discharged.*

<table>
<tr><td colspan="2">PATIENT NAME</td><td>DATE OF BIRTH</td><td>SEX</td></tr>
<tr><td>MEDICAL RECORD NUMBER</td><td colspan="3">DISPOSITION (circle) Discharged or Transferred</td></tr>
<tr><td>EMERGENCY CONTACT</td><td>TELEPHONE NUMBER</td><td colspan="2">NOTIFIED OF TRANSFER<br>(circle) Yes No</td></tr>
<tr><td>ATTENDING PHYSICIAN</td><td>NOTIFIED OF TRANSFER<br>(circle) Yes No</td><td colspan="2"></td></tr>
<tr><td>RECEIVING CARE SITE</td><td>METHOD OF TRANSPORT</td><td colspan="2">TRANSPORTING AGENCY</td></tr>
<tr><td>DATE TRANSFERRED</td><td>TIME TRANSPORT INITIATED</td><td colspan="2">TIME OF ARRIVAL AT RECEIVING FACILITY</td></tr>
<tr><td>ORIGINAL CHART OR INFO SHEET SENT WITH PATIENT(circle) Yes No</td><td colspan="3">ADVANCED DIRECTIVE COPY SENT WITH PATIENT (circle) Yes No (circle) Yes No</td></tr>
<tr><td>PRIMARY DIAGNOSIS</td><td colspan="3">SECONDARY DIAGNOSES</td></tr>
<tr><td colspan="2">EQUIPMENT OWNED BY SENDING FACILITY ACCOMPANYING PATIENT DURING TRANSPORT</td><td colspan="2">MEDICATION SENT WITH PATIENT<br>(circle) Yes No If yes, describe below:</td></tr>
<tr><td colspan="2">BELONGINGS SENT WITH PATIENT<br>(circle) Yes No If no, describe below:</td><td colspan="2" rowspan="2">COMMENTS</td></tr>
<tr><td colspan="2">NAME AND TITLE OF PERSONNEL MEMBER(S) ACCOMPANYING PATIENT TO ALTERNATE CARE SITE</td></tr>
</table>

## HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM

| 1. INCIDENT NAME | 2. DATE/TIME PREPARED | 3. PATIENT TRACKING MANAGER |
|---|---|---|
| | | |

**4. PATIENT EVACUATION INFORMATION**

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | | Accepting Hospital | Time Hospital Contacted & Report given |
| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| Patient Name | Medical Record# | Disposition<br>Home or Transfer | Evacuation Triage Category Immed Delayed Minor Expired | | Accepting Hospital | Time Hospital Contacted & Report given |

| Transfer Initiated (Time/Transport Co.) | Med Record Sent<br>Yes No | Medication Sent<br>Yes No | Family Notified<br>Yes No | Arrival Confirmed<br>Yes No | Admit Location<br>Floor ICU ER | Expired (time) |
| --- | --- | --- | --- | --- | --- | --- |

| 5. SUBMITTED BY | 6. AREA ASSIGNED TO | 7. DATE/TIME SUBMITTED |
| --- | --- | --- |
| **8.FACILITY NAME** | | |

**Purpose:** Record information concerning patient disposition during a hospital/facility evacuation **Origination**: Patient Tracking Manager
**Copies to:** Planning Section Chief and Documentation Unit Leader

## General Evacuation Supplies

Additional resources needed may be needed during evacuation such as flashlights, spotlights, electrical cords, water stations, personal protective equipment, work gloves, portable ventilators, and other non-patient related equipment.

| Resource | Storage Location | Purpose |
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## Appendix:

### Care Department Supplies

**Care Department Evacuation Supplies**

The following items are stored in each care department

| Resource | Storage Location | Purpose |
|---|---|---|
| Evacuation triage tags | | |
| Permanent medium markers | | |
| Labels and ball point pens | | |
| 'Room Clear' labels (pink fluorescent, 2x4 inches) | | To identify areas that have been checked and evacuated |
| Flashlights / headlamps (4) | | |
| Blankets / carrying canvas | | |
| Large envelopes | | For records / transfer documentation to accompany |
| Rubber Bands | | For medical records information |
| Clipboard | | |
| Patient Evacuation Tracking Form NHICS 260) | | |
| Master Patient Evacuation Tracking Tools NHICS 263) | | |
| Unit personnel/visitor tracking form | | |
| Extra footies | | For ambulatory without shoes |
| Fluorescent vest | | For department / evacuation lead |
| department supplies to be 'grabbed' if time allows | | |

**Patient Care Department Shelter in Place Supplies**

The following items are stored in each patient care department: (add additional

| Resource | Storage Location | Purpose |
|---|---|---|
| Bottled water | | |
| Food | | |
| Radio | | |
| | | |
| | | |
| | | |
| | | |

## Appendix:

### Pharmacy Evacuation Cache

*(Below is a sample; update to reflect your supplies)*

| Medication | Strength / concentration | Quantity |
|---|---|---|
| Acetaminophen | 375mg tab | 500 |
| ASA | 81mg chewable | 30 |
| Albuterol | MDI | 5 |
| Furosemide (lasix) | 40mg injectable | 5 |
| Furosemide (lasix) | 40mg tab | 20 |
| Oxycodone elixir | 10mg/5ml tubs | 20 |
| Ibuprofen | 200mg tabs | 100 |
| Acetaminophen | 160mg / 5ml | 1 bottle |
| Diphenhydramine | 50mg / 2ml injectable | 10 |
| Diphenhydramine | 25mg tab | 50 |
| Enoxaparin | 100mg / syringe | 15 |
| Droperidol | 5mg / 2ml | 15 |
| Haloperidol | 10mg tab | 25 |
| Olanzapine | 10mg tab | 25 |
| Lorazepam | 2mg/2ml injectable | 15 |
| Ativan | 1mg po | 25 |
| Insulin | Regular | 2 bottles |
| Insulin | 70/30 | 2 bottles |
| Marcaine | 0.25% with epi | 2 bottles |
| Hydromorphone | 1mg/2ml | 20 |
| Saline lock | 5ml | 50 |
| Syringe tuberculin with needle | | 20 |
| Syringe 12ml | Luer lock | 20 |
| Syringe | 3ml with 1 inch 23 ga. needle | 20 |
| Needle | 18 ga. 1.5 inch | 20 |
| Needle | 25 ga. 1.5 inch | 10 |

Appendix:

## Assembly Point Supplies

(*Below is a sample; update to reflect your supplies*)

| Item | Storage Location | Destination | Deployment Method (e.g., automatic upon evac, upon instruction from the IC, etc.) |
|---|---|---|---|
| **Administrative Items** | | | |
| Permanent markers | | | |
| Rubber bands for medical records | | | |
| Sheet protectors for transfer documentation to accompany patient | | | |
| NHICS Forms | | | |
| Evacuation tags | | | |
| Additional 'room clear' labels (100) | | | |
| Chart pads | | | |
| **Food Items** | | | |
| Bottled water | | | |
| Energy bars | | | |
| **Medical Items** | | | |
| IV Solutions | | | |
| D5 0.45NS – x bags | | | |
| NS – x bags | | | |
| Wheel Chairs (WC) | | | |
| Walkers | | | |
| Crutches | | | |
| Gloves, exam M, L | | | |
| Crash cart | | | |
| Portable oxygen cylinders (D type) | | | |
| First aid kits | | | |

## Appendix:

| **Personal Items** | | | |
|---|---|---|---|
| Sani-wipes | | | |
| Hand sanitizer | | | |
| Diapers, adult | | | |
| Sheets | | | |

| **Item** | **Storage Location** | **Destination** | **Deployment Method** (e.g., automatic upon evac, upon instruction from the IC, etc.) |
|---|---|---|---|
| Blankets | | | |
| Emesis bags | | | |
| Non-skid socks for ambulatory patients without shoes | | | |
| Facial tissues | | | |
| **Janitorial Items** | | | |
| Paper towels | | | |
| Flashlight | | | |
| Garbage bags, plastic | | | |
| Zip close plastic bags, gallon | | | |
| **"Infrastructure"** | | | |
| Tents | | | |
| Chairs | | | |
| Generators | | | |

## Appendix:

### Facility Shut Down and "Stay Team" Member Checklist

| Task | Assigned To | Complete |
|---|---|---|
| Change facility status to closed | Liaison Officer | |
| Identify the lockdown plan and how to harden exterior & critical infrastructure | Operations/Security Branch Director | |
| Define procedures for coordinating local public safety to determine inner and outer perimeters | Operations/Security Branch Director | |
| Procedure to account for safe evacuation of assigned "stay team" personnel | Logistics Section | |
| Define departmental procedures for securing and shutting down equipment and identifying personnel assigned to perform shutdown functions: (critical operations responsibilities) | | |
| Central / sterile supply | | |
| Dietary & foodservices | | |
| Hazardous waste (satellite and waste sites) | Safety Officer | |
| Hazardous materials storage locations | Safety Officer | |
| Information Technology (IT, telecomm, radio) | | |
| Finance | | |
| Lab | | |
| Morgue | | |
| Pharmacy (defined procedures for security and/or management of controlled substances) | | |
| Records | | |
| Utilities (see next chart for procedures) | | |

## Appendix:

### Utility Shutdown Procedures

| Utility | Location of Shut Off | Responsible Party Performing Shut Off | Procedure |
|---|---|---|---|
| Electricity | | | |
| HVAC | | | |
| Medical Gas - Oxygen | | | |
| Medical Vacuum | | | |
| Natural Gas | | | |
| Sewer | | | |
| Steam | | | |
| Telephone | | | |
| Water – Potable | | | |
| Water – Fire Sprinkler | | | |

## Appendix:

Incident Management Team Recovery Responsibilities

**COMMAND**

- Incident Commander
    - Assess if criteria for partial or complete reopening of the facility is met, and order reopening and repatriation of patients
    - Oversee restoration of normal hospital operations
- PIO: Conduct final media briefing providing situation status, appropriate patient information and termination of the incident
- Liaison Officer: Notify local emergency management, fire, EMS and Licensing & Certification of termination of the incident and reopening of the facility
- Safety Officer: Oversee the safe return to normal operations and repatriation of patients

**OPERATIONS**

- Restore patient care and management activities
- Repatriate evacuated patients
- Re-establish visitation and non-essential services

**PLANNING**

- Finalize the Incident Action Plan and demobilization plan
- Compile a final report of the incident and hospital response and recovery operations
- Ensure appropriate archiving of incident documentation
- Write after-action report and corrective action plan to include the following:
    - Summary of actions taken
    - Summary of the incident
    - Actions that went well  Area for improvement
    - Recommendations for future response actions

**LOGISTICS**

- Implement and confirm facility cleaning and restoration, including:
    - Structure
    - Medical equipment certification
- Provide debriefing and mental health support services for personnel and patients
- Inventory supplies, equipment, food, and water, and return to normal levels

**FINANCE/ADMINISTRATION**

- Compile final response and recovery cost and expenditure and estimated lost revenues summary and submit to the Incident Commander for approval
- Contact insurance carriers to assist in documentation of structural and infrastructure damage and initiate

## Appendix:

### Hierarchy of Repopulation Approval(s)

Dependent upon circumstances, the following sequential steps should be expected prior to the repopulation of evacuated hospital facilities.

| Steps | Date Completed |
|---|---|
| A. Local government agencies have removed restrictions, if any, related to the environmental quality in the area or facility for the types of patients to be moved back into the facility. | |
| B. Local fire department and/or law enforcement agency representative allows re-entry to the specific evacuated neighborhood in which the facility is located and/or allows re-entry to evacuated facilities, as applicable. | |
| C. If structural integrity or any major building system is compromised, DOB inspects and repopulation cannot occur until any red and yellow building tags are removed from the impacted building by DOB. | |
| D. If required, due to prolonged loss of power and refrigeration or breach of pharmaceutical security, State Pharmacy Board may conduct a site visit to approve measures taken to restore Pharmacy capacity and safety. | |
| E. The CEO/IC oversees an assessment of environmental safety, facilities, operations and resources, including the factors identified in the General All Hazards Repopulation Factors checklist below, and prepare the facility for repopulation. | |
| F. The CEO/IC maintains communication with the District Office regarding facility status, progress and estimated timeframes for reopening of facility (ies). Depending upon the circumstancesDOH may schedule a reportable event visit. | |
| G. Once the CEO/IC makes a determination, based on best judgment, that the facility is ready to repopulate, DOH is notified and: 1. If necessary, an DOH repopulation inspection is scheduled, or 2. Repopulation is initiated. | |

Appendix:

## General All-Hazards Re-Population Factors / Steps

*The following factors / steps should be considered as appropriate to the type of evacuation.*

| Factors / Steps | Status/Date |
| --- | --- |
| A. Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by DOB, fire marshal and Licensing & Certification (L&C). | |
| B. Air particulate exposure levels (e.g., smoke, chemicals) in buildings are documented to be reduced to acceptable/safe levels as defined by NYS/OSHA permissible exposure limits (PELS) and local Air Quality Management District standards using available methods (e.g., air scrubbers, open windows, blowers, HAZWOPER response, etc), if needed. Only test equipment appropriate to the hazard should be used to determine safe levels of habitability and may require an outside testing laboratory service. | |
| C. All interior and exterior surfaces/areas are clean and free of debris (e.g., counters, walls, drawers, closets, roof, parking facilities, etc). | |
| D. All filters in the facility, HVAC systems, and generators, etc. should be cleaned/replaced, if needed. | |
| E. Replace or clean linens, drapes, and upholstery, if needed. | |
| F. All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/ quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.). | |
| G. Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are returned to operational status. The facility's ability to provide essential services should be sustainable for the long term. | |
| H. Vandalism and/or looting damage, if applicable, is repaired and alleviated. | |
| I. Full and non-abbreviated generator and smoke detector tests are completed, if needed. | |
| J. HVAC systems are tested and operational, if needed. | |
| K. Utilities are tested and operational (electricity, water supply and quality, plumbing, etc.). | |
| L. Dietary services are operational and sustainable for the long term; in the case of damage to kitchens/equipment, program flex approval from L&C may be requested for contract services during repairs. | |

# Appendix:

Blank

# UNION PLAZA CARE CENTER

## e-FINDS
## Evacuation of Facilities in Disasters System

POLICY:
It is the policy of Union Plaza Care Center that in the event the NYSDOH activates the use of the e-FINDS Scanner and Wristbands system, Union Plaza will implement the additional tracking of the location of our residents while evacuating our residents.

PROCEDURE:
Once the Disaster Plan has been initiated by Administration and/or the NYSDOH - the designated on-site Supervisor will:

1) Contact the NYSDOH Duty Officer at 866-881-2809 and inform them of the initiation of the "Evacuation" and/or utilize the NYC OEM Emergency Radio (kept at the front desk) to inform the NYC OEM of the initiation of a facility-wide evacuation.

2) The hand-held SCANNER & WRISTBANDS will be stored in a brown box in the Nursing Suite. It will be brought up to the identified unit by a staff member designated by the Administrator/ DNS/Designee.

3) The Hand Held Scanner will be connected to the laptop kept in the nursing suite.

4) In addition to the use of the scanner and Wristbands - the "RESIDENT EVACUATION IDENTIFICATION TAG" Form will also be used and completed to keep a hard copy log (see attached).

## ... Evacuation of Fa... ities in Disaster Systems

### Getting Started

The **e-FINDS** Data Reporter and **e-FINDS** Administrator role have access to the patient tracking application. From the **My Account** link, on the menu bar (top right) of the Health Commerce System (HCS), click See what roles I hold to verify that you are in one of the e-FINDS roles. If you are not in an e-FINDS role, please contact your facility's HCS Coordinator. Locate your coordinators from **My Account** > Look up my coordinators. Click Update or verify my contact information to access and update your business and emergency contact information to receive communications.

### Open e-FINDS

1. Log on to the HCS (https://commerce.health.state.ny.us). **If you cannot remember your user id or password, please call Commerce Accounts Management Unit at 1-866-529-1890.**
2. Click **e-FINDS** in the **My Applications** panel (left side). If you do not see e-FINDS, then you are not in an e-FINDS role (see Getting Started).
3. Select your current location from the dropdown list.
4. Click **Submit,** and proceed to one of the following actions.

**Always VERIFY your location, if affiliated with more than one!**

### Evacuating Facility: Registers Multiple Patient/Resident

e-FINDS Administrator Role Only

1. Click **Register Patient/Resident > Multi Patient/Resident Input.**
2. Verify Evacuation Operation and Current Location.
3. Select Intended Destination.
4. Enter the number of barcodes to be assigned.
5. Click **Generate Fillable Spreadsheet.**
6. Enter known information, such as first name, last name, date of birth (mm/dd/yyyy), and gender.
7. Click **Save all Patient/Resident.**
8. Verify message: Successfully saved {correct # being evacuated} Patient/Resident and click **barcode** to view or update the patient or resident information.

### Evacuating Facility: Register Patient/Resident with Scanner

**Evacuating facilities may not have time to complete the registration process, so multiple time saving options are available**

1. Scan a barcode
   OR click **Register Patient/Resident > With Scanner.**
2. Confirm message: Barcode is located. You can register a new Patient/Resident with it.
3. **If time allows,** enter first name, last name, date of birth (mm/dd/yyyy), gender, etc.
4. Verify the Evacuation Operation OR select another operation from the list.
5. Verify the patient/resident current location is correct.
6. Select the Intended Destination Organization type, if necessary.
7. Select the Intended Destination.
8. Enter the Bulk Group; such as bus no. or transportation description.
9. Click **Register**. If the required fields are not complete, you will receive an error message. Click **Override** to bypass the error.
10. Confirm message: Patient/Resident info is updated.

### Evacuating Facility: Updates Multiple Patient/Resident

e-FINDS Administrator Role Only

1. Click **Update Patient/Resident > Multi Patient/Resident Update.**
2. Verify your location.
3. Select the Action Type:
   **Releasing Patient/Resident From this Location,** OR **Change Operation for Patient/Resident at this Location.**
4. Select the Intended Destination.
5. Enter the Bulk Group, for example transport via bus.
6. Click **Load All Patient/Resident.**
7. Select All OR select Update for each patient/resident.
8. Click **Release Selected Patient/Residents OR Change Operation for Selected Patient/Resident.**
9. Verify Successfully updated {#} Patient/Resident.

## Evacuating Facility: Generates Barcoded PDF Log OR Uploadable Barcode Spreadsheet

**e-FINDS Administrator Role Only**

1. Click **Manage Barcodes > Generate Barcodes Spreadsheet.**
2. Select or verify the current location.
3. Enter Start and End barcode numbers, e.g., 4—13 for ten patient/residents to be relocated.
4. Select the PDF if you want a scannable barcode log OR select EXCEL for the upload patient/resident option.
5. Click **Generate.**
6. Print the PDF OR save the Excel spreadsheet to your computer.

**Note:** PDF files cannot be uploaded, but could be sent with transport. The Excel file can be updated with patient/resident information and uploaded to e-FINDS. See upload instructions below.

## Evacuating Facility: Uploads Multi Patient/Resident File

1. Click **Register Patient/Resident > Patient/Resident Upload File.**
2. Verify the Evacuation Operation and current Location.
3. Click **Browse.**
4. Locate the Excel file with **saved** patient/resident information. Hint: search for nys_e-FINDS file name with facility id, date and time.
5. Click **Open** to add file.
6. Click **Upload.**
7. Verify the patient/resident information is updated, and edit information as needed.
8. Click **Save All Patients/Residents.**

**Note:** If the Excel file has no patient or resident information, then the file cannot be uploaded.

## Shelter-in-Place (SIP)

If an evacuating facility determines that a patient or resident would be safer if **not** moved to another location, then the patient or resident will shelter in place. If the patient or resident is already registered in e-FINDS, then click Shelter-In-Place to change the Intended Destination to the current location.

## Quick Search

1. Click **Home** on the e-FINDS menu bar.
2. Scan a barcode, enter a barcode number, OR enter first or last name in Quick Search (located top right). If necessary click **Quick Search.**
3. Locate the correct patient/resident record.
4. Click the Barcode (Serial ID) link.
5. Verify: Patient/Resident is found. You can update the information.
6. View, Add, or change the necessary information.
7. Click **Update Patient/Resident.**

**If a person has never been to your facility, you will NOT be able to search for them.**

## Receiving Facility: Updates Patient/Resident with Scanner

1. Click **Update Patient/Resident > With Scanner**
2. Scan a barcode and click **Submit,** if necessary.
3. Confirm message: Barcode is located. You can register new Patient/Resident with it OR Patient/Resident is found. You can update the information.
4. Enter or confirm information, including Evacuation Operation and the current patient/resident location.
5. Click **Register, Update,** or **Override.**
6. Confirm message: Patient/Resident info is updated.

## Receiving Facility: Updates Patient/Resident without Scanner

1. Click **Update Patient/Resident > Multi Patient/Resident Update.**
2. Verify your location.
3. Select **Checking in Patients/Residents into this location.**
4. Verify the patient or resident is correct.
5. Click **Select All** OR **Update** for each patient or resident being received.
6. Click **Check in Selected Patient/Resident.**
7. Confirm Message: Successfully updated {correct #} of Patient/Resident.

## UNION PLAZA CARE CENTER

**TITLE:** Missing Resident

**POLICY:** It is the policy of UNION PLAZA CARE CENTER to secure the safety and well-being of our residents.

**PROCEDURE:**

1. Upon admission each resident will be photographed and a copy of this photograph will be maintained in the residents chart.
2. Residents on all units will be accounted for on an hourly basis.
3. In the event that a resident is identified as a wanderer, a copy of the residents photo will be maintained at the security/reception desk.
4. Identified wanderers will be issued an Alarm Activated Identification Band.

In the event the above procedures prove insufficient, and a resident is found to be missing from a unit, the following procedures will be initiated:

1. The RN Supervisor/LPN charge nurse will initiate an immediate search of all areas of the residents unit, including bathrooms and storage areas
2. If the resident is not located on the unit, the DNS / Designee will be immediately informed.
3. Security guard shall be informed to announce "Dr. Find is in the building", indicating that the missing resident procedure should now be put into effect.
   a. In the event the Administrator /Designee is not in the facility, security shall call the Administrator to inform her/him of the search status.
   b. The security guard will be responsible to monitor security cameras at the front desk and try to locate the last known whereabouts
4. Each RN Supervisor /LPN Charge nurse will immediately initiate a search of the unit to identify any resident not belonging to their unit.
   a. The results of each unit search will be reported to the DNS/ Designee
5. A facility wide search will be instituted including all resident areas.
   a. Basement
   b. Parking Levels
   c. Recreation areas and Rooftop areas
6. If there are community locations that the resident has been known to frequent, these areas will be thoroughly searched.
7. If the resident is not found within two (2) hours, the facility will notify the following:
   a Local Law Enforcement Agencies
   b Local Hospital's Emergency Rooms
   c Resident's responsible party of record

8. The Nursing Supervisor shall document all information in the nurses note and (24) twenty-four hour report.

9. In the event that the resident has been found to be alert and oriented and has left the facility of his or her own volition, the resident will be discharged Against Medical Advice (AMA) after forty -eight (48) hours.

10. In the event that the resident is found to be demented or incompetent, the New York State Department of Health will be notified after twenty-four (24) hours.

11. In the event that the resident is located, the Nursing Supervisor shall document date, time and location where resident was found. Upon resident's return to the unit, nursing shall assess the resident's condition. Nursing Supervisor shall document any pertinent data regarding the resident condition (i.e.: bruises, cuts, marks, changing condition, etc.) The attending physician or alternate shall be contacted, and a complete physical examination of the resident shall be performed

12. A full investigation of the event will be conducted, and the NYS Department of Health will be notified.

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** 1135 waiver guidelines | |
| **Policy Date:** | **Policy Revision:** Revision Date 1/14/18 JGL |

POLICY: In the event of a disaster the President may declare a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions. This may include a waiver of certain requirements to aid in disaster response and recovery

PROCEDURE:

1. The facility will maintain MOUs (Memoranda of Understanding) with several facilities for continuing care of all residents. The facility will also maintain MOUs with facilities which may need to evacuate to the facility under the guidance of an 1135 waiver.
2. The facility will utilize NYSDOH web services, HCS, HERDS and E-FINDS for tracking and assistance.
3. 1135 waivers are for the purposes of Medicare, Medicaid, and CHIP reimbursement only– state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure. 1135 waivers include:
   a. Conditions of participation or other certification requirements
   b. Program participation and similar requirements
   c. Pre-approval requirements
   d. Requirements that physicians and other healthcare professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another state.
   e. Emergency Medical Treatment and Labor Act (EMTALA)
   f. Stark self-referral sanctions
   g. Performance deadlines and timetables may be adjusted (but not waived)
   h. Limitations on payment for healthcare items and services furnished to Medicare Advantage enrollees by non-network providers.
4. The lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility shall be the Administrator or Medical Director and their designee.
5. Facility will address DOH and surrounding facilities to coordinate efforts needed during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary
6. These waivers under section 1135 of the Social Security Act end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.
7. The facility shall follow the emergency plan in any case where emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility.

8. CMS has, in past disasters, implemented specific waivers or modifications under the 1135 authority on a "blanket" basis, when a determination has been made that all similarly situated providers in the emergency area needed such a waiver or modification.
    a. While blanket authority for these modifications may be allowed, the provider(s) should still notify the State Survey Agency and CMS Regional Office if operating under these modifications to ensure proper payment.

Reporting requirements (e.g. Minimum Data Set updates on residents) are suspended for all providers in the impacted areas in accordance with the Waiver authority.

| UNION PLAZA CARE CENTER | |
|---|---|
| **Policy Name:** Patient Record Policy | |
| **Policy Date:** | **Policy Revision:** Revision Date 1/13/18 |

**Purpose:**

To ensure that patient records are secure and readily available to support continuity of care during emergency.

**Policy:**

The Facility shall maintain medical records available until all its patients have been evacuated and its operations cease a system which can be transferred or connected to for continued patient care. In addition to any existing requirements for patient records found in existing laws, under this policy, does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this adds to such policies and procedures. Shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information.

**Procedure:**

1. The resident medical record shall be logged and transported with any transfer of the resident.
2. The facility EMR will be maintained on an offsite server with access control.
3. The Nursing HIPPA policy shall be followed.

**Survey Procedures**

**• Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or potential and actual donor for OPOs) information, and secures and maintains availability of records.**

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Communication with Family and Residents | |
| **Policy Date:** | **Policy Revision:** 1/15/18 |

**PURPOSE:** To maintain active and effective communications with and inform those in our care about disaster preparedness and implementation of the facility plan.

**Policy:**
The facility shall provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. We shall provide instructions on how to contact the facility in the event of an emergency on the public website and include the information as part of the facility's check-in procedures.

**Procedure:**

1. The admissions department will include an informational fact sheet about the facility EAP at time of admission. This will be reviewed with the family and resident.
2. Resident council will discuss the EAP with residents.
3. During the family council administration will remind families of the plan and answer questions about the plan.
4. A notice of the plan shall be posted at the security desk with the location of the plan so residents or family can review.
5. Common communication systems, such as email, telephone, and social media will be utilized to inform parties of concern about the implementation of the plan.

See attached social media guide.

# Emergency Management Training Guide

## Purpose

The purpose of this guide is to describe essential elements of an emergency management training program.

## Desired Outcomes

There are three major outcomes that your nursing home should expect to obtain as a result of the trainings:

- Staff will perform effectively in protecting the health and safety of Residents, staff, visitors, family, property and the environment;
- Staff will be prepared to work effectively with other emergency response and recovery organizations, by appropriate and timely use of resources, and by recovery of damages and operating costs, to the extent possible; and
- Staff will work in a safe manner to prevent injury to themselves and others.

## Evaluation of Training Effectiveness

Formal training requires evaluation so that the Nursing Home can be assured of the program's effectiveness and modifications can be made as needed. The Nursing Home shall provide some minimum evaluation instruments for each formal classroom experience to ensure the objectives of the course(s) have been achieved. Exercises, which by definition will have some form of evaluation as a formal record of the activity (HSEEP).

Additional measurement devices are used after exercises in the form of critiques, After Action Reports (AARs) and Improvement Plans (IPs). External audits to be used as a tool to evaluate the total training curriculum effort.

## Maintaining Training Records

A record must be kept of any training methodology that was performed for the Nursing Home, including who received the information and the results of any evaluation. Records of required training elements and participation must be kept with the individual's in-service record.

## Curriculum

Will include reading assignments, briefings, classroom instruction (with or without examinations), videotapes, online instruction and or demonstrations.

1. Emergency manual
2. Attend drills
3. FEMA website training
4. Homeland Security website training
5. Yonkers CERT training
6. Other added items as defined during drill after action reports.

### I. Reading Assignments

The reading assignment shall be accompanied with a "read and sign" sheet to be returned to the Administrator or Department Head. This will be copied and archive in Human Resources. The staff assigned to read materials will also keep a copy of the "read and sign" sheet for their personnel files.

### II. Briefings

Briefings provide precise instructions or essential information. They often involve fewer individuals than would be featured in classroom presentations. Sometimes a briefing is for a specific individual. There must be compelling reasons to hold briefings. These can include:

- Changes that require immediate awareness and change of behavior
- Warnings regarding impending threats to safety, health, the environment, or property
- Updates on current issues that can impact staff morale
- Directives from the Administrator or Department Head that require immediate attention
- Updates on information that a staff was not able to acquire because of a missed training opportunity—this fulfills a legal requirement to keep all of the organization properly trained in accordance with their assigned training curriculum

### III. Classroom Instruction

Classroom instruction provides an environment for transmitting information that can become acquired knowledge to the participant. Some classroom instruction can be provided by specialized training organizations. Some of these organizations can come

directly to the nursing home. Other training organizations may require staff to travel to another site. Training can be provided through such diverse organizations as:

- New York State Department of Health
- Nursing Home Trade Association
- Yonkers Department of Health & Mental Hygiene
- Yonkers Office of Emergency Management
- The Federal Emergency Management Agency (FEMA), Emmetsburg, Maryland
- The American Red Cross (ARC) through its local chapter
- Local colleges and universities specializing in emergency management courses

[1] FEMA Independent Studies can be assessed at http://training.fema.gov/IS/crslist.aspx

## IV. Videotape

The Nursing Home should keep an emergency management videotape/digital library for staff. The videos should include:

- Recordings of classroom presentations held recently
- Overview of Incident Command System
- EOC facility layout and operations
- Public Information
- Other specific interests as noted by staff (e.g. specific hazards, command and control, evacuation

Videotapes cannot be used to replace formal training requirements such as classroom training, drills and exercises.

## V. Online Instruction

The nursing home can post emergency management, self-guided training on its website for its staff. This can include short video presentations and Power Point slide shows. Other formal, accredited courses can be taken online through FEMA's website[1]. This training does not replace required formal nursing home classroom, drill, or exercise activities.

## VI. Demonstrations

Demonstrations develop skills for a limited function. This helps staff perform properly in drills, exercises and actual events. Typical demonstrations for the nursing home include:

- Use of computers along with software in the Emergency Operations Center (EOC)
- Use of fax machines and copiers (including electronic faxing and scanning of documents)
- Set up of the EOC or set up of a triage or isolation area
- Practice drills

# Emergency Preparedness Communication Options[1]

| Communication Option | Functionality | Limitations | Costs |
|---|---|---|---|
| **Management of Existing Phone Lines** | | | |
| Back-up Power Source for Internal Phone Switch (aka private branch exchange or PBX) | An internal phone switch powers the distribution and functioning of internal phone lines. If this phone switch loses electricity, then calls cannot be routed internally.<br>An institution will usually only have a limited number of direct, outside phone lines that are then routed by an internal switch to support an exponential number of internal extensions, paging, etc.<br>Must use uninterruptible power supply (e.g. batteries or connection to emergency generator) to power internal phone switch in case of electricity loss. | Cannot protect against a power or line outage that occurs at the local phone carrier's switch (e.g., external switch). | Cost of additional battery cells or connections to emergency generator. |
| Diversify Existing Phone Lines | To reduce dependence on one external phone switch, secure redundant phone lines for critical communication areas that run through a different central offices (external phone switch). Examples of critical communications areas include command center, ER, OR, ICU, nursing stations, security, switchboard, administration.<br>The goal is to protect against power loss or wiring trouble that can bring down a local carrier's central office and cut off all phone lines that run through that switch.<br>Your local carrier may have more than one central office (or switch) that can service your facility. Or another local carrier may use a different central office. | Only provides true redundancy if the back-up phone line is carried though a different central office/external switching station.<br>Some facilities may not be able to access more than one central office because of infrastructure limitations of local phone system.<br>Only protects against a service outage at one switching station but cannot protect against area-wide outage that effect multiple switching stations. | Cost of additional phone line (installation and monthly fees) |
| Secure Prioritized Repair of Existing Phone Lines | Telecommunication Service Priority (TSP) program is sponsored by the Federal Communications Commission (FCC) to prioritize repair of phone lines designated as critical to national security or emergency preparedness.<br>Health care facilities eligible under "Category C, [4] | Only certain phone lines can be designated as priority for repair. Will not cover all phone lines and does not provide interim communications capabilities<br>Must secure sponsorship by a Federal | No outright costs. |

[1] This document was prepared by GNYHA to assist members' assessment of communication options for emergency preparedness. It is intended to provide an overview and should not be construed as technical advice.

| | | | |
|---|---|---|---|
| | Hospitals and distribution of medical supplies"<br>Must be sponsored by a Federal Government agency.<br>HHS is designated sponsorship agency for health care. | government agency<br>TSP assignments must be renewed every two years. | |
| **Voice Communication - Cellular, Satellite and Radio** | | | |
| Cell Phone *(vendors: Voice Stream , AT&T, Verizon, etc.)* | Regular cellular phone coverage that can work when land-line phone switches are down. | Can lose cellular coverage if transmitter is damaged. (however, a cell-on-wheels (COW) can be used to restore cellular coverage on a temporary basis). | Will depend onmodel of phone, number of users and service contract. |
| Cell Phone with Two-Way Digital Radio (*vendor: Nextel*) | A phone with regular cell phone capabilities and two-way digital radio capabilities.<br>Two-way digital radio does not use regular phone line switches, allowing continued service even if phone switches go off-line.<br>Two-way digital radio can be used for person-to-person communications (similar to a regular phone call).<br>For phones within a fleet (i.e., phones that are programmed to work together), there is ability to broadcast a message to every phone in fleet. Message can be traditional voice communication or an e-mail message sent via keypad or the internet. | Can lose cellular coverage if transmitter is damaged. (however, a cell-on-wheels (COW) can be used to restore cellular coverage).<br>Usage bills can be substantial. Direct two-way digital radio will have no fee but there will be a charge for group minutes (group broadcast)<br>For broadcast feature to work, phone must be programmed as part of a fleet. A phone can not be part of more than one fleet.<br>Important to consider quality of cellular coverage for your area. | Will depend on phone model, specifics of service contract and number of users in fleet.<br>Basic models phones may be free with service contract while more sophisticated phones will run from $100-$250.<br>Basic phone service costs approx $10 per month.<br>Medium to high service costs more in range of $30-50 per month. |
| Wireless E-mail device *(vendor: Blackberry)* | Wireless, handheld device that allows users to read and respond to e-mail from an existing e-mail account.<br>Utilizes wireless data networks that run two-way radio transmissions (and some satellite transmission).<br>Can receive pages through existing telephone or internet paging systems.<br>Can access internet using filters to limit information transmitted (to reduce costs and increase readability on small screen). | For access for corporate e-mail, system must run a Microsoft or Lotus e-mail program.<br>Can lose coverage within a building or in a dead-spot within wireless data network. | Depends on number of users, type of unit and type of services (e-mail, paging, internet, etc) |
| Satellite Phone *(vendors: Motient, Iridium)* | Satellite phone transmits voice and data messages via satellite. Satellite phone to satellite phone communication will work when phone switches and cellular transmitters are down. | Urban area will have line of sight issues – satellite unit may need to be hard wired to antenna.<br>Administrative function for talk group. | $500 for antenna plus labor to install and wire.<br>$2,000 to $5,000 for satellite phone unit |

| | | | |
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| | Satellite phone can also be used to place regular telephone and/or two-way digital radio communications (presuming that phone switches are working). Can also handle fax and data transmissions.<br>Transmission will work only if satellite unit is within a line of sight or hard-wired to satellite antenna (antenna placed on top of building).<br>There is an administrative function necessary to set up and maintain user rights to satellite talk group. | To speak from satellite phone to satellite phone – both users must be using same vendor/satellite system (e.g. Iridum user cannot speak with Motient user).<br>Location of satellite receiver determines access to phone lines. E.g. if receiver location does not have phone service because switches are down, the satellite system cannot access regular phone lines. | (advisable to have two – one as back-up).<br>$30-50/month for talk group access. |
| 800 Megahertz Radios (e.g. Motorola) | 800 megahertz radio allows voice transmission over a designated radio frequency.<br>Use hand-held radio unit to communicate with the Mayor's Office of Emergency Management and other health care facilities on a designated frequency.<br>NYS is developing a state-wide emergency radio system. It may use a different frequency (700 megahertz) but a receiver can be used transmit across frequencies | May require purchase of an antenna if coverage is poor. Because of high frequency, it can be difficult to transmit through building walls.<br>Existing radio units will need to be programmed for health care designated frequency. | Portable unit costs approximately $3,000.<br>A base station costs approximately $5,000. |
| Amateur Radio | Amateur radio can provide health care facilities with a voice communication method of last resort. Will work when phone switches, cellular transmitters and other radio systems are down.<br>Integrate with existing NYC RACES amateur radio program sponsored by NYC Mayor's Office of Emergency Management.<br>Secure hospital based amateur radio hardware and develop plan to operate system using amateur radio operators (may be drawn from existing hospital staff)<br>Need to designate a call channel/frequency for communications | Only an individual can hold an amateur radio license. A hospital or SNF cannot hold the license.<br>Need to integrate amateur radio into health care facilities existing emergency preparedness structure. Conduct drills and testing.<br>Portable radio units may not be able to penetrate building walls. May require antenna on top of building.<br>Antenna could interfere with cellular coverage.<br>Communications are not secure.– anyone can listen. | Approx $150-$300 for portable radio<br>An antenna and base radio-set up may cost several thousand dollars. |
| **Data Communication – Frame Relay, ISDN, Cable and VoIP** | | | |
| Frame Relay (data) | Frame relay is a protocol for transferring data between two points in a wide area network (WAN) or two local area networks (LANs)<br>In effect, frame relay allows a dial-up connection to a | Communications via frame relay are not secure. Information being sent over shared lines.<br>Communications (or frames) containing | Approx $300-$600 per month depending on complexity of connections. More |

| | | | |
|---|---|---|---|
| | service provider's data network (most often the telephone company). As opposed to using your own T-1 lines, frame relay makes use of the service provider's existing data lines (most often T-1 or T-3 lines).<br>Creates a permanent virtual circuit that seems like a continuous connection to the user but has a much lower cost than a continuous connection.<br>Works well in conjunction with ISDN | errors can be dropped – although error rate is very small. Customer can select a level of service to reduce number of dropped frames (performance guarantees)<br>Protect against loss or damage to your institution's T-1 or other data lines. Cannot protect against loss of data line functionality by service provider. | expensive for performance guarantees |
| ISDN (Integrated Services Digital Network) | ISDN is a communications standard for sending voice and data over digital telephone lines or normal telephone wires. A dial up connection into an ISDN data line allows point-to-point transmission of data.<br>ISDN is generally available through local phone carriers and is reliant on functioning phone switches.<br>Works well in conjunction with frame relay technology. | ISDN is dependent on phone switch and will go out if phone switch goes down. | Monthly charge of approx $30 plus a per character transmission fee |
| Cable Modem *(vendors: Road Runner, Verizon, etc)* | Allows two-way data transmission between user and cable TV operator. Provides a continuous connection to the internet that is independent from telephone lines.<br>Dependent on operation of cable lines.<br>Can provide internet access for multiple PCs attached to one LAN | Requires firewall to ensure security against a continuous, open connection to the internet. Current firewall can be adapted for this purpose.<br>Can be slow depending on number of users on cable line. | Monthly charge of $40-60 for cable service.<br>Additional costs for multiple PCs.<br>New firewall, if necessary, can cost upwards of $10,000 |
| VoIP (Voice Over Internet Protocol) | An internet protocol that allows voice communications to be delivered over a data network (i.e., the internet).<br>Can provide a backup to traditional phone systems because it does not rely on the public telephone network for whole length of transmission.<br>Can send information both externally (via internet) and internally (via intranet) | Timely delivery of voice messages can be a problem. Vendors may provide quality of service guarantees for timely delivery.<br>In some cases the public telephone network is used to route voice communication into a data network. As such, the system will go down if the telephone network goes down. | Avoids long distance telephone charges<br>Operational costs to be determined. |
| Diversify Existing Data Lines | Maintain a redundant data line to protect against a power loss or trouble with wiring that effects one external switching station.<br>Data line must run through different data line switch to achieve true redundancy. | Protects against service outage on one data line switch but cannot protect against area or system-wide outages | Cost of additional data line (installation and monthly fees) |

Consolidated Edison Company
of New York, Inc.
4 Irving Place
New York NY 10003
www.conEd.com

April 13, 2007

MR. JOHN KEARNEY, CHIEF ENGINEER
UNION PLAZA NURSING
33-23 UNION STREET
FLUSHING NY 11354

Re: Emergency Contact Information
Account Number: 29-9031-0127-2001

Dear Customer:

In recent weeks, we have been in touch with your staff to update the contact information that we have on record for your facility. In conjunction with that initiative and as part of our Emergency Preparedness Plan, we wanted to take this opportunity to provide you with an emergency contact telephone number.

Should you experience a power interruption or any emergency which impacts upon your service facilities, please call us at: 1-877-427-2255. Your call will be handled on a priority basis by a Customer Service Representative. Our personnel are available to handle your call seven days a week, twenty-four hours a day.

Beginning on or about May 1st 2007 we will be instituting an automated notification system whereby you will be contacted at the telephone number you have provided when extreme weather predictions could impact our service to your facility. We plan to test the system during the first week of May; the test message will begin and end with the words "This is a test". Once complete, we will contact you if the system indicates contact was not made with your facility.

Please be reminded that this phone number should be used only in the event of an emergency. We appreciate your cooperation in this matter. If you have any questions please feel free to contact John A. McGregor at 718-802-5436.

Sincerely,

*Steven J. Lewandowski*

Steven J. Lewandowski, Manager
Brooklyn/Queens Energy Services

# Union Plaza Nursing Home

## Communications Contingency Plan

POLICY:
It is the policy of Union Plaza Care Center to ensure the care, safety and well-being of all its residents. In the event of a failure of telephone line/system, communication contingency plans will go into effect.

PROCEDURES:
I. No External capability - no outgoing or incoming calls, but internal system is operational

1. The emergency cell phone - located in the red box in the nursing office suite (917-992-1302) will be kept fully charged at all times.
2. In the event of an emergency, this cell phone and charger will be moved to the security desk by Administration or by Senior Nursing Personnel.
3. All department heads and RN supervisors will immediately be informed of the situation.
4. All employees will be informed that personal cell phone use will allowed during the duration of the emergency. Cell phone use on behalf of the needs of the nursing home will be reimbursed.
5. Arrangements will be made with pharmacy services, laboratory and radiology services to receive reports via on-line, messenger service, delivery, as needed.
6. Social services will be responsible to coordinate informing all family members of the situation and of the emergency cell phone number.
7. Administration/ Nursing will be responsible to ensure that all attending physicians and consultants being utilized will kept informed.
   a. Dialysis units will be informed of the emergency number.
   b. Ambulette company will be informed.
8. Admissions will be responsible to inform hospitals of the emergency number.
9. If phone services are not restored in a timely manner, the Department of Health will be notified.

II. No Internal capability

1. Walkie Talkies will be provided to: Security desk, all units, Nursing Office, Administration, 9th floor - Recreation Department, Rehab Department - Lower level, Engineering and Housekeeping Departments.

Union Plaza Care Center
33-23 Union Street, Flushing, NY 11354
Tel: 718-670-0700 Fax: 718-670-0726

Dear Family member/ Visitor:

We are currently having trouble with our phone lines. We hope to get it fixed soon. Until then, if you need to contact the facility you can call our temporary cell phone number at

# 917-992-1302.

Sorry for the inconvenience.

Thank you for your consideration and cooperation during this time.

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Emergency Communication[1] Policy | |
| **Policy Date:** 1/14/17 | **Policy Revision: 1/14/2018** |

**Purpose:**

This policy exists to assure that information disclosed during an emergency by Union Plaza Care Center is timely, accurate, comprehensive, authoritative and relevant. Adherence to this policy is intended to provide an effective and efficient framework to facilitate the timely dissemination of information. The facility maintains primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies.

1. The facility shall maintain alternate means of communication in accordance with the Communication matrix.
2. Emergency radios for interior communications are available from the engineering Dept. and tested monthly.
3. In the event of a loss to external wired communication the OEM radio is available at the front security desk and will be relocated to the EOC.
4. The communications matrix shall be utilized for continued operation upon loss of any part the system.
5. Utilize and keep current the HERDS communication data.
6. NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems are alternative methods which may be utilized.

NOAA NYC WEATHER WATCH: http://www.weather.gov/okx/

**NYC Amateur Radio Emergency Communications Service, Inc.**
**Email: info@nyc-arecs.org | Phone: 646-862-7847**
**NY State Non-Profit #4273028**
IRS **01(c)3 #45-4055545**

| | | | |
|---|---|---|---|
| | **FDNY Queens Dispatch** | **482.03125 R** | **141.3** |
| **EMS** | Queens West Dispatch | 482.51875 R | 146.2 |
| **EMS** | Queens East Dispatch | 483.03125 R | 141.3 |
| **NYPD** | Queens InterOp | 482.8125 | 167.9 |

7. The backup communications shall be implemented upon loss of primary systems as per the matrix. The ICS commander will dictate to the PIO the back-up system to be utilized.
8. The backup communication system will be tested routinely and confirm proper coordination
with local communication systems. Information about the Office of emergency communication, which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Shall be utilized https://www.dhs.gov/office-emergency-communications

[1] Risk Communication: An interactive process of exchange of information and opinion among individuals, groups, and institutions; often involves multiple messages about the nature of risk or expressing concerns, opinions, or reactions to risk messages or to legal and institutional arrangements for risk management. http://store.samhsa.gov/product/Risk-Communication-Guidelines-for-Public-Officials/SMA02-3641

## Nursing Home Surveillance and Reporting System: Communications

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### Internet Access

- Type of Service(Check all that apply)* — [*Air Card] [Cable] [Dial Up] [**DSL**] [Other] [T1 or faster]
- Please select your Internet Provider:* — [Spectrum] [**Other**]
- If you have an Internet Provider other than one listed above, please enter the name here. — **SPECTRUM**
- <b>Facility Contact for Internet Service</b><br> Name* — **Charlton Rhee**
- Phone* — **7186700722**
- Email* — **unionplazacares@gmail.com**

### Departments with Internet Access**

- *Please answer the following questions for each department that has Internet Access. If you only have one department with Internet Access, please enter your data and select Save. If you have additional departments with Internet Access, please select Save and Add Another to add another department.*
- The following group has internet access:* — Administration, Nursing Suite, Admissions, Rehab, Psychology, Bookkeeping, Dietary, Nursing Units 2, 3, 4, 5, 6, 7, 8, Recreation Offices
- Where are the computers located?* — **Lower Level, First Floor, all units, 9th floor**
- Are the computers located in an area with backup power?* — [**Yes**] [No]
- Are there any computers available to key staff on a 24/7 basis?* — [**Yes**] [No]
- *Please answer the following questions for each department that has Internet Access. If you only have one department with Internet Access, please enter your data and select Save. If you have additional departments with Internet Access, please select Save and Add Another to add another department.*

### Satellite Phone

Does your facility utilize a satellite phone(s)?* [Yes] [**No**]

### Satellite Phone Numbers**

- *If you have Satellite phones, please enter each phone number individually. If you only have one phone number, please enter your data and select Save. If you have mopre than one phone number, please click Save and Add Another to enter another phone number.*
- What is (are) the phone number(s) of your satellite phone(s)? (###-###-####)
- Number of fixed satellite phones
- Number of handheld satellite phones
- Does your satellite phone system have two way radio capabilities? — [Yes] [**No**]

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- <br>What provider do you use for satellite phone service?

## Radio Communications

- Are you connected to your County Office of Emergency Management (OEM) by radio system?* [Yes] [No]
- If yes, what is the title of your contact at the County Office of Emergency Management (OEM)?
- Does your facility have a relationship with a local Amateur Radio Emergency Services organization?* [Yes] [No]
- If Yes, Please provide the contact name at this organization:
- What is the email address of the liaison named

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above?

## New York City Nursing Homes Only

- Are you connected to your City Office of Emergency Management (OEM) by radio system? [Yes] **[No]**
- If yes, what is the title of your contact at the City Office of Emergency Management (OEM)?

*Required Fields. **Repeatable Sections.

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Communication with NYS DOH and NYC DOHMH | |
| **Policy Date:** | **Policy Revision:** 1/14/18 |

**PURPOSE:**
To maintain active and effective communications with NYS DOH and DOHMH through the Health Commerce. System (HCS) and NYC MED to ensure the facility is regularly informed on health alerts that may affect residents. HCS and NYC MED include public health information such as:

- Up-to-date health alert information delivered to registered email inbox and archived on the Web,
- An online document library on public health topics, and
- An online community to exchange information and ideas with colleagues.

Health alerts will be monitored by registered users from the Nursing Home. These include Administrator(s), Medical Director, Nursing Director, Quality Improvement Staff, Infection Control Practitioner, and other clinical providers or designee will enact this policy upon hearing of the potential threat of a health emergency.

**PROCEDURES:**

- The following staff will be registered on NYS HCS:
  - Administrator
  - Medical Director
  - Nursing Director
  - Quality Improvement Staff
  - Infection Control Practitioner
  - Clinical providers
- Health alerts will be disseminated to facility staff in the following manner:
  - When first notified, alerts will be forwarded by mass email
  - Copies of alerts will be made and distributed to all clinical providers
  - Health alerts will be posted in the Nursing Stations / Bulletin Boards
  - Intranet
  - If time sensitive, an ad hoc meeting will be called
- Nursing Home will make every reasonable effort to rapidly distribute health care and educational information to residents and their families based upon the language and literacy level of the community it serves.
- Facility status report form NHICS shall be updated and reported to NYS DOH and OEM via the HERDS system and the best available communication system.

| Union Plaza Nursing Home | |
|---|---|
| **Policy Name:** Communication with NYC oem | |
| **Policy Date:** | **Policy Revision:** 1/15/18 |

# Contacting the City in the Event of an Emergency

Take time now to plan how you will talk to friends or emergency workers in an emergency. During an emergency, your normal way of communicating may be affected by changes in environment, noise, service disruptions or confusion. Your emergency plan should include different ways you can communicate with others. **Make a plan**

There are resources available to help you locate family and friends that have been affected by a disaster. **Learn more**

## When to Call 911:

- When you are in immediate danger or witness a crime in progress.
- For a serious injury or medical condition.
- Any other situation needing urgent attention.
- Do NOT call 911 for non-emergencies or to report a power outage (to allow telephone capacity for emergency calls).

## When to Call 311:

- When you need access to non-emergency services or information about City government programs.
- Do NOT call 311 for emergencies.
  - Other ways to connect to 311:
  - Contact **311 online.**
  - Text 311-692.
  - Use a Video Relay Service (VRS) at 212-NEW-YORK, (212-639-9675.)
  - Use TTY or Text Telephone at 212-504-4115.
  - Call (212) NEW-YORK (212-639-9675) from outside New York City.
  - Skype at NYC311

## Emergency Telephone Tips

- If you call 911, specify the type of emergency (fire, medical, police) and be prepared to answer questions. During a medical emergency, turn a light on so that emergency responders can find your home.
- During emergencies, please use the telephone only when absolutely necessary to keep the lines free for emergency calls. If you have broadband Internet access, use NYC.gov.
- If you have a hearing disability, you can request police, fire, and medical assistance from public pay phones and/or emergency call boxes. For more information, visit the **Mayor's Office for People with Disabilities online**.

If the 911 system becomes unavailable for any reason, call the **fire department dispatcher and emergency medical service** or **your local police precinct**.

# More Resources

## Federal, State, and Local Government Resources

**Unless otherwise noted, contact City government offices by calling 311 (212-639-9675 for Video Relay Service, or TTY: 212-504-4115).**

Federal Emergency Management Agency (FEMA)

- **Ready.gov**
- **FEMA.gov**
- 1-800-621-FEMA (1-800-621-3362)

New York State Division of Homeland Security and Emergency Services

- **Visit the website**

New York City Human Resources Administration

- **Visit the website**

## Insurance Resources

Tip: buy the right insurance. If you rent your home, renter's insurance will insure the items inside your apartment. If you are a homeowner, make sure your home is properly insured — flood and wind damage are not covered in a basic homeowner's policy.

New York City Comptroller

- **Visit the website**
- 212-669-3916 (hotline); **action@comptroller.nyc.gov**
  - If you believe damage to your property was the fault of the city, you can submit a claim with the Comptroller, who will investigate the situation and possibly offer a financial settlement for the damage.

- Claims must be filed within 90 days of a flood event.

National Flood Insurance Program

- **Visit the website**
- 1-888-379-9531

FEMA Region II Coastal Analysis and Mapping

- **Visit the website**
  - The Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRMs) are used to determine who must buy flood insurance and where floodplain development regulations apply. Note: in June 2013, FEMA Region II released preliminary revisions to New York City flood zones as a result of a new coastal flood study to update the information shown on the Flood Insurance Rate Maps (FIRMs). As the next step in the flood map update process for New York City, FEMA will be issuing Preliminary FIRMs and a Preliminary Flood Insurance Study (FIS), a narrative report of a community's flood hazard. These maps and study are the official version of the Preliminary Work Maps that were released in June 2013, and will go through a public review and comment period as well as an official appeals period. For more information about the flood map update process, visit **NYC.gov/floodmaps**.

New York State Department of Financial Services

- **Visit the website**
- 1-800-342-3736

United States Small Business Administration

- **Visit the website**; **disastercustomerservice@sba.gov**
- 1-800-659-2955

United States Department of Housing and Urban Development

- **Visit the website**
- 1-888-297-8685

Insurance Institute for Business & Home Safety

- **Visit the website**
- 813-286-3400

Insurance Information Institute

- **Visit the website**

- 212-346-5500

## Utilities

Tip: if you rely on medical equipment that requires electric power, ask your utility company if the medical equipment qualifies you to be listed as a life-sustaining equipment customer. Learn more about **listing as a life-sustaining equipment customer**.

**Con Edison**

- **Visit the website**
- 1-800-75-CONED (1-800-752-6633); TTY: 1-800-642-2308

Public Service Electric and Gas Company – Long Island (PSEG LI)

- **Visit the website**
- 1-800-490-0025; TTY: 631-755-6660

National Grid

- **Visit the website**
- 718-643-4050; TTY: 718-237-2857

## Nongovernmental and Not-for-Profit Service Providers

American Red Cross in Greater New York

- **Visit the website**
- 1-877-733-2767

Salvation Army: New York Division

- **Visit the website**
- 212-337-7200

New York Cares

- **Visit the website**
- 212-669-6100

New York Disaster Interfaith Services

- **Visit the website**
- 212-669-6100

Neighborhood Housing Services of New York City, Inc.

- **Visit the website**
- 212-519-2500

Catholic Charities of the Archdiocese of New York

- **Visit the website**
- 1-888-744-7900

United Jewish Appeal

- **Visit the website**
- 212-980-1000

National Organization on Disability's Emergency Preparedness Initiative

- **Visit the website**
- 202-293-5960; TTY: 202-293-5968

## Mental Health

NYC Well

For mental health information, a referral, or if you need to talk to someone, call **NYC Well**, New York City's confidential, 24-hour Mental Health Hotline.

- English: 1-888-NYC-WELL (1-888-692-9355), Press 2
- Relay Service for Deaf/Hard of Hearing: Call 711
- Español: 1-888-692-9355, Press 3
- 中文: 1-888-692-9355, Press 4

Interpreters are available for 200+ languages. Stay on the line, and you will be connected with a counselor who can connect you to translator services.

| Union Plaza Nursing Home | |
|---|---|
| **Policy Name:** Communication with state OEM | |
| **Policy Date:** | **Policy Revision:** 1/15/18 |

## NYS Division of Homeland Security and Emergency Services (DHSES)

**Albany**
NYS Division of Homeland Security and Emergency Services
1220 Washington Avenue
State Office Campus
Building 7A Suite 710
Albany, NY 12242
518-242-5000

**New York City**
NYS Division of Homeland Security and Emergency Services
633 Third Avenue
32nd Floor
New York, NY 10017
212-867-7060

## Office of Counter Terrorism

1220 Washington Avenue
State Office Campus
Building 7A, Suite 710
Albany, NY 12242
518-242-5000
website@dhses.ny.gov

## Office of Emergency Management

1220 Washington Avenue
Building 22, Suite 101
Albany, NY 12226-2251
518-292-2275

## Office of Interoperable & Emergency Communications

State Campus, Building 7A, Suite 710
1220 Washington Avenue
Albany, New York 12242
518-322-4911
DHSES.OIEC@dhses.ny.gov

## State Fire

State Office Campus
1220 Washington Avenue
Building 7A, Floor 2
Albany, NY 12226
518-474-6746
Fax: 518-474-3240
fire@dhses.ny.gov

**City DOH**

- ***Metropolitan Area/Regional Office:*** 90 Church St., New York, NY 10007-2919

| | | |
|---|---|---|
| 212-417-4100 | Information | |
| 212-417-5550 | Regional Director | Johnson, Celeste M |
| 212-417-5550 | Deputy Director for Administration and Operations | O'Donnell, Michael |

- ***Task Force Life and the Law:*** 90 Church St., New York, NY 10007-2919

| | | |
|---|---|---|
| 212-417-5444 | Executive Director | |

**NYS DOH**

- ***Office of the Commissioner:*** Corning Tower, Empire State Plaza, Albany, NY 12237

| | | |
|---|---|---|
| 518-474-2011 | Commissioner | Zucker, Howard A., M.D. |
| 518-474-2011 | Executive Assistant to the Commissioner | Silvia, Jacqueline |
| 518-474-2011 | First Deputy Commissioner | Heslin, Gene, M.D. |
| 212-417-6275 | Chief of Staff | Greene, Danielle, DrPH, MCHES |
| 518-474-2011 | Executive Deputy Commissioner | Dreslin, Sally R |
| 518-474-2011 | Assistant to the Executive Deputy Commisioner | Williams, Tonya |
| 518-473-0525 | Director, Internal Audit | Christensen, Diane |
| 518-474-8565 | Chief Health Digital Strategist | Nattanmai, Mahesh |

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Occupancy Communication[1] Policy | |
| **Policy Date:** | **Policy Revision:** Revision Date **1/14/17** |

**Purpose**: To provide information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee).

**Policy:** Shall report occupancy of the facility, the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The facility will assess the ability to overbed as room and staffing permit without affecting its ability to provide assistance and care. The facility will report the types of "needs" required during an emergency and shall communicate to the appropriate authority not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc. so as to continue appropriate care.

> Note: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident Command Center or state-wide coordination of the disaster would likely be a fire-related agency.

**Procedure:**

1. The facility shall implement the NHICS system upon activation of the EOP
2. The PIO will utilize the best communication system to update status.
3. The Facility shall notify NYS DOH via the herds system of status and availability of beds.
4. Any additional or emergency requirements will be sent via the Liaison to NYS DOH and local OEM
5. Verification of notification shall be recorded in the incident log with contact information.

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Risk Communication[1] Policy | |
| **Policy Date: 3/3/15** | **Policy Revision:** Revision Date **12/21/17** |

**Purpose:**
This policy exists to assure that information disclosed during an emergency by Union Plaza Nursing Home is timely, accurate, comprehensive, authoritative and relevant. Adherence to this policy is intended to provide an effective and efficient framework to facilitate the timely dissemination of information.

**Procedure:**

1. Upon notification of an event that will impact the life, safety and operations of the Nursing Home, the assigned Public Information Officer (PIO) and / or spokesperson will serve as the conduit for information to internal and external stakeholders, including residents, staff, visitors and families as approved by the Incident Commander.

2. The PIO / Spokesperson will leverage all readily available resources such as but not limited to federal / state / city agencies, trade association, news outlet and social media to gather vital information and verify and validate accuracy.

3. The PIO / Spokesperson will make every effort to rapidly communicate with residents, their family members, local community and leverage all channels of communication including social media outlets that can be utilized to disseminate information in the event of an emergency.

4. Relevant resources will be leveraged to translate into the language / literacy level of the various internal and external stakeholders (e.g. staff, board of directors, media, resident population and their family members).

5. Staff is to refer all external inquiry to the PIO / Spokesperson. Staff is to refrain from saying statements such as: I'm not allowed to talk or have to get permission to do so. Instead, staff is to say: "Union Plaza Nursing Home policy is to refer all external inquiries to our Public Information Officer or Spokesperson. You can reach them at (7186700722)".

6. Staff is to contact PIO / Spokesperson if and when they have been approached by the media. Even though they were referred to appropriate point of contact.

---

[1] Risk Communication: An interactive process of exchange of information and opinion among individuals, groups, and institutions; often involves multiple messages about the nature of risk or expressing concerns, opinions, or reactions to risk messages or to legal and institutional arrangements for risk management.
http://store.samhsa.gov/product/Risk-Communication-Guidelines-for-Public-Officials/SMA02-3641

7. The facility shall maintain alternate means of communication in accordance with the Communication matrix.

8. Emergency radios for interior communications are available from the engineering Dept. and tested monthly.

9. In the event of a loss to external wired communication the OEM radio is available at the front security desk and will be relocated to the EOC.

10. An Emergency Backup Communications Information sheet was created and distributed providing information in the event of both a Phone Loss Emergency and an Internet outage Emergency providing phone information and Wi-Fi passwords (see attached).

UNION PLAZA CARE CENTER

# EMERGENCY BACKUP COMMUNICATIONS INFORMATION

## LOBBY—BEHIND FRONT DESK

347-732-9758

## NURSING OFFICE—REDBOX

917-992-1302

PORTABLE WIFI

1) ADNS OFFICE 2) ADMINISTRATION

In the event of an emergency and the PHONE SYSTEM is down—The alternatives to make and receive phone calls are:

1) Backup telephone - located behind the front desk

2) Portable cellphone located in the red box in the Nursing Suite in front of the MDS Office (Tanya's door)

** Hold power button down (red arrow) until phone turns on.

* * * * * * * * * * * * * * * * * * * * * * * * * * * * *

In the event the INTERNET is down for a long period of time—we have 2 Backup Verizon Wifi Jet-packs:

| | WIFI NAME | PASSWORD |
|---|---|---|
| WIFI 1 | E8D6 | 492c5956 |

(UPTO 10 USERS AT ONE TIME)

LOCATION: ADNS Office—Nursing Office

| | | |
|---|---|---|
| WIFI 2 | 8C52 | f05144ac-upto 10 users |

LOCATION: Asst. Admin. Office—Administration

(UPTO 10 USERS AT ONE TIME)

**Hold power button down (red arrow) until unit turns on.

# POST SHEET ON WALL NEXT TO RADIO

**Radio Quick Start Guide**

While your radio may look intimidating, we have great news for you-
*Nearly everything you'll need to do with this radio will be done with two controls.*

Upon setting up your radio, we will ensure it is on the correct frequency to make your job as easy as possible: All you'll need to do is turn on your radio, and know the proper way to speak on it.

After pushing down the **Power/Volume** dial to turn your radio on, you're ready to talk.

1. Listen for five seconds to ensure no one else is talking before you speak.
2. Squeeze the **Talk** button, and inhale before speaking.
3. Begin the conversation by stating our name twice, followed by your own organization, as follows:

   *"OEM,OEM, this is ABC Nursing Home."*

4. Release the **Talk** button, and wait for a response. You may now have a standard conversation.
5. Once all conversations are finished, conclude your conversation in the following format:

   *"Thank you, OEM. ABC Nursing Home."*

**Additional Notes:**

Speak slowly and clearly at all times.
Keep transmissions under 10 seconds, if possible.
Do not touch any other radio buttons or dials unless directed to do so.
Keep a pen and paper near your radio in order to copy down important messages.
Always remember to wait for a break before speaking in order to ensure that you are heard.



# POST SHEET ON WALL NEXT TO RADIO

SATELLITE PHONE USED ONLY WHEN ALL OTHER PHONES/INTERNET ARE DOWN! KEPT IN ADMINISTRATION.

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## Your IsatPhone

- Programmable assistance button
- Ear piece
- Ambient light sensor
- LED tracking indicator
- LED status indicator
- Handsfree rest
- Tracking button
- Volume up key
- Volume down key
- Screen
- Right selection key
- Navigation keys
- Left selection key
- Call button
- Centre selection key
- End button
- Handsfree rest
- Keypad
- Microphone
- Micro USB port
- USB/audio protective cover
- 2.5mm audio connector
- Strap attachment point
- LED status indicators

## Status icons

| | |
|---|---|
| Keypad locked | GPS fix required |
| Alarm set | USB connection |
| Call divert on | Conference call activated |
| Unread message | Closed user group number |
| Message sent | New voicemail |
| Microphone muted | Missed call |
| Loud profile active | Loudspeaker activated |
| Vibrate profile active | Silent profile active |
| Phone memory full | Message memory full |
| Bluetooth is paired | SIM card memory full |
| Bluetooth headset connected to your phone | Bluetooth on |
| Wired handsfree headset connected | Assistance button activated |

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# Making and Receiving calls

1 Switch on your phone by holding down the red key for several seconds.

2 Stand outside with a clear view of the sky and the antenna pointing upwards.

3 Check your phone is connected to the satellite network - **Inmarsat** is displayed at the top left of the screen.

4 Ensure you have at least two bars of signal strength.

5 Ensure there is sufficient battery power.

6 Ensure that your phone has a GPS fix – the GPS fix required icon is not displayed.

7 Dial the full international number and press the green key, eg. +44 1621 123456 .

8 To end a call, press the red key .

9 Switch off your phone by holding down the red key until the screen shuts down.

## Making a call

Enter the full international number by dialling either + (hold down the **0** key for 3 seconds) or **00**, country code, area code (without the leading 0), telephone number and press the green key , eg. **00 44 1621 123456** or **+ 44 1621 123456** . A **Calling** message and the name of the person being called (if listed in your Phonebook or SIM contacts) will display on the screen. When the call is answered, the screen will show the call time in minutes and seconds. To end the call press the red key .

## Making a call from saved contacts

Select **Menu** > **Contacts** > **Phonebook**. Scroll to the desired name using the navigation keys, or enter the first letter of the name in the search field. The matching contacts will be listed. Highlight the name and press the green key . See Phonebook and Contacts on **page 40** for more information.

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## Re-dialling a number

Press the green key, select from the list of previously dialled numbers using the navigation keys and press the green key to start the call. Your phone stores 30 dialled numbers. Alternatively, select **Menu** > **Call log** > **Dialled calls**, select the person you wish to call and press the green key.

## Re-dialling automatically

To switch **Auto re-dial** on or off, select **Menu** > **Settings** > **Call settings** > **Auto re-dial** and make your selection. The default setting is off.

When activated, if your call did not complete, your phone displays **Retry?** and the reason why the connection was unsuccessful. Press **Select** to automatically re-dial the number three times until the call is answered. If you press any key or receive a call during this time, re-dialling is interrupted. If the re-dial is successful the phone beeps, then rings. Select **Close** if you do not want to retry.

## Receiving a call

To receive a call, your antenna must be deployed and your phone connected to the satellite. Press the green key to accept the call or press the red key to reject it. You will see **Call from** followed by either the name of the caller (if listed in your Phonebook or SIM contacts), the calling number, or **Number unknown**.

If you do not wish your phone to play a ringtone, set your active profile to silent or vibrate only. See Sounds, ringtones and profiles on **page 45** for more information. To mute the ringing tone when a call comes in, press **Silence**.

## Declining a call

Press the red key. The call is disconnected and the caller details are stored in **Missed calls** for later retrieval.

## Returning a call

Your phone automatically stores the numbers of the last 20 phone calls you have answered or missed. To return a call, select **Menu** > **Call log**. Select the appropriate folder, eg. **Missed calls** or **Received calls**, highlight the contact and press the green key.

## Making a call while on another call

You can put your current call on hold and make a second call at any time. Select the contact by selecting **Options** > **Contacts** > **Phonebook** or by dialling the full international number. When you press the green key, your current call will automatically be put on hold. By selecting **Swap** you can switch between calls at any time. You can end either call at any time by selecting **Options** > **End held call** or **End active call**.

# Union Plaza Nursing Home

## Communications Contingency Plan

POLICY:
It is the policy of Union Plaza Care Center to ensure the care, safety and well-being of all its residents. In the event of a failure of telephone line/system, communication contingency plans will go into effect.

PROCEDURES:
I. No External capability - no outgoing or incoming calls, but internal system is operational

1. The emergency cell phone - located in the red box in the nursing office suite (917-992-1302) will be kept fully charged at all times.

2. In the event of an emergency, this cell phone and charger will be moved to the security desk by Administration or by Senior Nursing Personnel.

3. All department heads and RN supervisors will immediately be informed of the situation.

4. All employees will be informed that personal cell phone use will allowed during the duration of the emergency. Cell phone use on behalf of the needs of the nursing home will be reimbursed.

5. Arrangements will be made with pharmacy services, laboratory and radiology services to receive reports via on-line, messenger service, delivery, as needed.

6. Social services will be responsible to coordinate informing all family members of the situation and of the emergency cell phone number.

7. Administration/ Nursing will be responsible to ensure that all attending physicians and consultants being utilized will kept informed.
   a. Dialysis units will be informed of the emergency number.
   b. Ambulette company will be informed.

8. Admissions will be responsible to inform hospitals of the emergency number.

9. If phone services are not restored in a timely manner, the Department of Health will be notified.

II. No Internal capability

1. Walkie Talkies will be provided to: Security desk, all units, Nursing Office, Administration, 9th floor - Recreation Department, Rehab Department - Lower level, Engineering and Housekeeping Departments.

UNION PLAZA CARE CENTER

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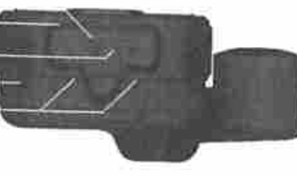
SATELLITE PHONE USED ONLY WHEN ALL OTHER PHONES/INTERNET ARE DOWN! KEPT IN ADMINISTRATION.

## Your IsatPhone




## Status icons

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| **Policy Date:** | **Policy Revision:** Revision Date **1/14/17** |

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4. Any additional or emergency requirements will be sent via the Liaison to NYS DOH and local OEM
5. Verification of notification shall be recorded in the incident log with contact information.

| Union Plaza Care Center | |
|---|---|
| **Policy Name:** Communication with Family and Residents | |
| **Policy Date:** | **Policy Revision:** **1/15/18** |

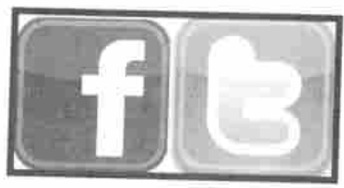
**PURPOSE:** To maintain active and effective communications with and inform those in our care about disaster preparedness and implementation of the facility plan.

**Policy:**
The facility shall provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. We shall provide instructions on how to contact the facility in the event of an emergency on the public website and include the information as part of the facility's check-in procedures.

**Procedure:**
1. The admissions department will include an informational fact sheet about the facility EAP at time of admission. This will be reviewed with the family and resident.
2. Resident council will discuss the EAP with residents.
3. During the family council administration will remind families of the plan and answer questions about the plan.
4. A notice of the plan shall be posted at the security desk with the location of the plan so residents or family can review.
5. Common communication systems, such as email, telephone, and social media will be utilized to inform parties of concern about the implementation of the plan.

See attached social media guide.

# Social Media Guide for Emergency Preparedness & Response



Social media is an umbrella term used in describing a variety of communication mediums and platforms including social networks, blogs, mobile applications, and others. The rise of social media has created opportunities for emergency managers to spread messages about preparedness as well as use it as a tool to disseminate timely and critical information during emergency situations. However, it also a tool that needs to be mastered. This guide will assist Nursing Home public information officers and / or spokespersons with some basic awareness necessary to effectively leverage these platforms.

While social media can provide real-time information, it can also be a source of unconfirmed rumors and false information. For this reason, it is critical to obtain credible information from official sources for situational awareness and prior to sharing any information with colleagues and partner organizations. Below you will find helpful guidance in how to obtain credible information from City, State, and Federal agencies on the social media platform.

Do not forget to promote your social media accounts in your current webpage and inform all internal and external stakeholder of your newly establish account(s). Although there are numerous social media outlets for the Public Information Officer and Spokesperson to leverage, it is best to find one that meets the needs and style of those who will manage the account. In this guide, we will cover the two most prominent social media channels, Twitter & Facebook.

**Common Steps to Adopting the Use of Social Media in Emergency Management**

- Focus first on the outcome you wish to achieve
- Be prepared to adapt how you engage your audience
- Choose a few tools and develop them well
- Create a trial account before creating an official one
- Develop a mentorship and demonstrations from experienced users
- Establish news feeds (RSS)
- Leverage partners and volunteers

Source
https://tww.twitter
https://www.facebook.com/

# Twitter

**What it is:**

Twitter is a free information network made up of 140-character messages called Tweets. It's an easy way to discover the latest news related to subjects you care about.

- Tweets must be less than 140 characters, so using abbreviations and shortened links are a must.
- Because of its immediacy, Twitter is a great way to obtain and provide real-time updates during emergency situations. During citywide emergencies, the most up-to-date official incident information will be tweeted from the following 2 Twitter accounts:
    - NYC.gov official twitter account - @nycgov
    - NYC Mayor's Office - @nycmayorsoffice

  Other city agencies will retweet this information, but this will be the source for the latest information.
- Follow relevant Twitter users that would be relevant to Nursing Homes, as well as accounts focused on the topic of emergency preparedness such as:
    - New York State Department of Health - @HealthNYGov
    - New York City Department of Health & Mental Hygiene - @nycHealthy
    - New York State Division of Homeland Security & Emergency Services - @NYSDHSES
    - New York City Office of Emergency Management- @NYCOEM
    - Notify NYC @NotifyNYC
    - Centers for Disease Control and Prevention - @CDCemergency,
- Do not forget to follow your respective Nursing Home Trade Association

**User Names (@):**

- All usernames or handles are preceded by the "@" symbol. Be sure to mention user names in your tweets.
- Reply: Starting a tweet with a user name indicates you are directly addressing that user. This is a good way to respond to users and have a conversation.

**Twitter Etiquette:**

- **Retweet (RT)**: Share their favorite tweets by 'retweeting' them. To retweet, just use the retweet button or type 'RT' followed by the user name, and then copy the tweet. Or use the RT button.
- **Hashtag (#)**: The # symbol, called a hashtag, is used to mark keywords or topics in a Tweet. It was created organically by Twitter users as a way to categorize messages.

Source
https://tww.twitter
https://www.facebook.com/

USING HASHTAGS TO CATEGORIZE TWEETS BY KEYWORD:

- People use the hashtag symbol # before a relevant keyword or phrase (no spaces) in their Tweet to categorize those Tweets and help them show more easily in ***Twitter Search.***
- Clicking on a hashtagged word in any message shows you all other Tweets marked with that keyword.
- Hashtags can occur anywhere in the Tweet – at the beginning, middle, or end.
- Hashtagged words that become very popular are often Trending Topics.
- Searching for hashtags is a great way to follow what's going on with a particular topic. ***Try searching #firesafety or #NPM (for National Preparedness Month).***

**Twitter Alerts:**

Twitter Alerts is a new feature that helps users get important and accurate information from credible organizations during emergencies, natural disasters or moments when other communications services aren't accessible. Below are two sample tweets that were used during real emergencies:

Source
https://tww.twitter
https://www.facebook.com/

Profile Picture

FEMA

**FEMA** @fema

Username

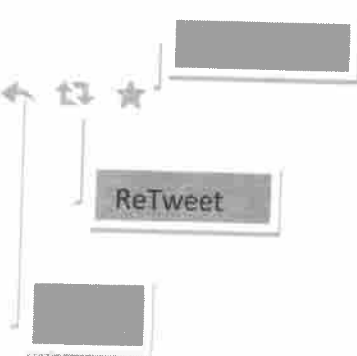
Follow

Hashtag Example

#Sandy East coast, search for open shelters by texting: SHELTER + a zip code to 43362 (4FEMA). Ex: Shelter 01234 (std rates apply)

5:41 PM - 28 Oct 2012

3,808 RETWEETS 361 FAVORITES




Source
https://tww.twitter
https://www.facebook.com/

# Facebook

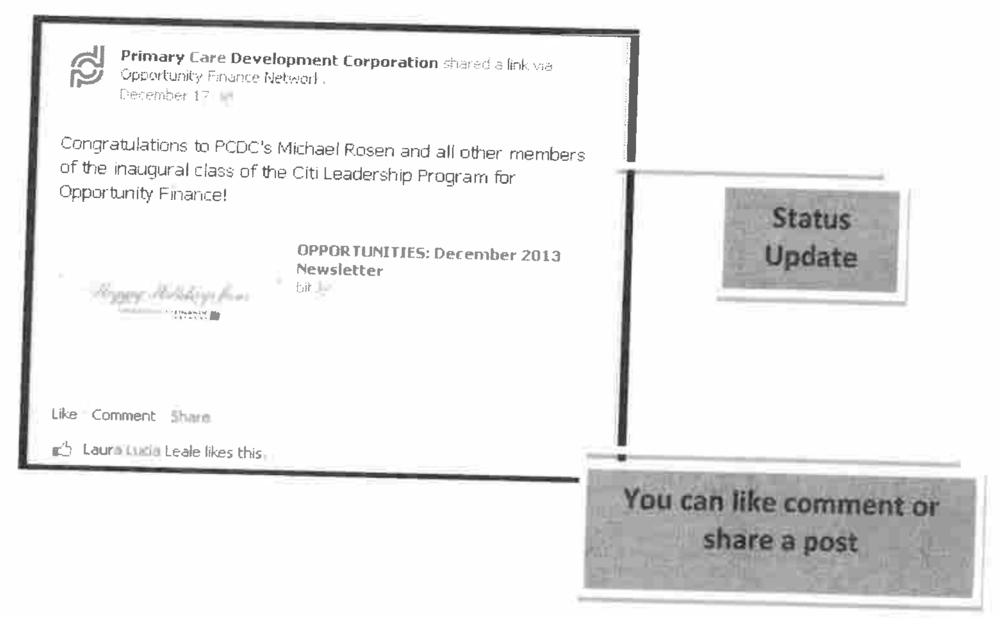
**What it is:**

Facebook is a popular free social networking website that allows registered users to create profiles, upload photos and video, send messages and keep in touch with friends, family and colleagues.

- Set up a page and choose some attractive photos or logos of the Nursing Home. Then start posting interesting content. Do not forget to connect with other entities that provide information that is relevant to the nursing home sector.
- Once users "like" your page, your posts will show up in their news feeds, just like their friends.
- There is no character limit to status messages but etiquette dictates that status updates should be succinct and to the point.
- You share information through "Status Updates" on your account page.

**What should you post?**

- Important news, hot topics of the day, memorable photos or videos, or just fun stuff.
- Try to find a balance between your content and content from outside sources.
- Post regularly - several times a week works if you are consistent.
- To promote the page, link to it on your website and let people know about it as often as possible.
- Ask questions in your posts to prompt responses and comments.
- Use Facebook as your page to "Like" other emergency preparedness organizations and interact with them.
- Ask questions in your posts to prompt responses and comments.




Source
https://tww.twitter
https://www.facebook.com/

# INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A

**5. CURRENT ORGANIZATION**

(Fill in additional positions as appropriate)

INCIDENT COMMANDER

LIAISON/PUBLIC INFORMATION OFFICER

SAFETY OFFICER

MEDICAL DIRECTOR/SPECIALIST

OPERATIONS SECTION CHIEF

PLANNING SECTION CHIEF

LOGISTICS SECTION CHIEF

FINANCE/ ADMINISTRATION SECTION CHIEF

RESIDENT SERVICES BRANCH DIRECTOR

INFRASTRUCTURE BRANCH DIRECTOR

**PURPOSE:** COMBINES NHICS FORMS 201+202+203+204+215A
**ORIGINATION:** INCIDENT COMMANDER OR PLANNING SECTION CHIEF
**COPIES TO:** ALL IMT STAFF

# NHICS 201 | INCIDENT BRIEFING

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. SITUATION SUMMARY** (for briefings or transfer of command)

**4. HEALTH AND SAFETY BRIEFING** Identify potential incident health and safety hazards and implement necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. (Summary of NHICS 215a)

1.

2.

3.

4.

**5. MAP/ SKETCH** (Attach sketch showing the total area of operations, the incident site/area/ impacted and threatened areas, and/or other graphics depicting situational status and resource assignment, as needed.)

☐ See Attached

**PURPOSE:** BASIC INFORMATION REGARDING THE INCIDENT SITUATION AND RESOURCES ALLOCATED
**ORIGINATION:** INCIDENT COMMANDER OR DESIGNEE
**COPIES TO:** ALL IMT STAFF

# NHICS 202 | INCIDENT OBJECTIVES

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|
| 3. INCIDENT OBJECTIVES | | |
| | | |
| 4. FACTORS TO CONSIDER Considerations in relationship to the objectives and priorities, including weather and situational awareness. | | |
| | | |
| 5. NHICS 215A – INCIDENT ACTION PLAN (IAP) SAFETY ANALYSIS and/ or SITE SAFETY PLAN? ☐ YES ☐ NO | | |
| Approved Site Safety Plan Locations: | | |
| 6. PREPARED BY | PRINT NAME: ____________ SIGNATURE: ____________<br>DATE/TIME: ____________ FACILITY: ____________ | |
| 7. APPROVED BY | PRINT NAME: ____________ SIGNATURE: ____________<br>DATE/TIME: ____________ FACILITY: ____________ | |

**PURPOSE**: DESCRIBES BASIC INCIDENT OBJECTIVES AND SAFETY CONSIDERATIONS
**ORIGINATION**: PLANNING SECTION CHIEF
**COPIES TO**: ALL IMT STAFF

# NHICS 214 | ACTIVITY LOG

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

| 3. NAME | | 4. IMT POSITION | |
|---|---|---|---|

| 5. ACTIVITY LOG | |
|---|---|
| DATE/TIME | MAJOR EVENTS, DECISIONS MADE AND NOTIFICATIONS |
| | |
| | |
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| | |
| | |
| | |

| 6. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

**PURPOSE**: DOCUMENT INCIDENT ISSUES, DECISIONS MADE, AND NOTIFICATIONS.
**ORIGINATION**: ALL IMT STAFF
**COPIES TO**: PLANNING SECTION CHIEF

# NHICS 214 | ACTIVITY LOG

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD | | |
|---|---|---|---|---|
| | | DATE: | FROM: | TO: |
| | | TIME: | FROM: | TO: |

| 3. NAME | | 4. IMT POSITION | |
|---|---|---|---|

**5. ACTIVITY LOG**

| DATE/TIME | MAJOR EVENTS, DECISIONS MADE AND NOTIFICATIONS |
|---|---|
| | |
| | |
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| | |
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| | |

| 6. PREPARED BY | PRINT NAME: | | SIGNATURE: | |
|---|---|---|---|---|
| | DATE/TIME: | | FACILITY: | |

**PURPOSE**: DOCUMENT INCIDENT ISSUES, DECISIONS MADE, AND NOTIFICATIONS.
**ORIGINATION**: ALL IMT STAFF
**COPIES TO**: PLANNING SECTION CHIEF

# NHICS 205 | COMMUNICATIONS LIST

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD |
|---|---|---|
| | | DATE: FROM: / / 2018 TO: |
| | | TIME: FROM: TO: |

**3. INTERNAL CONTACTS**

| NAME | NHICS ASSIGNMENT | PHONE (PRIMARY & ALTERNATE) | FAX | E-MAIL | ALTERNATE COMMUNICATION DEVICE | COMMENTS |
|---|---|---|---|---|---|---|
| UNION PLAZA | | 7186700700 | 7186700726 | unionplazacares@gmail.com | 3477329758 | Seperate Hardline phone @ front desk (white phone) |
| | | | | | 9179921302 | Emergency Cellphone Nursing REDBOX |
| | | | | | inmarsat Sat Phone | SATELLITE PHONE Assist Admin Office |
| | | | | | | behind door |
| | | | | | PORTABLE WIFI JETPACK | WIFI 1 Asst. Admin Office behind Door REDBOX |
| | | | | | PORTABLE WIFI JETPACK | WIFI 2 Asst. DNS Office Top Right Desk Drawer |
| | Incident Commander | | | | | |
| | Operations Section Chief | | | | | |

**PURPOSE:** PROVIDES INFORMATION ON ALL COMMUNICATION DEVICES ASSIGNED
**ORIGINATION:** LOGISTICS SECTION CHIEF
**COPIES TO:** ALL IMT STAFF
**NOTE:** CAN BE PREFILLED BEFORE INCIDENT AND UPDATED AS NEEDED

# NHICS 252 | SECTION PERSONNEL TIME SHEET

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

3. TIME RECORD

| # | EMPLOYEE (E)/ VOLUNTEER (V) NAME ( PRINT) | E/V | EMPLOYEE NUMBER | NHICS ASSIGNMENT | DATE/TIME IN | DATE/TIME OUT | TOTAL HOURS | SIGNATURE (TO VERIFY TIMES) |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |

* MAY BE USUAL NURSING HOME VOLUNTEERS OR APPROVED VOLUNTEERS FROM COMMUNITY

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE:** RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY
**ORIGINATION:** INCIDENT MANAGEMENT TEAM PERSONNEL AS DIRECTED BY THE INCIDENT COMMANDER
**ORIGINAL TO:** FINANCE/ADMINISTRATION SECTION CHIEF
**COPIES TO:** PLANNING SECTION CHIEF

# NHICS 252 | SECTION PERSONNEL TIME SHEET

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. TIME RECORD**

| # | EMPLOYEE (E)/ VOLUNTEER (V) NAME ( PRINT) | E/V | EMPLOYEE NUMBER | NHICS ASSIGNMENT | DATE/TIME IN | DATE/TIME OUT | TOTAL HOURS | SIGNATURE (TO VERIFY TIMES) |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |

* MAY BE USUAL NURSING HOME VOLUNTEERS OR APPROVED VOLUNTEERS FROM COMMUNITY

| 4. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

**PURPOSE:** RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY
**ORIGINATION:** INCIDENT MANAGEMENT TEAM PERSONNEL AS DIRECTED BY THE INCIDENT COMMANDER
**ORIGINAL TO:** FINANCE/ADMINISTRATION SECTION CHIEF
**COPIES TO:** PLANNING SECTION CHIEF

# IHICS 255 | MASTER RESIDENT EVACUATION TRACKING

**INSTRUCTIONS**

**PURPOSE:** Records the disposition of residents during a facility evacuation.

**ORIGINATION:** Resident Services Branch Director

**COPIES TO:** Operations Section Chief and Planning Section Chief

**NOTES:** Completed with information taken from each NHICS 260 - Resident Evacuation Tracking form. If additional pages are needed, use a blank NHICS 255 and repaginate as needed

| NUMBER | TITLE | INSTRUCTIONS |
|---|---|---|
| 1 | **Incident Name** | Enter the name assigned to the incident. |
| 2 | **Operational Period** | Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies. |
| 3 | **Resident Evacuation Information** | |
| | **Resident Name** | Enter the full name of the resident. |
| | **Medical Record #** | Enter medical record number. |
| | **Medical Record Sent** | Indicate yes or no. |
| | **Disposition** | Indicate the resident's disposition. |
| | **Mode of Transport** | Indicate the mode of transport (CCT, ALS, BLS, Van, Bus, Car) |
| | **Accepting Facility Name and Contact Info** | Enter accepting (receiving) facility name and contact information |
| | **Time Facility contacted & report given** | Enter time prepared (24-hour clock). |
| | **Transfer Initiated (Time/ Transport Co.)** | Enter time, vehicle company, and identification number. |
| | **Medication Sent** | Indicate yes or no. |
| | **MD/Family Notified** | Indicate yes or no. |
| | **Arrival Confirmed** | Indicate yes or no. |
| 4 | **Prepared by** | Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility. |

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| 'SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: | | SIGNATURE: | |
|---|---|---|---|---|
| | DATE/TIME: | | FACILITY: | |

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

RPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
IGINATION: RESIDENT SERVICES BRANCH DIRECTOR
PIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

3. RESIDENT EVACUATION INFORMATION

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| 'SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE:** RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION:** RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO:** OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______<br>DATE/TIME: ______ | SIGNATURE: ______<br>FACILITY: ______ |
|---|---|---|

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD | |
|---|---|---|---|
| | | DATE: FROM: | TO: |
| | | TIME: FROM: | TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ____________ | SIGNATURE: ____________ |
|---|---|---|
| | DATE/TIME: ____________ | FACILITY: ____________ |

**PURPOSE:** RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION:** RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO:** OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD |
|---|---|---|
| | | DATE: FROM: TO: |
| | | TIME: FROM: TO: |

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
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| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

3. RESIDENT EVACUATION INFORMATION

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
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| ESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| . PREPARED BY | PRINT NAME: ____ | SIGNATURE: ____ |
|---|---|---|
| | DATE/TIME: ____ | FACILITY: ____ |

RPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
IGINATION: RESIDENT SERVICES BRANCH DIRECTOR
PIES TO: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

| 1. INCIDENT NAME | | 2. OPERATIONAL PEROD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. RESIDENT EVACUATION INFORMATION**

| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
|---|---|---|---|---|---|---|
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| SIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
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| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |
| RESIDENT NAME | | | MEDICAL RECORD # | | MED RECORD SENT | ☐ YES ☐ NO |
| DISPOSITION | MODE OF TRANSPORT | ACCEPTING FACILITY NAME & CONTACT INFO | TIME FACILITY CONTACTED & REPORT GIVEN | TRANSFER INITIATED (TIME/ TRANSPORT CO.) | MEDICATION SENT | ☐ YES ☐ NO |
| | | | | | MD/FAMILY NOTIFIED | ☐ YES ☐ NO |
| ☐ HOME<br>☐ FACILITY TRANSFER<br>☐ TEMP. SHELTER | | | | | ARRIVAL CONFIRMED | ☐ YES ☐ NO |

| 4. PREPARED BY | PRINT NAME: ________ | SIGNATURE: ________ |
|---|---|---|
| | DATE/TIME: ________ | FACILITY: ________ |

**PURPOSE**: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: OPERATIONS AND PLANNING SECTION CHIEF

# NHICS 259 | FACILITY CASUALTY/FATALITY REPORT

| 1. INCIDENT NAME | | 2. OPERATIONAL PERIOD<br>DATE: FROM: TO:<br>TIME: FROM: TO: |
|---|---|---|

**3. REPORTED CASUALTY/FATALITY**

| RESIDENT NAME | | MEDICAL RECORD # | |
|---|---|---|---|
| **INJURY** | **TRANSFER DATE / TIME** | **RECEIVING FACILITY** | **EXPIRED DATE / TIME** |
| | | | |
| **RESIDENT NAME** | | **MEDICAL RECORD #** | |
| **INJURY** | **TRANSFER DATE / TIME** | **RECEIVING FACILITY** | **EXPIRED DATE / TIME** |
| | | | |
| **RESIDENT NAME** | | **MEDICAL RECORD #** | |
| **INJURY** | **TRANSFER DATE / TIME** | **RECEIVING FACILITY** | **EXPIRED DATE / TIME** |
| | | | |
| **RESIDENT NAME** | | **MEDICAL RECORD #** | |
| **INJURY** | **TRANSFER DATE / TIME** | **RECEIVING FACILITY** | **EXPIRED DATE / TIME** |
| | | | |

| 4. PREPARED BY | PRINT NAME: ______ | SIGNATURE: ______ |
|---|---|---|
| | DATE/TIME: ______ | FACILITY: ______ |

**PURPOSE**: DOCUMENT THE NUMBER OF INJURIES AND FATALITIES
**ORIGINATION**: RESIDENT SERVICES BRANCH DIRECTOR
**COPIES TO**: COMMAND STAFF AND GENERAL STAFF

# NHICS 260 | RESIDENT EVACUATION TRACKING FORM

| 1. DATE | | 2. FACILITY NAME | |
|---|---|---|---|

| 3. RESIDENT NAME | | 4. AGE | | 5. MEDICAL RECORD # | |
|---|---|---|---|---|---|

| 6. SIGNIFICANT MEDICAL HISTORY | | 7. ATTENDING PHYSICIAN | |
|---|---|---|---|

| 8. FAMILY/GUARDIAN NOTIFIED | ☐ YES ☐ NO | NAME/CONTACT INFORMATION | |
|---|---|---|---|

| 9. TRANSPORTATION EQUIPMENT | 10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY): | | |
|---|---|---|---|
| ☐ HOSPITAL BED<br>☐ GURNEY<br>☐ WHEEL CHAIR<br>☐ AMBULATORY<br>☐ SPECIAL MATTRESS | ☐ IV PUMPS<br>☐ OXYGEN<br>☐ VENTILATOR<br>☐ BLOOD GLUCOSE MONITOR<br>☐ RESPIRATORY EQUIPMENT | ☐ SERVICE ANIMAL<br>☐ G TUBE PUMP<br>☐ MONITOR<br>☐ FOLEY CATHETER<br>☐ OTHER | List "OTHER" below:<br>____________<br>____________ |

| 11. SPECIAL NEEDS | |
|---|---|

| 12. ISOLATION | ☐ YES ☐ NO | TYPE: | | REASON: | |
|---|---|---|---|---|---|

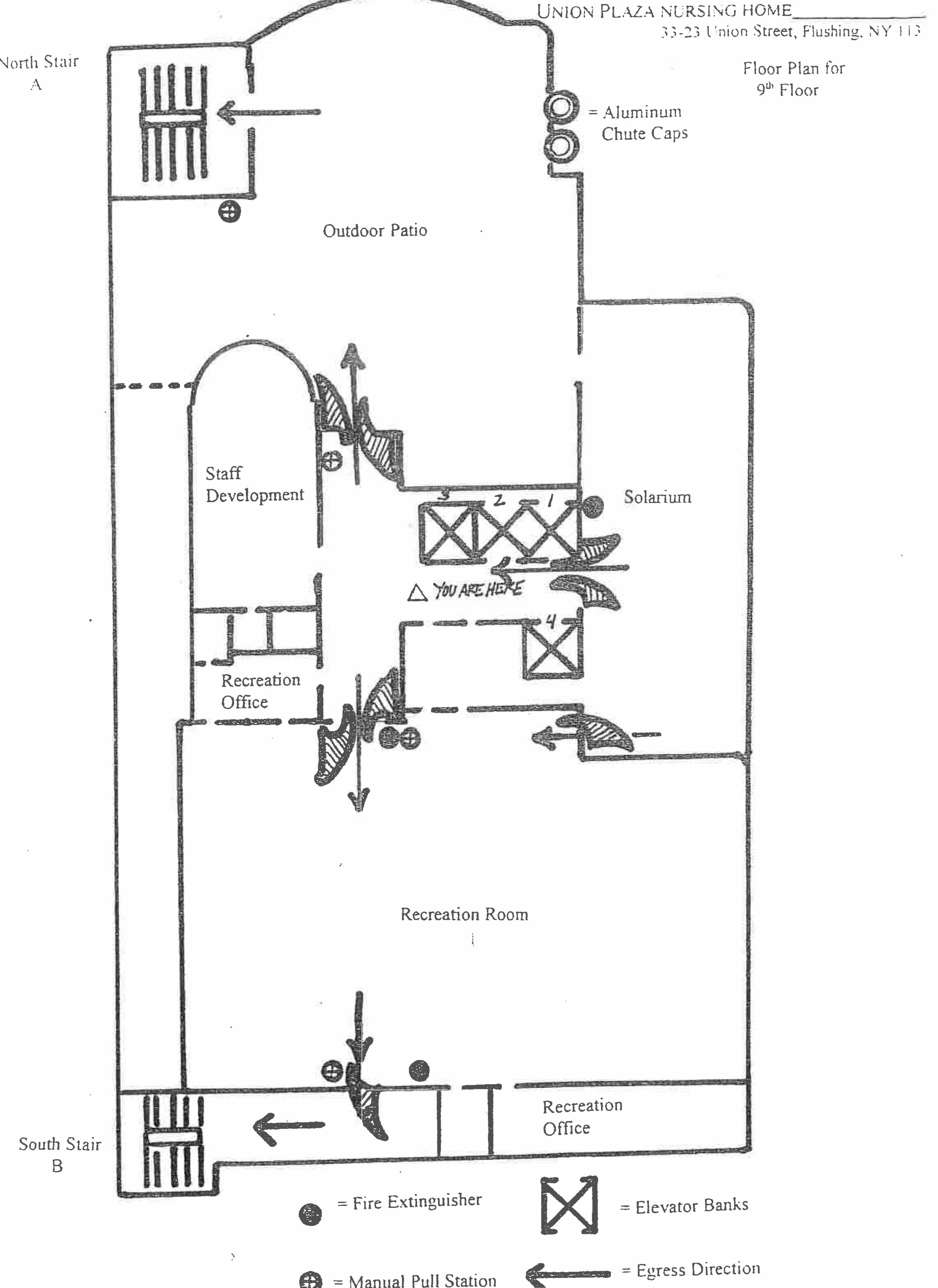
| 13. EVACUATING LOCATION | | | |
|---|---|---|---|
| ROOM# | | TIME | |
| ID BAND CONFIRMED | ☐ YES ☐ NO | | |
| BY | | | |
| MEDICAL RECORD SENT | ☐ YES ☐ NO | | |
| FACE SHEET/TRANSFER TAG SENT | ☐ YES ☐ NO | | |
| BELONGINGS | ☐ WITH RESIDENT<br>☐ LEFT IN ROOM<br>☐ NONE | | |
| VALUABLES | ☐ WITH RESIDENT<br>☐ LEFT IN ROOM<br>☐ NONE | | |
| MEDICATIONS | ☐ WITH RESIDENT<br>☐ LEFT IN ROOM<br>☐ NONE | | |

| 14. ARRIVING LOCATION | | | |
|---|---|---|---|
| ROOM# | | TIME | |
| ID BAND CONFIRMED | ☐ YES ☐ NO | | |
| BY | | | |
| MEDICAL RECORD RECEIVED | ☐ YES ☐ NO | | |
| FACE SHEET/TRANSFER TAG RECEIVED | ☐ YES ☐ NO | | |
| BELONGINGS RECEIVED | ☐ YES<br>☐ NO | | |
| VALUABLES RECEIVED | ☐ YES<br>☐ NO | | |
| MEDICATIONS RECEIVED | ☐ YES<br>☐ NO | | |

| 15. TRANSFERRING TO ANOTHER FACILITY/ LOCATION | | | |
|---|---|---|---|
| TIME TO STAGING AREA | | TIME DEPARTING TO RECEIVING FACILITY | |
| DESTINATION | | DEPATURE TIME: | |
| MODE OF TRASNPORT | ☐ AMBULANCE UNIT ☐ HELICOPTER ☐ BUS ☐ OTHER: _____ | | |
| ID BAND CONFIRMED | ☐ YES ☐ NO | ID BAND CONFIRMED BY | |

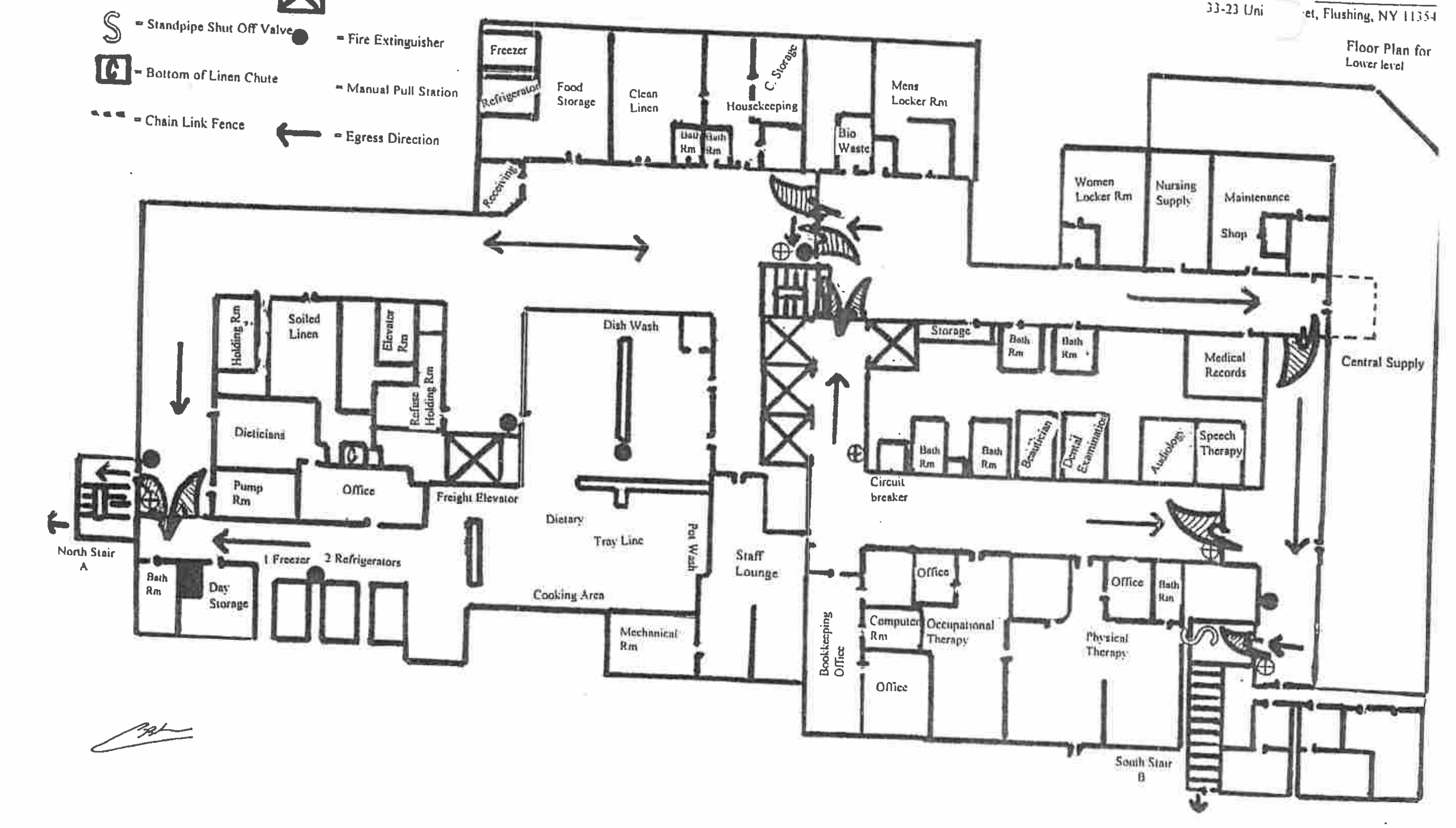
| 16. PREPARED BY | PRINT NAME: ____________ | SIGNATURE: ____________ |
|---|---|---|
| | DATE/TIME: ____________ | FACILITY: ____________ |

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING


UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY 113
Floor Plan for
9th Floor
North Stair
A
= Aluminum
Chute Caps
Outdoor Patio
Staff
Development
Solarium
3
2
1
4
YOU ARE HERE
Recreation
Office
Recreation Room
South Stair
B
Recreation
Office
= Fire Extinguisher
= Elevator Banks
= Egress Direction
= Manual Pull Station

33-23 Uni et, Flushing, NY 11354

Floor Plan for Lower level



UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY 11354

Floor Plan for
Lobby Level

UNION PLAZA NURSING HOME

33-23 Union Street, Flushing, NY 11354

Floor Plan for
2 thru 8

North Stair
A

3 2 1

Dining Room

△ YOU ARE HERE

4

T.R.

Mid
Lounge

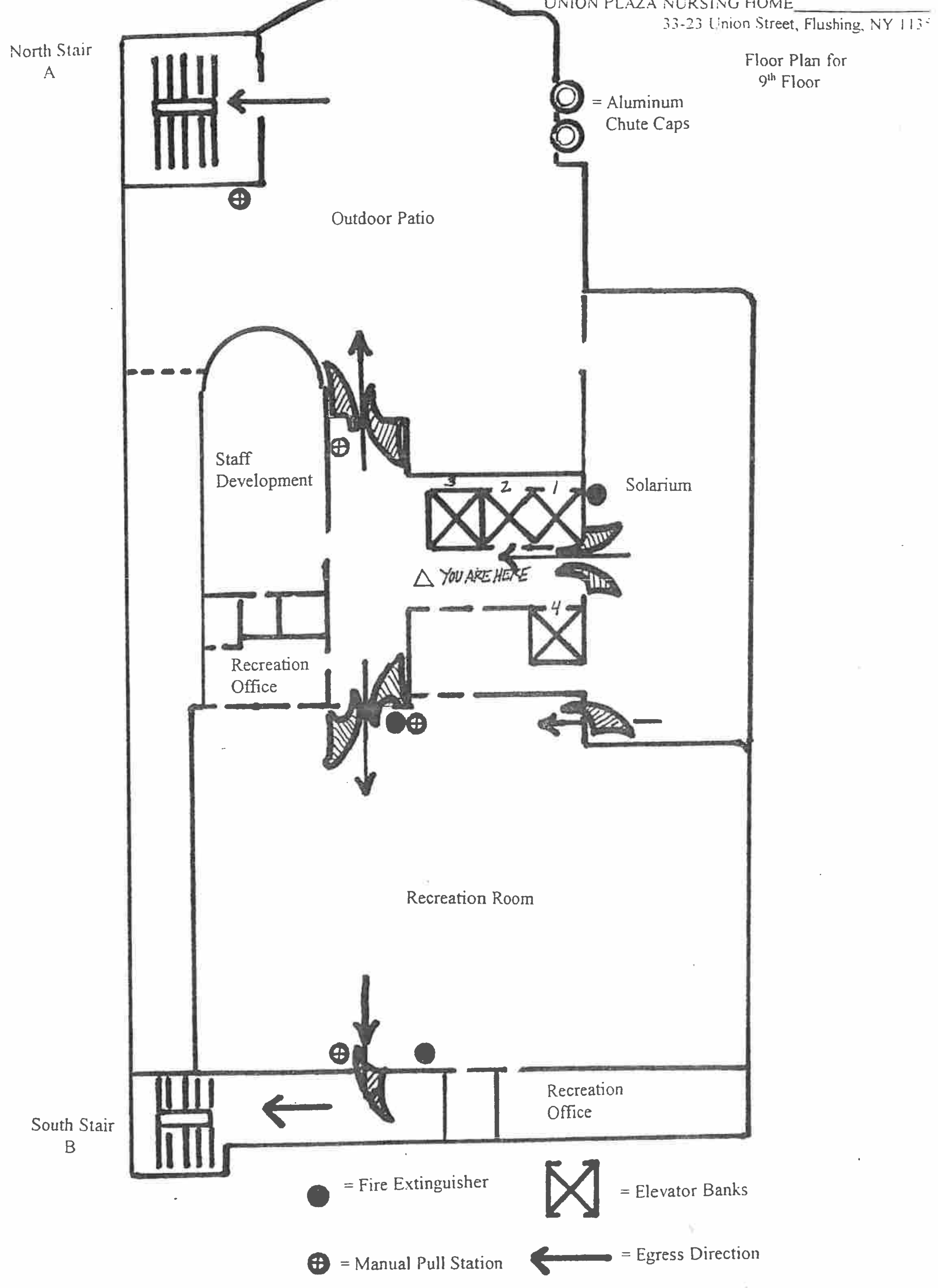
South Stair
B

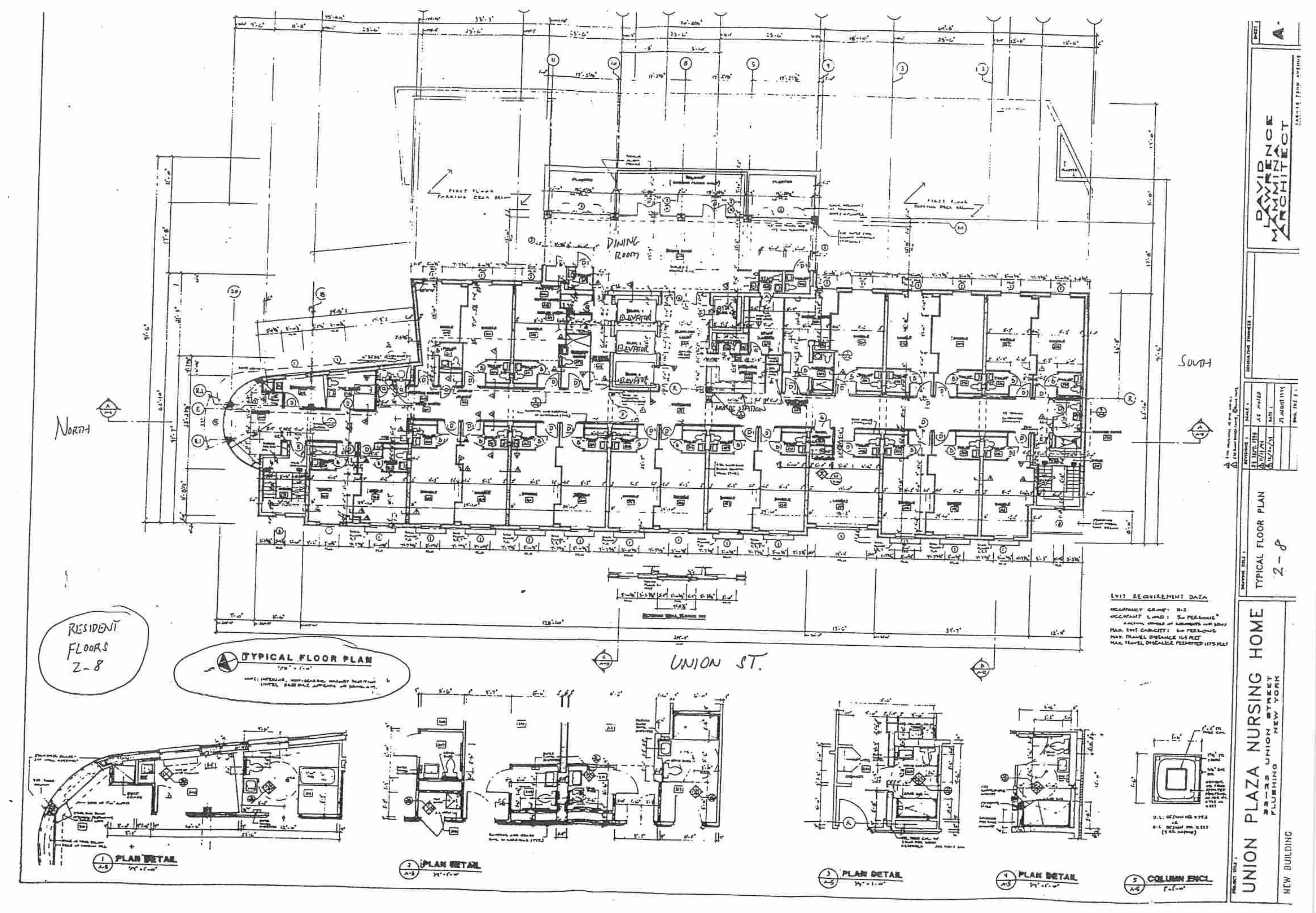
= Elevator Banks

= Fire Extinguisher

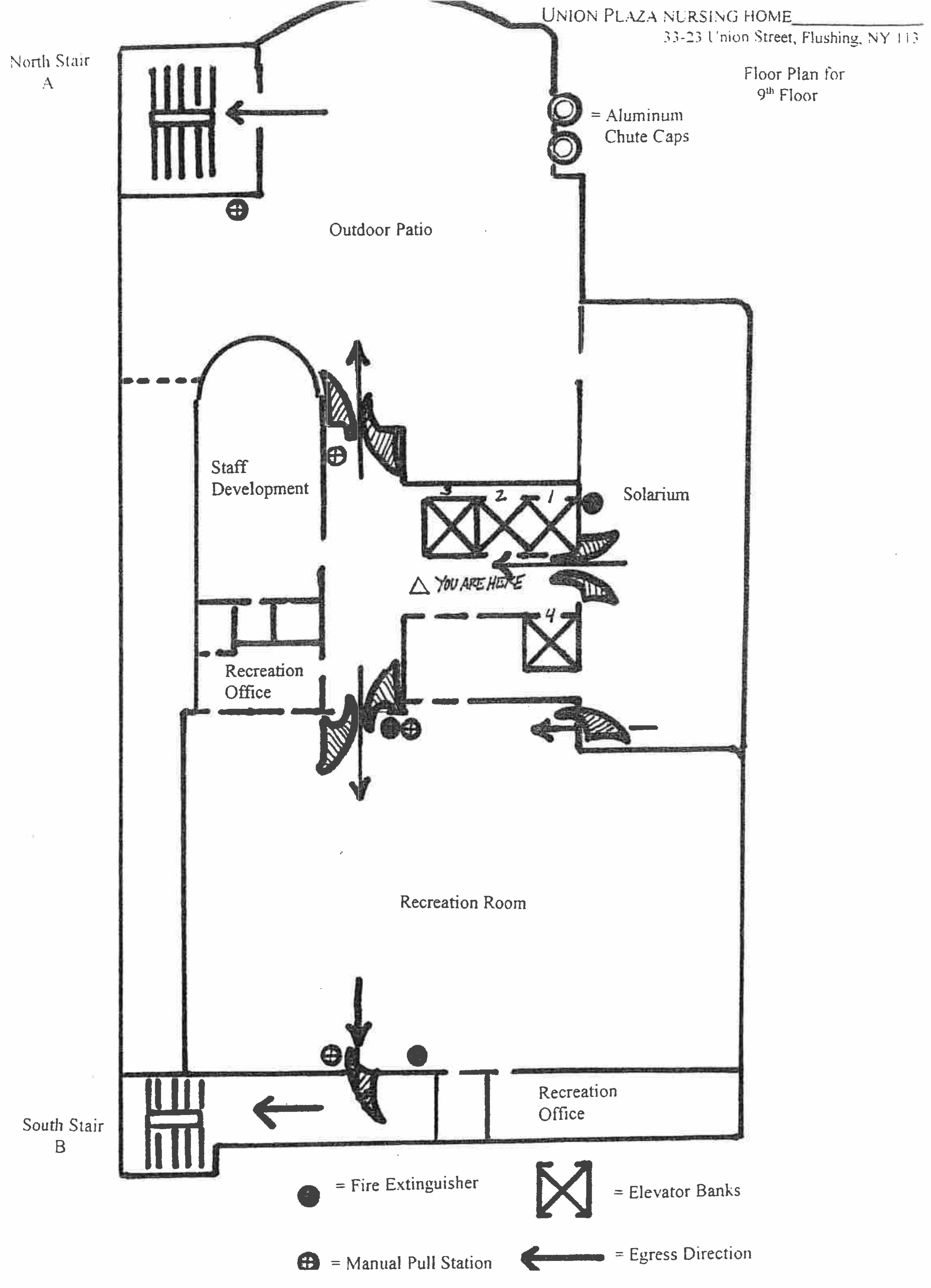
= Manual Fire Station

= Egress Direction


UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY 113
Floor Plan for
9th Floor
North Stair
A
= Aluminum
Chute Caps
Outdoor Patio
Staff
Development
Solarium
YOU ARE HERE
Recreation
Office
Recreation Room
South Stair
B
Recreation
Office
= Fire Extinguisher
= Elevator Banks
= Manual Pull Station
= Egress Direction



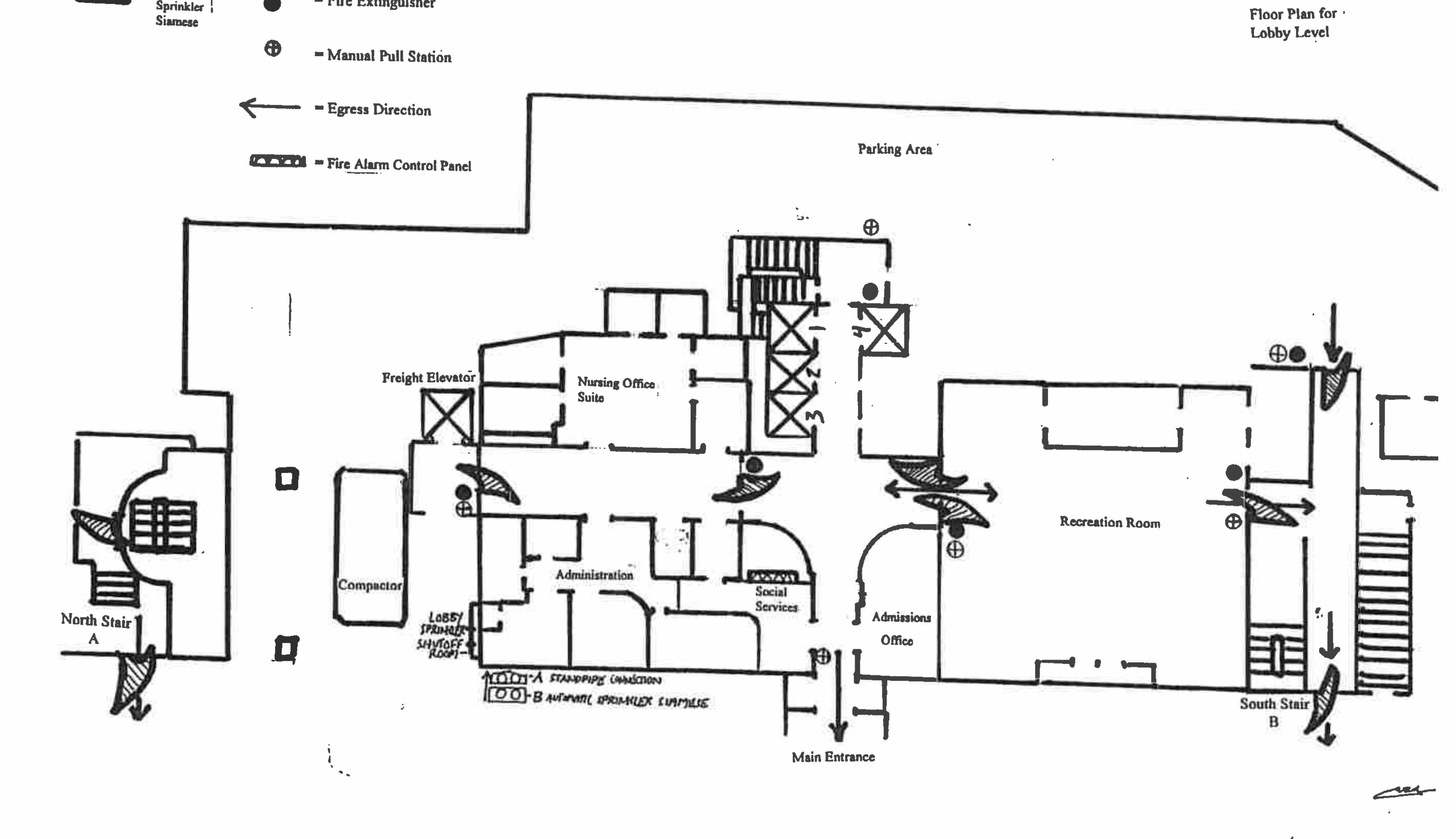
DINING ROOM
ELEVATOR
NURSE STATION
North
SOUTH
UNION ST.
RESIDENT FLOORS 2-8
TYPICAL FLOOR PLAN
EXIT REQUIREMENT DATA
PLAN DETAIL
PLAN DETAIL
PLAN DETAIL
PLAN DETAIL
COLUMN ENCL.
DAVID LAWRENCE MAMMINA ARCHITECT
TYPICAL FLOOR PLAN
2-8
UNION PLAZA NURSING HOME
FLUSHING NEW YORK
NEW BUILDING


UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY 113
Floor Plan for
9th Floor
North Stair
A
= Aluminum
Chute Caps
Outdoor Patio
Staff
Development
Solarium
3
2
1
YOU ARE HERE
4
Recreation
Office
Recreation Room
South Stair
B
Recreation
Office
= Fire Extinguisher
= Elevator Banks
= Manual Pull Station
= Egress Direction

UNION PLAZA NURSING HOME

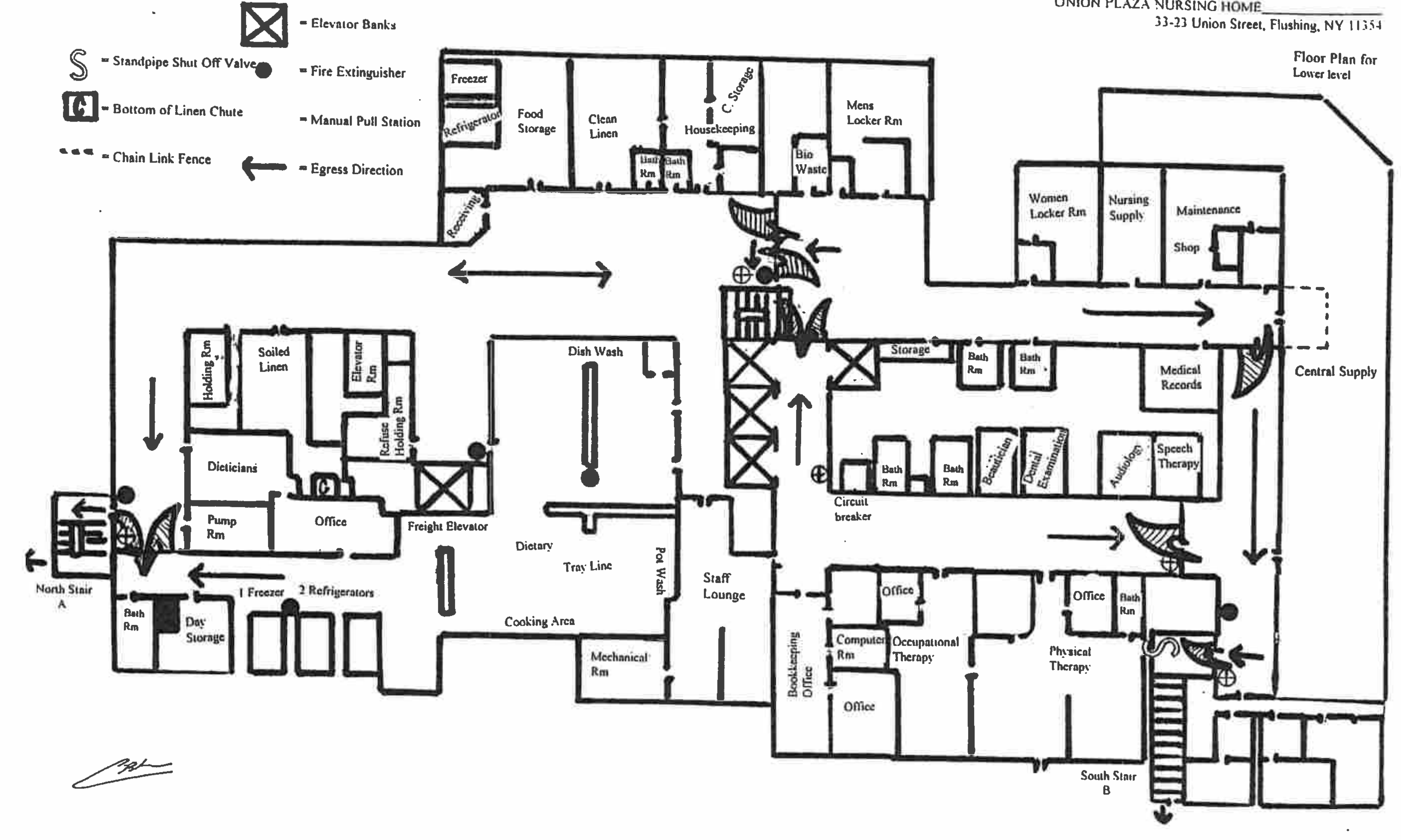
33-23 Union Street, Flushing, NY 11354

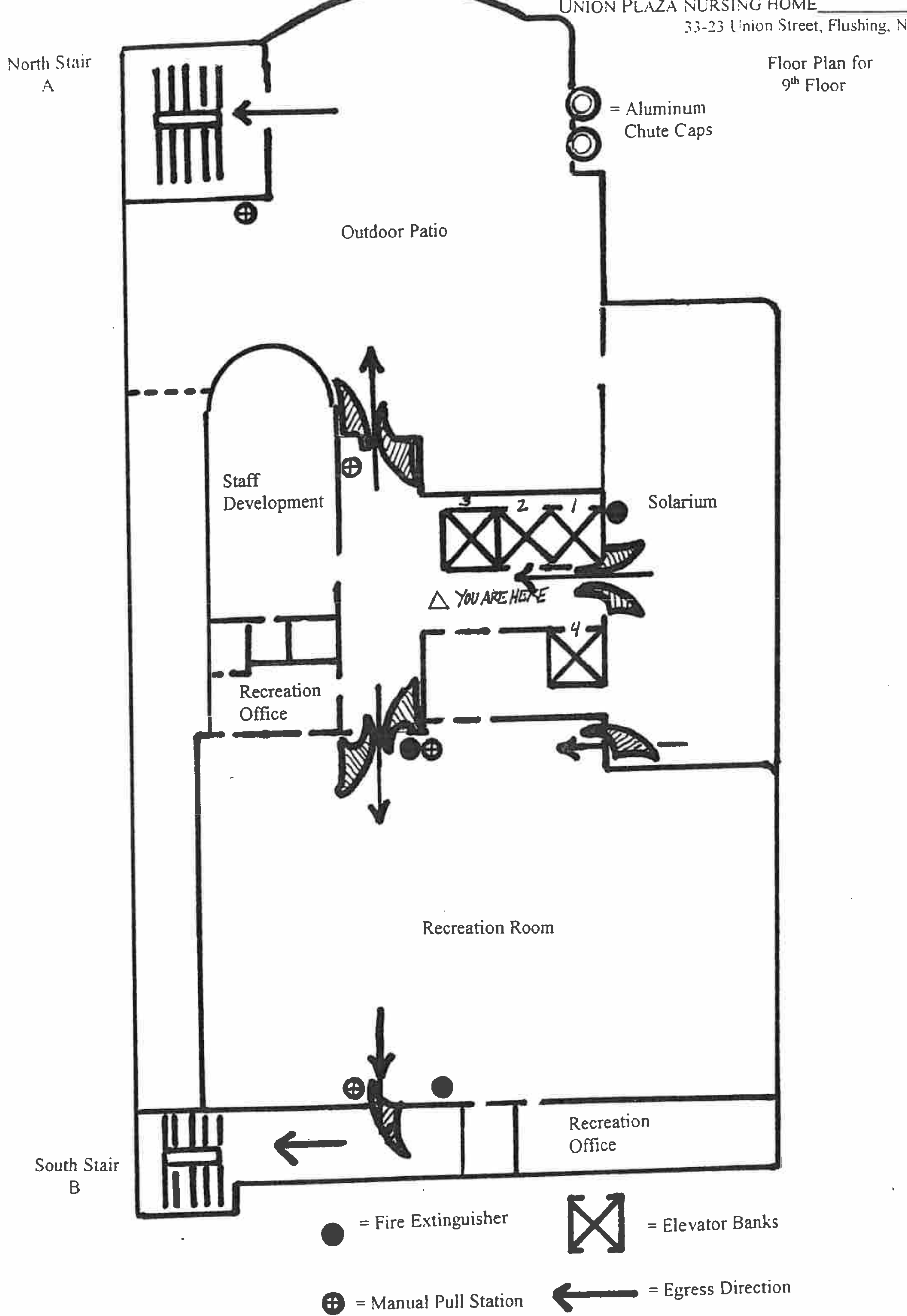
Floor Plan for Lobby Level



UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY 11354

Floor Plan for Lower level




UNION PLAZA NURSING HOME
33-23 Union Street, Flushing, NY
Floor Plan for
9th Floor
North Stair
A
= Aluminum
Chute Caps
Outdoor Patio
Staff
Development
Solarium
3
2
1
4
YOU ARE HERE
Recreation
Office
Recreation Room
Recreation
Office
South Stair
B
= Fire Extinguisher
= Elevator Banks
= Manual Pull Station
= Egress Direction

UNION PLAZA NURSING HOME

33-23 Union Street, Flushing, NY 11354

Floor Plan for
2 thru 8

North Stair
A

Dining Room

△ YOU ARE HERE

3 2 1

4

T.R.

Mid
Lounge

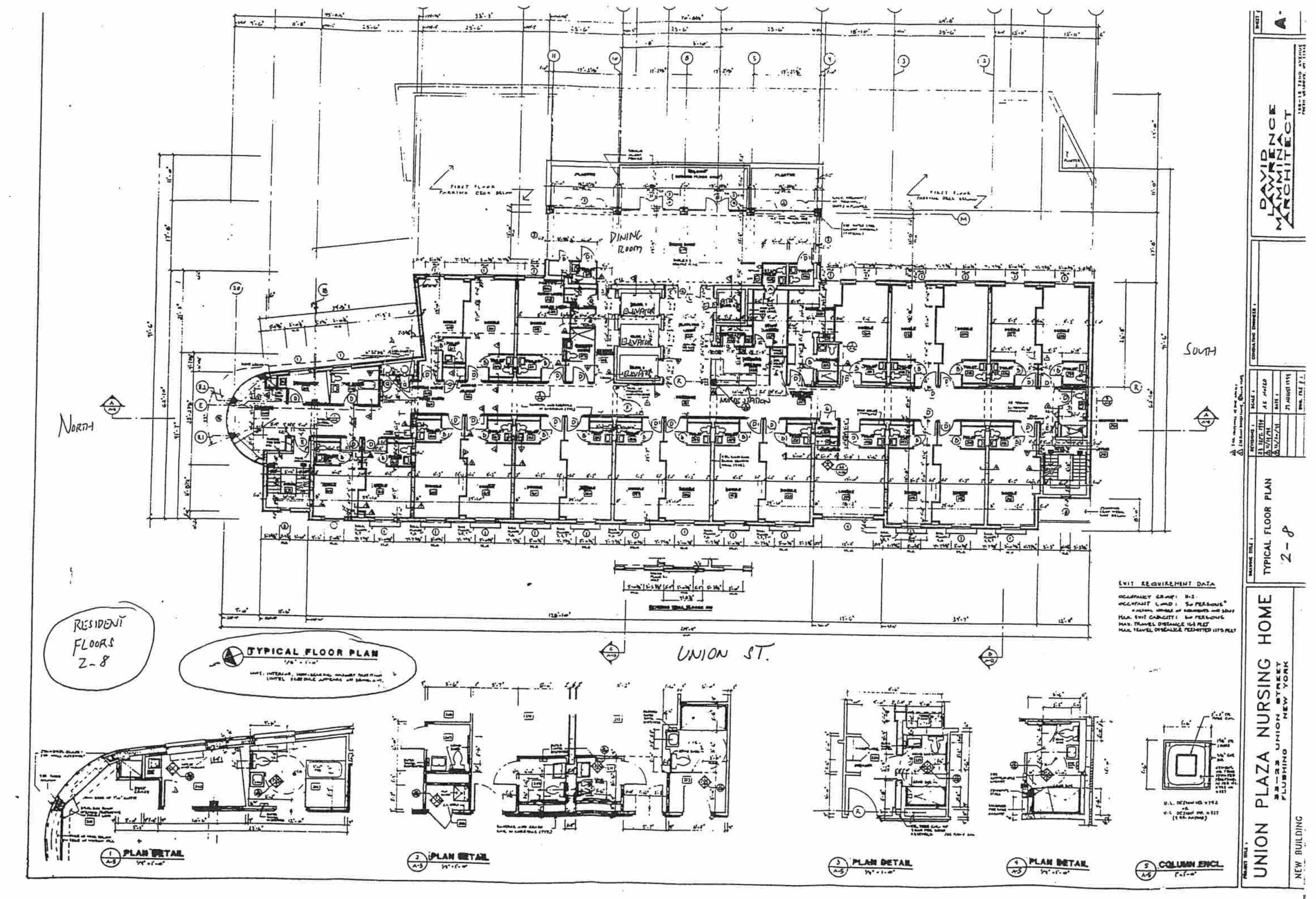
South Stair
B

= Elevator Banks

= Fire Extinguisher

⊕ = Manual Fire Station

= Egress Direction



DINING ROOM
NORTH
SOUTH
NURSE STATION
ELEVATOR
RESIDENT FLOORS 2-8
TYPICAL FLOOR PLAN
UNION ST.
EXIT REQUIREMENT DATA
PLAN DETAIL
PLAN DETAIL
PLAN DETAIL
PLAN DETAIL
COLUMN ENCL.
DAVID LAWRENCE MAMMINA ARCHITECT
TYPICAL FLOOR PLAN
2-8
UNION PLAZA NURSING HOME
33-23 UNION STREET
FLUSHING NEW YORK
NEW BUILDING