CHCA Colorado Health Care Association & Center for Assisted Living

2019 Educational Courses

Emergency Preparedness Compliance in SNF and LTC Communities with Focus on Armed Intruder/Active Shooter Awareness

Presented by:

Stan Szpytek

Fire and Life Safety

Emergency Preparedness and Compliance

E

P V

G H Y U

L J O X B C

S Z P Y T E K

Stan Szpytek, Fire and Life Safety, Inc.

o **Entered Fire Service in 1977 as Cadet Firefighter**

o **Hired as a Career Firefighter in 1983- Ranks Achieved:**

- **Paramedic**
- **Engineer**
- **Lieutenant**
- **Captain**
- **Fire Marshal / Emergency Manager**
- **Deputy Fire Chief**

o **Honorably Retired in 2003**

o **Founder of Fire and Life Safety, Inc.- 2000**

o **Gallagher Bassett RCCS- 2002**

o **Arizona Health Care Association Consultant- 2009**

o **CAHF Life Safety / Disaster Planning Consultant- 2010**

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OIG Report: 4/13/12

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

"Gaps Continue to Exist in Nursing Home Emergency Preparedness Response During Disasters"

- 24 facilities, 7 states, 2007 – 2010 disasters
- Staffing shortages
- Resident Care esp. feeding tubes and ventilators
- Resident ID and tracking
- Shelter in Place supplies
- Communication
- Most providers DO NOT use an emergency management model like the Incident Command System

- 92% of all nursing homes in the country met federal requirements for emergency plans

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Tools: Recommended Tool for Effective Health Care Facility Planning

Change on the Horizon….

CMS: Proposed Rule

- December 27, 2013

- Existing guidance on Emergency Preparedness not comprehensive enough for complexities of actual emergencies

- Proposed rule will impose extensive emergency preparedness conditions

CMS

ALL HAZARDS

- Risk Assessment Planning

  - Assess critical capabilities for emergencies and disasters
  - "All Hazards" approach
  - Emergency Operations Plan (EOP) must be developed and maintained to address identified risks (hazards and perils)

CMS

- Policies and Procedures
  - Require development, implementation of EOP and P&P based on Risk Analysis
    - Facility
    - Community-based (care-related, power, cyber attack)
  - Reviewed annually
  - Identification of "specific" amounts of subsistence for patients and staff
  - Critical Medications

CMS

- Policies and Procedures
  - Facility Population
    - Assess persons at risk
    - Types of services provided in an emergency
    - Continuity of Operations
      - Delegation of Authority
      - Succession Plans
  - Cooperation and Collaboration (Integration)
    - Local   Tribal
    - Regional   State / Federal

CMS

- Policies and Procedures
  - Cooperation and Collaboration
    - Integrated Response
    - Develop Methods and Documentation
    - Local Healthcare Coalitions
    - 24/7 Contact Information
      - In addition to 9-1-1
      - Alternate contact modes if phone service is out

CMS

- Policies and Procedures

  – Alternate Sources of Energy
    - Maintain temperatures
      – Resident safety and health
    - Storage of provisions
    - Emergency lighting
    - Fire protection systems
    - Sewage and waste systems

    - Risk Assessment of Capabilities
      – May reveal the need replace or expand
        » Battery power may be insufficient

CMS

- Policies and Procedures
  – Tracking
    - Residents
    - On-duty staff
      – Documentation of specific names

  – Safe Evacuation
    - Care and treatment
    - Staff responsibilities
    - Transportation
    - Relocation sites identified
    - Communications with external resources

CMS

- Policies and Procedures

  – Shelter-in-Place
    - Staff / Volunteers
      – Expanded requirements

  – System of Medical Documentation
    - Preserves residents' information
    - Confidentiality
    - Secures records
    - Maintains availability

CMS

- Communications Plan

  - Requires development and maintenance of an emergency preparedness communication plan that complies with federal and state law

  - Reviewed annually

CMS

- Communication Plan (Primary / Alternate)
  - Names and contact information
    - Staff
    - Entities providing services to clinic
    - Patients' physicians
    - Other facilities
    - Volunteers
    - Emergency Officials
      - Federal
      - State
      - Tribal
      - Local
      - Other sources of assistance

CMS

- Methods of Sharing Information
  - Patient's information with other health care providers
    - Maintain continuity of care

  - A means of providing information about the general condition and location of residents under the facility's care

CMS

- Sharing Information on <u>Occupancy Needs & Capabilities</u>

  – With Authorities Having Jurisdiction (AHJ), Incident Command Center or designee

  – A process to communicate the provider's specific needs during an emergency

  – A process to communicate the provider's ability to provide assistance during an emergency

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CMS

- Training and Testing

  – Requires development and maintenance of a well-organized, effective emergency preparedness training and testing program
    - Based on the EOP
    - Based on Communications Plan
    - Based on P&P
    - Ensures that staff can demonstrate knowledge

  ✓ Reviewed annually and updated as needed

CMS

- Training and Testing

  – Initial training on emergency preparedness polices and procedures consistent with their roles during an emergency
    - New and existing staff
    - Contractors
    - Volunteers

  – Annual Training

  – Maintain documentation of all training

CMS

- Training and Testing

  – Drills and Exercises
    - Annual full-scale, community-based exercise
      – Exempt if provider experiences a real-world incident
      – If no community-based exercise is available, conduct an individual facility-based, full-scale exercise

    - A second community-based or individual facility-based full-scale exercise

      OR

    - Tabletop exercise (TTX)

CMS

- Emergency and Standby Power Systems

  - Based on risk analysis, current systems may be insufficient
  - Installation per NFPA standards
  - Testing per NFPA standards
  - Enhanced on-site storage or re-fueling

CMS

- Integrated Health Systems

  – CHC can participate in health system's EP program
    - Individual provider must demonstrate active participation
    - Individual HVA for clinic
    - Program is applicable to clinic operations

"Inclusion"

New "E" Tags

- **001**- Must establish and maintain a comprehensive Emergency Preparedness "Program"
- **004**- Must develop and maintain an Emergency Preparedness Plan
  - Reviewed and update annually
- **006**- All Hazards Plan
  - Facility and community based analysis
  - Including missing residents
  - Specifically address "identified" emergencies

New "E" Tags

- **007**- Addresses patient population and continuity of operations
  - Capabilities and capacities
  - Delegation of authority and succession planning
- **009**- Cooperation and collaboration
  - Documentation of efforts
- **013**- Policies and procedures based on Emergency Plan, risk assessment and communication plan

New "E" Tags

- **015-** Provision of subsistence
  - Food, water, medication, etc.
  - Alternate source of energy
- **018**- System to track residents and staff
- **020**- Evacuation provisions
- **022**- Shelter in place provisions
- **023**- Medical documentation
- **024**- Volunteers and other emergency staffing provisions

New "E" Tags

- **025**- Arrangements with receiving facilities
  - Continuity of services
- **026**- 1135 Waiver
  - Care and treatment at alternate care site
- **029-** Develop and maintain a Communications Plan
  - Complies with Federal, state and local laws
  - Reviewed and updated annually
- **030**- Maintain updated contact information
  - Staff, vendors, docs,, other facilities, volunteers

New "E" Tags

- **031**- Maintain updated contact information
  - Preparedness staff
    - Federal, state, tribal, regional, local
  - State licensing and certification agency
  - Office of state long-term care ombudsman
  - Other sources of assistance
- **032**- Primary and alternate means of communication
- **033**- Method of information sharing
  - With other health care providers

New "E" Tags

- **034**- Means of providing information to the Incident Command Center
  - LTC's occupancy
    - Needs
    - Ability to provide assistance
- **036**- Training and testing requirements
- **037**- Training program
  - Frequency
- **039**- Exercises and drills
  - Full scale and TTX requirements

New "E" Tags

- **041**- Emergency and stand-by power systems
- **042**- Integrated healthcare system requirements
  - Allowances for participation in system
    - Demonstrate participation
  - Illustrate unique circumstance, patient population and services offered
  - Includes an unified and integrated emergency plan

CMS

- EFFECTIVE DATE- 11/16/2016

  - Implementation one (1) year after effective date, **11/16/2017.** Expectation:
    - A "program" allows for the continual building of a comprehensive system of healthcare response to emergencies
    - Constantly evolving, updated frequently
    - Robust training, drills and exercises
    - Ready for immediate implementation
    - "Culture" of Preparedness

Harvey !

Anything Can Happen……….
Anytime……...Anywhere………

- CT School Shooting- December 14, 2013

Anything Can Happen……….
Anytime……...Anywhere………

- Sunday (3/29/09) at approx. 10 am
- 7 Killed in NURSING HOME Shooting

Toledo, OH ALF Stand-off

- 4/28/09
- Director of Activities Held Hostage by Estranged Husband…..

Double Murder-Suicide at California Senior Center…

June 25, 2011......
Car Crashes into Nursing Home

Transformer Fire…

F I R E !!!!

Wildfire…

Wildfire…

Flooding…

Oklahoma 2013

San Bruno, CA….

First Responders…

Situational Awareness…
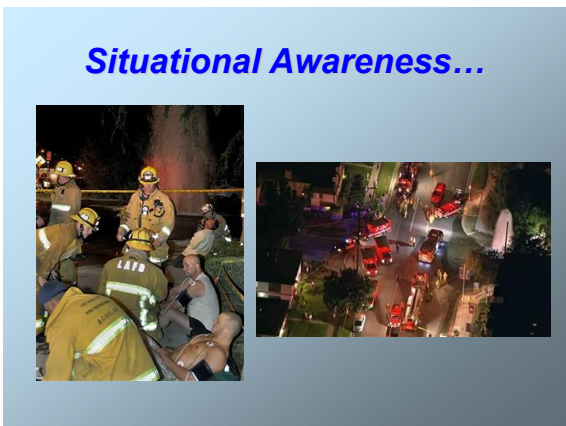
Baltimore Train Crash and Explosion

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West, Texas- April 2013

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Not All Incidents have to be Major Catastrophes

Real Life Incidents

Share Your Story!

59

Reaction to Disaster or Crisis……

It's not what you think….

THE
UNTHINKABLE

WHO SURVIVES WHEN
DISASTER STRIKES—
AND WHY
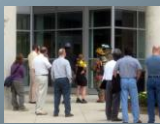
MS Estonia Disaster- 1994

Beverly Hills Supper Club

John Davidson
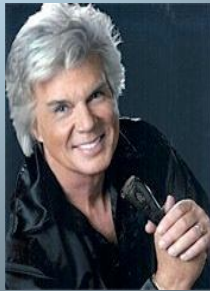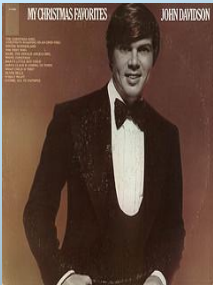
Beverly Hills Supper Club- 1977
165 Dead / 200 Injured

World Trade Center- 9/11/01

Rick Rescorla…

Costa Concordia- 1/13/13
32 Dead

Failure to Respond……

- Subconscious Need for Normalcy
- Overwhelming Sense of Denial
- Optimistic Bias
- Unable to Comprehend Scope of Event
- Lack of Safety Culture
- No Planning / Preparedness
- Poor Training
- No Practice / Rehearsal

Challenges......

**Disaster!
Do we have a plan for
EVERYTHING?**

Severe Weather......

Plan for EVERYTHING…..

- **Does Your Facility Have a Meteorite Plan?**
- **Virginia's Doctor's Office Hit By Meteorite- 1/18/10**
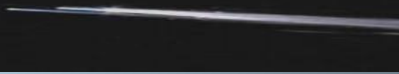
OBVIOUS THREATS…..

- Midwest = Tornado / Severe Weather
- Coastal = Hurricane / Tropical Depression
- North / Northeast = Winter Storms
- Desert = Excessive Heat
- Fault Zones = Earthquake
- Island / Coastlines = Tsunami
- Flood Zones = Flooding

What's beyond the fence?

Light Industrial Parks

Transportation…..
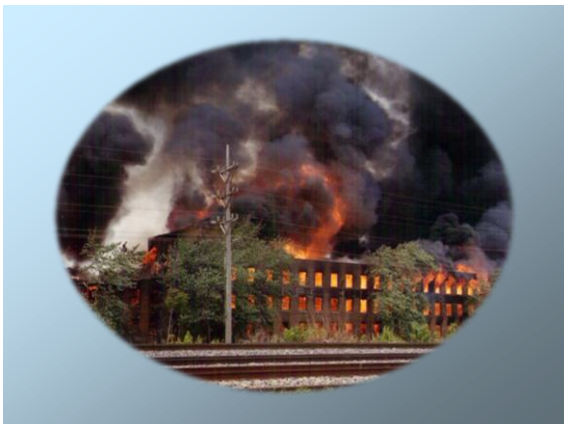
Proximity to Hazards…

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Military Installations…

Across the Street ?

SNF METH LAB FIRE

Room at Park Haven Nursing Home where a fire on March 4, 2012 caused by a meth lab in the room killed one person and injured six others

Haz Mat Scene…

CBRNE
Accident or Terrorism….

- Chemical
- Biological
- Radiological
- Nuclear
- Explosive

What if your community is down the street?

How prepared is your community?

How prepared are they?

Beyond Your Control……

Can't Happen Here?

Impact on Senior Services…

Lessons For Us …

Disaster planning and exercises are the key to survival not the written plan

Phone service will go down – text may not

96 hours of supplies are not enough

EHRs helpful in long run – in short term have paper kits

The desperate public will show up

It could be hours to days before help arrives

You and your staff will be profoundly impacted

HAZARD VULNERABILITY ASSESSMENT

HVA

WHAT potential threats and perils may impact the community and your facility?

HVA Factors…..(RISK)

EVENT TYPE (Specific)

- Probability
  - Likelihood of Occurrence

- Severity = Impact
  - Human
  - Property
  - Business

- Mitigation = Preparedness + Response
  - Preparedness
  - Internal Response
  - External Response

How is an HVA Created?

Probability + Impact → (Unmitigated) **Risk** − Mitigation & Preparedness → (Mitigated) **Risk**

Hazard Vulnerability Assessment (HVA)

GROUP DISCUSSION:
WHAT ARE YOUR UNIQUE HAZARDS?
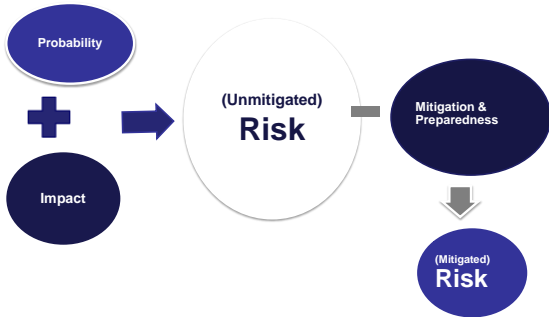
ALL HAZARDS PLANNING

"All Hazards" Emergency Management

- **Addresses your Residents' Unique Clinical and Support Need**
- **Focuses on your High Risk Threats**
- **Reflects Local Emergency Planning Considerations**
- **Includes**
  - **System for Command**
  - **Communications**
  - **Resources and Assets and Supply Needs**
  - **Safety and Security**
  - **Staff Responsibilities**

Training……

FIRE DRILL.
The Nurses, Domestic Staff and Porters have periodical instruction in Fire Drill.

Disaster Drills (Functional)…

Full Scale Drills (Community)…

MOCK DISASTER DRILL IN PROGRESS

Tabletop Exercise (TTX)

TTX at the Facility…

Collaboration

The last thing you want to do is meet for the first time in a disaster – Build relationships now

Rescue and evacuation require outside resources

Contact list for key response partners:

- •OES/EMS/Fire/Law Enforcement
- •State licensing agency
- •Transportation
- •Vendors
- •Trade Association/Red Cross

Local Level…

Provider Level- EXTERNAL

Large Scale Incidents

Legal Basis for ICS

| HSPD-5 | Management of Domestic Incidents |
| HSPD-8 | National Preparedness |

Mandates
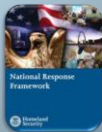
NIMS and the Incident Command System (ICS)

One of the most important 'best practices' that has been incorporated into the NIMS

is the Incident Command System (ICS), a standard, on-scene, all-hazards incident management system already in use by firefighters, hazardous materials teams, rescuers and emergency medical teams.

The ICS has been established by the NIMS as the standardized incident organizational structure for the management of all incidents.

www.fema.gov/txt/nims/nims_ics_position_paper.txt

A System . . . Not a Facility

Dispatch

On-Scene Command

Coordination Resource Centers

Multiagency Coordination System

Coordination Entities/ Groups

Emergency Operations Centers

INCIDENT COMPLEXITY & RESOURCE NEEDS…

Incident Complexity   **Resource Needs**   **ICS Structure**

Complexity

NursingHome NHICS
INCIDENT COMMAND SYSTEM

NHICS Functions

- The 5 NHICS Functions include:
  - Incident Command
  - Operations
  - Planning
  - Logistics
  - Finance and Administration
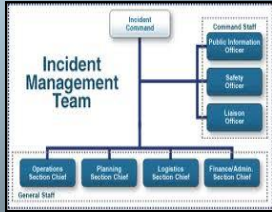
Essential Responsibilities of NHICS Functions

NHICS FUNCTIONS	ESSENTIAL RESPONSIBILITIES
Incident Command	Lead/Manage
Operations	Carry out the actions that must be done
Planning	Collect Information, Analyze and Plan
Logistics	Get Stuff to support Operations
Finance and Administration	Finance, Administration and Clerical Support

Key Concept:

The Incident Command position is the only position that is ALWAYS activated and the authority and responsibility for the incident management belongs to them.

WHAT ARE THE BENEFITS OF NHICS?

✓ **Empowers staff**

✓ **Promotes interoperability**

✓ **Efficiency covered through delegation**

✓ **A process that applies to ALL HAZARDS**

✓ **The CAHF EOP Template follows the NHICS framework**

Incident Action Planning Management By Objectives

- Flexible, Measurable & Attainable Objectives
- Identified Time-Frames (Operational Period)

S	**SPECIFIC**	Details exactly what needs to be done
M	**MEASURABLE**	Achievement or progress can be measured
A	**ACHIEVABLE**	Objective is accepted by those responsible for achieving it
R	**REALISTIC**	Objective is possible to attain (important for motivational effect)
T	**TIMED**	Time period for achievement is clearly stated

Common Terminology

- Plain English
- Common names
- Helps to define:
  - Organizational functions (e.g. Command, Logistics)
  - Resource descriptions (e.g. personnel, equipment, supplies)
  - Facilities (e.g. EOC, ALCC)

Why Plain English?	
EMT	EMERGENCY MEDICAL TREATMENT
EMT	EMERGENCY MEDICAL TECHNICIAN
EMT	EMERGENCY MANAGEMENT TEAM
EMT	EASTERN MEDITERRANEAN TIME (GMT +0300)
EMT	EFFECTIVE METHODS TEAM
EMT	EFFECTS MANAGEMENT TOOL
EMT	EL MONTE, CA (AIRPORT CODE)
EMT	ELECTRON MICROSCOPE TOMOGRAPHY
EMT	EMAIL MONEY TRANSFER

◈ Incident Action Plan

- **Incident Action Planning: Management by Objectives**
  - → Setting the operational period
  - → Determining overall priorities
  - → Establishing specific measurable and attainable objectives
  - → Setting strategies for the objectives
  - → Identifying needed resources
  - → Issuing assignments
  - → Monitoring and evaluating efforts
  - → Documenting results

COMMAND STRUCTURE

Job Action Sheets…

- Tasks in the Job Action Sheets are grouped according to time periods:

  – Immediate Response (0-2 hours)

  – Intermediate Response (2 – 12 hours)

  – Extended Response and System Recovery (greater than 12 hours)

JOB ACTION SHEETS

Incident Response Guides

Indicate critical actions to be taken or considered

Are organized by IMT position

Include fields that allow the IMT member to add his/her initials when actions are completed

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INCIDENT RESPONSE GUIDE
EARTHQUAKE

EARTHQUAKE

MISSION

To maintain facility operations for a minimum of 96-hours following a major earthquake that may impact the structural integrity of the facility, and to ensure the continuum of care for residents, visitors, and casualties of the event.

DIRECTIONS

Read this entire response guide and use as a checklist to ensure tasks are addressed and completed. For each response period, all activated IMT positions should refer to their Job Action Sheet for additional actions. Each IRG is intended to be a starting point and not all inclusive. Customize to your facility.
Note: Section duties and responsibilities remain the responsibility of the Incident Commander unless delegated.

OBJECTIVES

- Account for all residents, visitors, and staff; assess for injuries and need for transfer to acute care facility.
- Initiate damage assessment of facility; determine need for shelter-in-place or facility evacuation (full or partial).
- Initiate resident tracking if evacuation is required.
- Assess ability for facility self-sustainment for a minimum of 96-hours.

RAPID RESPONSE CHECKLIST

- **If you are physically able** – DROP, COVER and HOLD ON
  - DROP to the ground.
  - Take COVER by getting under a sturdy desk or chair (cover your head and neck with your arms and hands). Keep away from glass, windows or anything that could fall near you.
  - HOLD ON to your shelter until the shaking stops.
  - Be prepared for aftershocks.
- **If a resident is in a wheelchair** –
  - Tell/assist the resident to LOCK their wheels in a safe position.
  - Tell the resident to COVER their head and neck with their arms.

⇨ The Leader

- Some one identified - Everyday - Every shift
- Trained to the "all hazard" plan and the high risk events for this facility
- Authority to make decisions
- The only position that is always activated
- Duties: Assess the situation, establish priorities, prepare assignments, determine objectives and decide strategy
- NHICS calls this the "**Incident Commander**"

⇨ The Helpers

- Called "**Command Staff**"
- May or may not be needed, depending on incident
- Assist an answer to the Incident Commander:

⇨ **Safety Officer**

⇨ **Public Information Officer**

⇨ **Liaison Officer**

⇨ **Medical Director/Specialist**

⇨ **The Doers**

- Coordinate tactical activities and implement actions consistent with the objectives identified by the Incident Commander
- Resident care
- Search and rescue
- First aid
- Assess physical plant and clean up or repair
- Perform the actual response duties
- NHICS calls this **"Operations"**

⇨ **The Thinkers**

- Gather information for all functions
- Prepare action plans
- Keep abreast of changes (intelligence)
- Analyze the situation and prepare recommendations and reports
- Documentation of response
- NHICS calls this **"Planning"**

⇨ **The Getters**

- Acquire needed staff, supplies and equipment in support of operations
- Arrange for transportation
- Keep track of resources
- Set up alternate communications
- Establish staffing patterns
- NHICS calls this **"Logistics"**

⇨ The Payers

- Track personnel overtime
- Screen volunteers
- Procurement and purchasing
- Track costs
- Handle claims
- NHICS calls this **"Finance/Administration"**

Operationalizing ICS…

The *POWER* of the Vest…

EXAMPLE

Fire Alarm System Activation….

✓ **INCIDENT COMMANDER is** established

EXAMPLE

Smoke is confirmed in resident wing….

✓ **OPERATIONS** sector is activated

EXAMPLE

Evacuation of facility due to a confirmed fire is possible….

✓ **PLANNING** sector is activated

EXAMPLE

Moving records, supply, staff, etc. due to complete facility evacuation….

✓ **LOGISTICS** sector is activated

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EXAMPLE

Staff recalled, expenditures being made to manage the incident….

✓ **FINANCE / ADMINISTRATION** sector is activated

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Non- Emergency Events
V.I.P. Visits…

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•Incident Management Team (IMT) Chart

•*Missing Resident*

•*Full Evacuation*

- Incident Commander
- Medical Director/Specialist
- Safety Officer
- Liaison Officer
- Public Information Officer
- Operations Section Chief
- Planning Section Chief
- Logistics Section Chief
- Finance/Admin Section Chief
- Resident Services
- Situation
- Service
- Staff Time
- Infrastructure
- Documentation
- Support
- Procurement/Costs/Claims
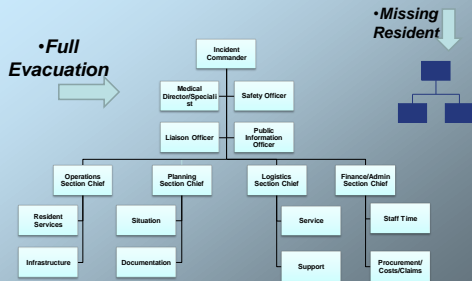
Key Concept:
WORTH REPEATING

The Incident Command position is the only position that is ALWAYS activated and the authority and responsibility for the incident management belongs to them.

NHICS TOOLS

Disaster Preparedness Program

- Revised 2017
- Guidebook
- Training Modules (4 Power Points)
- Forms (18 Forms)
- Incident Planning Guide (Master)
- Incident Response Guides (11 Hazards)
- Job Action Sheets (One for 10 Positions)

Can be downloaded from:
https://www.cahfdisasterprep.com/nhics

A Few Word about NHICS Forms

- **NHICS 2017 provides 18 NHICS Forms:**

  – Use only the forms you need

  – Use throughout the life of an activation

  – OK to customize if necessary but retain the form number and name for standardization

- **The advantages of using NHICS Forms:**

  Clear, standardized documentation of response and recovery activities

  Quality assurance tool

  May assist in reviewing the response

  May assist in financial recovery

Systems to Track Residents/Clients and On-duty Staff

Shelter-in-Place

APPENDIX J - SHELTER IN PLACE

DECISION TO SHELTER IN PLACE

The biggest decision our Incident Commander (IC) (the Administrator or designee) may need to make is whether to stay or go in response to a threatened or actual emergency. This decision is always based on the best interests of the residents; shelter in place is often the preferred method over facility evacuation due to the stress to residents associated with evacuation to another facility or alternate care site.

If the threat is fast moving (e.g., an internal building fire), the decision may be made rapidly, without the opportunity to consult with local fire, law, or county emergency management officials. Situations that may warrant shelter in place include:

- Severe weather
- Hazardous materials incidents
- Nuclear accidents
- Earthquakes
- Wildfires
- <Add any facility specific hazards>

PROCEDURES

Once our IC makes the decision to shelter in place, the following activities occur:

INITIAL (See Rapid Response Guide – Shelter in Place)

AHCA NCAL

Shelter In Place: Planning Resource Guide for Nursing Homes

Purpose of this Document

The ULTIMATE Goal:

Interoperability

Welcome to IS-700.A
National Incident Management System (NIMS), An Introduction

http://training.fema.gov/IS/NIMS.asp

Welcome to **IS-100.HCb**
Introduction to the Incident Command System (ICS 100) for Healthcare/Hospitals

→ http://training.fema.gov/IS/NIMS.asp

Emergency Management Institute

FEMA

This Certificate of Achievement is to acknowledge that

TAYLOR D DEWEY

has reaffirmed a dedication to serve in times of crisis through continued professional development and completion of the independent study course:

IS-00100
Introduction to the Incident Command System, (ICS 100)

Issued this 6th Day of July, 2008

Cortez Lawrence, PhD
Superintendent
Emergency Management Institute

0.3 CEU

CAHF DISASTER PREPAREDNESS APP

disaster preparedness program dpp

Formalized Contingencies…

Resident Identification

EMERGENCY EQUIPMENT
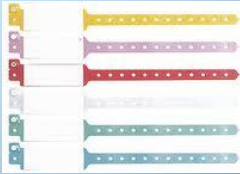
Modes of Transportation

Challenges…

Suitable Re-Location Sites…

FATALITY MANAGEMENT

Recovery and Restoration…

Something to Consider…

SECURITY

Even if this is a good depiction of your maintenance director, this does NOT represent a good site security plan…...

Potential Risk Exposure

- Emergency Operations Plans (aka Disaster Plans)

  - Development of comprehensive "All Hazards" plans
    - NIMS Concepts

  - Integration of an Incident Management Model like ICS

  - Regular review

  - Regular updating

  - Revisions as needed

  - Remote access to plans

Potential Risk Exposure

- Expectations- Facility will have adequate…
  - Planning

  - Preparedness

  - Response

  - Recovery

- Formalized Contingencies
  - No "hand-shake" agreements

- Business Continuity Planning

- *Vi!* Communities can't control what comes their way

- Understand that "It <u>can</u> happen to you"

- Facilities can control levels of preparedness, response and recovery capabilities

- Understand Human Nature = Culture of Preparedness

- Know the Hazards and Perils = HVA

- Command and Control = All Hazards EM

- Plan to Recover = Limited Service Disruption

- Know the Regulations & Trends = Compliance

- Robust Disaster Management = Reduced Risk Exposure

Bottom Line

The worst time to develop a plan is when you NEED a plan….

Emergency Preparedness and Compliance

Stan Szpytek, President
Fire and Life Safety, Inc.

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Armed Intruder and Active Shooter in the Long Term Care Facility

Plan...Respond...and *Survive "The Unthinkable"*

© 2016 Sorensen, Wilder & Associates

Seminar Objectives

Review
• **Active Shooter Concepts**
• **A LTC Case Study with Catastrophic Outcomes**

Learn
• **The Active Shooter Safety Action Plan**
• **The Safety Transition Adjustment Formula (STAF) Protocol**
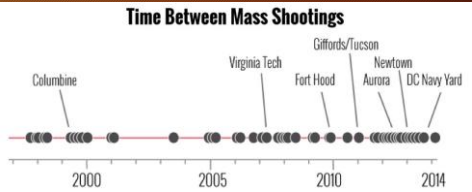
Remain
• **Safe and Alive During an Active Shooter Event**

Active Shooter Incidents... They're Getting To Common

Time Between Mass Shootings

Columbine   Virginia Tech   Giffords/Tucson   Newtown
             Fort Hood   Aurora   DC Navy Yard

2000   2005   2010   2014

Data analysis by Harvard School of Public Health   Mother Jones

The prevailing attitude:
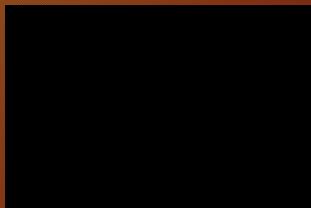**"*It won't happen here.*"**

Even Hollywood is in on it...

Westchester Senior Living
Tempe, AZ- July 27, 2016

San Bernardino

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On The Loose...Terror in the Streets

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Developing Your Active Shooter Program

Five Steps to Protect Our Stakeholders

1. Conduct Security Vulnerability Assessment
2. Develop An Active Shooter Emergency Response Plan
3. Develop an Active Shooter Training Program
4. Train Staff on How to Respond to an Active Shooter Event
5. Plan for Recovery

_____

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Policy Development and Training

Step 1: Conducting a Security Vulnerability Assessment (SVA)

- Threats

- Vulnerabilities
  - People
  - Programs
  - Technology
  - Training

- Opportunities for Improvement

Policy Development and Training

Step 2: Develop An Active Shooter Emergency Response Plan

Make it realistic to the threat:
- PHASE® Event: Shooter has a specific target
- CAVE® Event: Shooter looks for high body/casualty counts; shoots as many as possible
- There will be no "Code Team" responding
- Completely unpredictable
- Chaos
- Survival in part will be based on preparedness

Policy Development and Training

Step 2: Develop An Active Shooter Emergency Response Plan

- Develop plan focused on staff and residents
  - Active Shooter Safety Action Plan
  - STAF-P

- *Denial* has no survival value
  - *It won't happen here...*

- Develop a plan with a survival mindset

  - Lines of survival: exits, hiding places, barriers, weapons of opportunities

Policy Development and Training

Step 3: Active Shooter Training

- Your training strategy:
  - Provide a range of options and choices for occupants to make decisions
- Survival is not a random outcome— survival is the result of training and preparedness!!!
- The four-step approach to training
  - Awareness
    - Preparedness
      - Drills and exercises
        - Evaluations and improvements

Training
Knowledge useful abilities, backbone of ce quired for a tr

Policy Development and Training

Step 3: Active Shooter Training

- **Orientation**

- **Department Specific**

- **At least annual review**

Policy Development and Training

Drills

- **How do we practice and train?**
  - **In-service, stand-up, all-staff, etc.**
  - **Tabletop exercises**
  - **Functional drills and exercises**

- **How often do we need to practice and train?**
  - **Frequency should be clearly defined in policy**
  - **At least annually**
  - **Periodic drills or tabletop exercises**

Policy Development and Training

Step 4: Active Shooter Response

The first response to an active event is the same for TRAINED and UNTRAINED (and UNPREPARED) people ...

STARTLE and FEAR

Policy Development and Training

Step 4: Active Shooter Response

Trained and Prepared:
- Anxiety
- Recall what they have learned
- Ready to act as they have been trained

Untrained and Unprepared:
- Panic
- Frozen with fear; disbelief and denial
- Stay frozen in shock and denial

Policy Development and Training

Step 5: Post-incident Recovery

Our Disaster Recovery Plan Goes Something Like This...
HELP! HELP!
DILBERT
By Scott Adams

Policy Development and Training

Step 5: Post-incident Recovery

Recovery
- Initiate the facility Crisis Management Plan
  - EAP Resources / Coalition Resources
- Return to normal or safer state of affairs as quickly as possible
- May take days, months or years
- Have a recovery plan in place BEFORE the event occurs

Anything ~ Anytime ~ Anywhere

- Friday, May 12, 2017
- 2 nursing home employees killed
- Respond police chief killed

Anything ~ Anytime ~ Anywhere

- Thursday, July 12, 2018
- Assisted Living Facility
- Private contractor
- Shot in parking lot
- Shooter- Estranged husband
- Weapon- Shotgun
- Multiple gunshot wounds
- Domestic-violence related

Reaction to Disaster or Crisis

It's not what you think.

Failure to Respond

- Subconscious need for normalcy
- Overwhelming sense of denial
- Unable to comprehend scope of event
- Optimistic bias
- Lack of safety culture
- No planning or preparedness
- Poor training
- No practice or rehearsal

Fail

Situational Awareness:
Part of Emergency Operations Plan Development!

What If Your Facility Is Across The Street?

How Vulnerable Are They?

Concepts

Armed Intruder and Active Shooter in the Long Term Care Environment:
Plan...Respond...and *Survive "The Unthinkable"*

Concepts

PHASE® Incident

CAVE® Incident

Rapid Response

PHASE®   Incident

PHASE Incident

P: Personal
H: Hostile
A: Agenda
S: Singular
E: Event

PHASE Incident

Personal: This incident is not random and occurs between known persons. The incident is driven by an emotional cause (passion, rage, love, revenge, etc.)

Hostile: The offender's action toward the victim is driven by emotion and will be brutally violent

Agenda: The offender has a premeditated plan and has come to the facility prepared to carry it out

Singular: The incident will be over once the agenda has been completed; not a continuous act

Event: The quantified incident

PHASE Incident Examples

PHASE® Incident

- Domestic dispute
- Mercy killing
- 'Wrongful death'—targeting caregiver
- Resident mistreatment/abuse
- Child custody
- Employee harassment
- Employee termination

CAVE® Incident

CAVE Incident

C: Continuous
A: Active
V: Violent
E: Event

CAVE Incident

Continuous: The offender will continue the incident until (s)he is stopped by some outside force

Active: The offender's agenda has no clear end point. (S)he may have an objective, but it is very broad and not clearly defined

Violent: Because the objective is broad, the offender needs a grandiose method to carry it out (e.g., large quantities of weapons, munitions, and possibly explosives). The method of violence delivery is usually well thought out

Event: The quantified incident

CAVE Incident Examples

- Mental illness
- 'Wrongful death' (departmental-wide)
- Resident mistreatment/abuse
- Employee termination
- Political agenda
- Personal agenda

Evolution of PHASE® into CAVE®

Evolution of PHASE® into CAVE® Incident
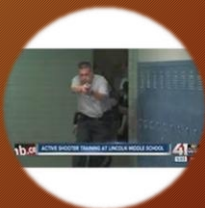
Can it evolve?
- Mindset
- Factors

Evolution of PHASE® into CAVE® Incident

Mindset
- **PHASE® characterizations review**
  - **Personal**
    - **Emotions are HIGH!!!**
  - **Agenda**
    - **Thorough pre-plan event**
    - **Determined**
    - **Resolute**

Rapid Response

Rapid Response

- **A trained, coordinated law enforcement technique to respond to and mitigate the potentially high casualty count from an active-shooter incident**
- **Developed after and due to the Columbine High School mass shooting in 1999**
- **Primary objective: Enter the facility, proceed to the sound of gunfire, stop the threat**
  - **The initial entry team will bypass the wounded and those in need of help**
  - **The second entry team is tasked with assisting the wounded and directing evacuation**

Rapid Response

Response to Law Enforcement Arrival

- Officers will be in different uniforms but will be clearly identifiable as police
- Follow law enforcement directions
- Do not have any items in your hands
- Keep your hands up. Try and remain calm
- Do not run or make sudden movements toward officers
- Do not yell, scream, or speak with officers
- Expect to be detained, searched, and questioned

Case Study

Armed Intruder and Active Shooter in the Long Term Care Environment:
Plan...Respond...and *Survive "The Unthinkable"*

Pinelake Health & Rehab
Carthage, NC

Case Study:
Pinelake Health & Rehab • Carthage, NC

Facility Overview

- Skilled nursing, Alzheimer's care, rehabilitation therapy, and hospice care
- 110 beds on campus
  - 90 resident beds
  - 20 special care (Alzheimer's/dementia)

Aerial View of Pinelake Health & Rehab
Carthage, NC

PINELAKE HEALTH & REHAB

Case Study:
Pinelake Health & Rehab • Carthage, NC

On Sunday, March 29, 2009, at approximately 10:00 a.m., an act of violence at Pinelake Health & Rehab in Carthage, North Carolina ended several lives and wounded residents, staff, and a visitor—both physically and emotionally.

Case Study:
Pinelake Health & Rehab • Carthage, NC

Incident Overview

- The gunman, Robert Stewart, arrives on location and parks in the front of the building
- Stewart fires multiple rounds into the PT Cruiser of his estranged wife, who is an employee of the facility
- Before entering the building, Stewart shoots a visitor, Michael Cotton, in the shoulder
- Stewart enters the building to search for his estranged wife, Wanda Stewart
- Unable to find her because she is in a locked dementia unit, Stewart begins to shoot at residents and staff

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Case Study:
Pinelake Health & Rehab • Carthage, NC

Incident Overview

- Nurse Jerry Avant Jr. identifies the incident and makes a facility-wide "lockdown" announcement
- Avant begins to move and secure residents but is shot by Stewart and later dies from the injuries
- A police officer arrives on scene and challenges Stewart, who turns his gun at the officer
- The officer is shot, but returns fire, hitting and injuring Stewart and stopping his attack
- The officer takes Stewart into custody

Case Study:
Pinelake Health & Rehab-Carthage, NC

Police Response: Cpl. Justin Garner

"He acted in nothing short of a heroic way today, and but for his actions, we certainly could have had a worse tragedy," said Moore County District Attorney Maureen Krueger. *"We had an officer, a well-trained officer, who performed his job the way he was supposed to and prevented this from getting even worse than it is now."*

www.wral.com/news/local/story/4837676/

Case Study:
Pinelake Health & Rehab • Carthage, NC

Incident Discoveries and Aftermaths
- 7 residents and 1 staff member killed
- 3 injured, including the gunman
- Stewart brought multiple firearms to the facility and a bag of ammunition
  - 12-gauge shotgun
  - .22 caliber rifle
  - .22 Magnum semi-automatic pistol
  - .357 Magnum revolver
- The 12-gauge shotgun was Stewart's primary weapon of choice

Case Study:
Pinelake Health & Rehab • Carthage, NC

John W. Goldston, 78

Margaret Johnson, 89

Jessie V. Musser, 88

Jerry Avant Jr., 39, nurse

Louise Vocht De Kler, 98

Tessie Garner, 75

Lillian Dunn, 89

Bessie Hedrick, 78

" Robert Stewart entered Pinelake that day with a specific reason—to chase down Wanda Stewart. He brought four guns and a bag of ammunition with the intent of creating mass casualties. "

Opening statement to jurors by Tiffany Bartholomew, Assistant District Attorney for Moore County, North Carolina, at the homicide trial of Robert Stewart on August 1, 2011

Motive

" Stewart doesn't recall what happened the day of the shooting and can't be held legally responsible for his actions. Stewart overdosed on the sleep-aid Ambien the night before the shootings and also was taking antidepressants at the time. "

Attorney Jonathan Mergerian (defense attorney for Robert Stewart)

Defense Argument

Case Study:
Pinelake Health & Rehab • Carthage, NC

On Saturday, September 3, 2011, Robert Stewart, 45, was found guilty of second-degree murder for killing eight individuals while the influence of antidepressants and six (6) Ambien pills.

He was sentenced to 142 years in prison.

Case Study:
Pinelake Health & Rehab • Carthage, NC

Summary and Conclusions

• A quick announcement of "Lockdown" by nurse Jerry Avant Jr. alerted staff and residents, saving countless persons
• Nurses and CNAs were able to secure and save many patients in locked areas that were unable to be accessed by the gunman
• A quick, composed response by a well-trained Carthage police officer stopped the shooting rampage, preventing further casualties
• Robert Stewart will spend the rest of his life in jail
• Several families filed wrongful death civil suits against the parent company of Pinelake Health & Rehab for lack of safety procedures and related issues

PALOS FIRE DISTRICT

Stop

Drop

Roll
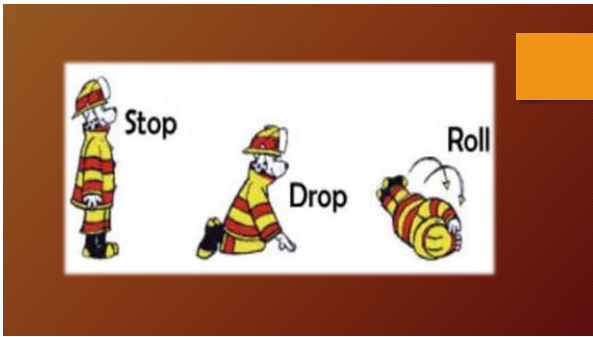
Active Shooter Safety Action Plan

The 4 "*OUTS*" of surviving an active-shooter incident

Active Shooter Safety Action Plan

Get Out	Hide Out
YOU	
Keep Out	Take Out

Active Shooter Safety Action Plan

Get Out	Hide Out
YOU	
Keep Out	Take Out

Active Shooter Safety Action Plan

Get Out

- Exit the facility as quickly as possible
- Leave personal belongings behind
- Encourage people to go with you
- Use the "bounding overwatch" technique to move groups of people and yourself from point of cover to cover if you are not aware of the offender's location
- Stay focused and quiet
- When in a safe location, call 911
- Follow police directions

911

Things to remember regarding 911

- **Who should call 911?**
  - Anyone and everyone!
- **When should you call 911?**
  - When it's safe to do so!
- **How should you call?**
  - If possible, use a facility phone. This will allow the 911 operator to positively identify the address you are calling from without you having to give it
  - If using a cell phone, the 911 operator may not be able to identify your location unless you give them the address!

911

Information to give the 911 Operator

- **Facility name and location**
- **Your name**
- **Nature of the event**
- **Description of the subject or shooter (if known)**
- **Type of weapon(s)**
- **Persons injured—number and extent**

Firearm Tutorial

Firearm Styles

- It is not important that you are a 'firearm expert' when giving information to the 911 operator
- You do not need to know make, model, or caliber
- If possible, give the 911 operator the style of firearm
  - Handgun: A firearm that can be held in one's hand (e.g., a pistol or revolver)
  - Long gun: A firearm that is designed to be fired by mounting on one's shoulder (e.g., a rifle or shotgun)
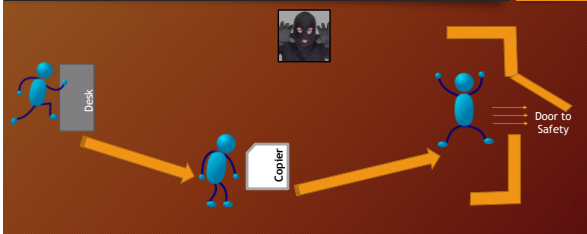
Firearm Tutorial

Weapon Types

Handgun

Long gun

Active Shooter Safety Action Plan

Get Out:

The Bounding Overwatch

Active Shooter Safety Action Plan

Desk

Copier

Door to Safety

Active Shooter Safety Action Plan

Get Out: The faster and smarter you move to "Get Out," the lower the probability you will be shot by the bad guy. Moving targets are hard targets to hit.

Active Shooter Safety Action Plan

Statistically, trained and prepared law enforcement officers involved in a gunfight only hit 18 to 27% of targets.

The likelihood of being hit by a bullet fired by the offender during an Active Shooter Event is low if you move quickly!

Active Shooter Safety Action Plan

Get Out | Hide Out
YOU
Keep Out | Take Out

Active Shooter Safety Action Plan

Hide Out
- Inconspicuous place
- Cover yourself
- Call 911 if able and safe to do so
- Be QUIET
- Silence cell phones, pagers, etc.
- Be still – Stay Focused
- Hide in 'plain sight'
- Play dead

HIDING
IN
PLAIN
SIGHT
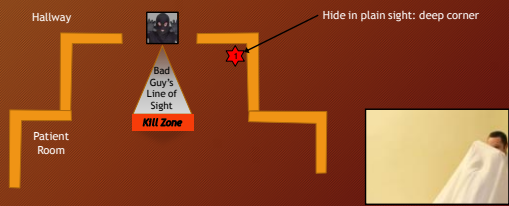

Active Shooter Safety Action Plan

Hide Out: *It's easy to miss something you're not looking for!*
- Hiding in Plain Sight
- The bad guy is looking for targets of convenience and opportunity
- If you can hide out of the bad guy's Line of Sight, chances are low (s)he will not see you
- Can be utilized to hide residents
- Because of the police Rapid Response, the bad guy will be moving quickly and not take time to search for victims

Active Shooter Safety Action Plan

Hide Out

Hallway

Hide in plain sight: deep corner

Bad Guy's Line of Sight

Kill Zone

Patient Room

Active Shooter Safety Action Plan

COVER

VS.

CONCEALMENT

- Hides you
- STOPS Bullets

- Hides you
- DOES NOT STOP Bullets

Active Shooter Safety Action Plan

Get Out | Hide Out

YOU

Keep Out | Take Out

Active Shooter Safety Action Plan

Keep Out

- Lock/deadbolt
- Big, heavy things
  - Furniture (desks, bookshelves, etc.)
  - Medical equipment
  - Hospital beds
- Lots of smaller things
- Body fluids: fecal matter???
- Once secure, call 911

Active Shooter Safety Action Plan

Get Out	Hide Out
YOU	
Keep Out	Take Out

Active Shooter Safety Action Plan

Take Out

- The FIGHT of—and for—your LIFE
- Commit to the act…
- …and do not stop until the threat has ended
- STRENGTH in numbers
- Weapons of opportunity in the workplace
- Position of Tactical Advantage
- Diversion and confusion prior to the fight
- Speed, aggression, surprise
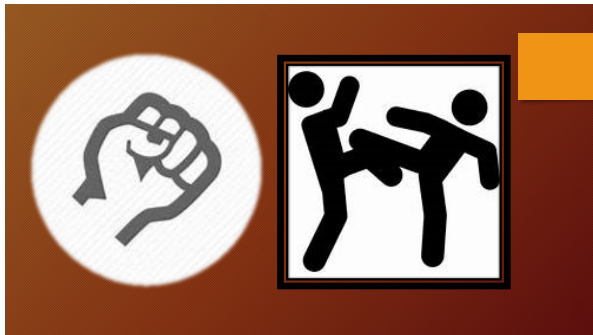
Active Shooter Safety Action Plan

**Take Out**
Make no bones about it—this is a fight for your
LIFE!

"Are you guys ready? OK. Let's roll."

Todd M. Beamer

United Airlines Flight 93
10:03 a.m.   September 11, 2001

Active Shooter Safety Action Plan

Opportunity

- What is 'opportunity'?
- Look for behavior patterns
- An opportunity to act may only occur once
- Have a plan and commit to action
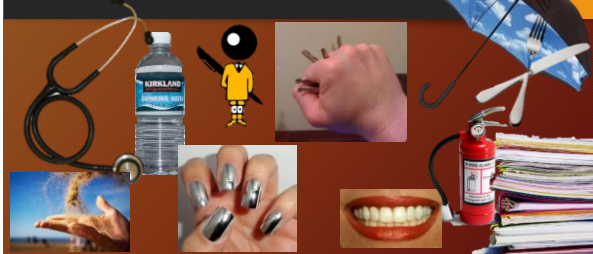- If you miss the moment of opportunity, you may not have it again
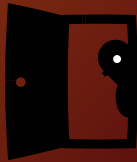
"When opportunity knocks, answer the door"

Bay County School Board Meeting • Panama City, FL
Tuesday, December 14, 2010 (approximately 2:00 p.m.)

Weapons of Opportunity

Active Shooter Safety Action Plan

You need to combine a *position of tactical advantage* **and a** *diversion* **with a** *committed action* **to successfully defeat the Offender.**
Speed-Aggression-Surprise

S.A.S.

Safety Transition Adjustment Formula Protocol STAF-P

Armed Intruder and Active Shooter in the Long Term Care Environment:
Plan...Respond...and *Survive "The Unthinkable"*

The Dilemma—What about my *residents*?!?!

Resident Safety *and* Personal Safety During a PHASE® or CAVE® Incident

- How do I protect myself?
- How can I protect my residents?
- When should I act?
- How should I react?

Introducing the *Safety Transition Adjustment Formula Protocol*
(STAF-P)

SAFETY

S
T
A
F
-
P

RESIDENTS   EMPLOYEES
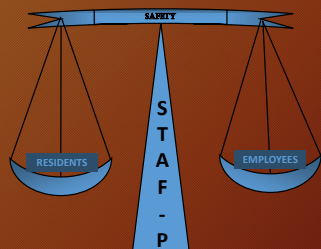
Safety Transition Adjustment Formula Protocol (STAF-P)
"...balancing the safety of residents and employees"

Resident Safety *and* Personal Safety During a PHASE® or CAVE® Incident

What is the <u>S</u>afety <u>T</u>ransition <u>A</u>djustment <u>F</u>ormula Protocol (STAF-P)?

- A formula that plans employee actions during a fluid PHASE® or CAVE® incident, ensuring the maximum survivability chances for both residents and personnel
- Driven by policy, procedure, and training
- Designed to save as many residents and personnel during a PHASE® or CAVE® incident
- A balancing act between resident and personal safety dictated by the shooter's actions

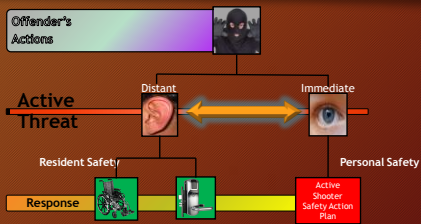## Resident Safety *and* Personal Safety During an Active Shooter Event

Recognition of a PHASE® /CAVE® Incident

- What does 'gunfire' sound like
  - Inside
  - Outdoors
- Screaming
- Crying
- Running
- Fire alarms
- Anxiety

11:25.02

Safety Transition Adjustment Formula Protocol
(STAF-P)

Offender's Actions

Distant — Immediate

Active Threat

Resident Safety — Personal Safety

Response — Active Shooter Safety Action Plan

Safety Transition Adjustment Formula Protocol
(STAF-P)

Protocol

• Which residents do I attend to first?

• How do I attend to them?

• Know that you may not be able to secure all residents before the Offender enters your area

• The end goal of the STAF protocol is to save as many lives, including yours, as possible during an incident in which the offender is trying to take them!

Safety Transition Adjustment Formula Protocol
(STAF-P)

Protocol

• You are making decisions for the residents
• Are you able to lockdown the entire unit/wing/floor and barricade it?
• If not, whom do I attend to first?
   • Residents who are able to act without assistance following caregiver directive
   • Ambulatory/mobile residents
   • 'High-maintenance' residents

Safety Transition Adjustment Formula Protocol
(STAF-P)

Active Shooter Rule of Thumb:

In the midst of a CAVE® incident, the active shooter will be looking for targets of convenience and opportunity. The shooter is looking for mass casualties. As (s)he moves from area to area in your facility, (s)he is not likely to take time to breach a door or do a room-by-room search looking for victims. The shooter knows (s)he must move quickly before police intervene.

Review

- **Policy Development and Training**

- **PHASE® Incident / CAVE® Incident**

- **Active Shooter Safety Action Plan**
  - The 4 'Outs': Get, Hide, Keep and Take

- **Safety Transition Adjustment Formula (S.T.A.F.) Protocol**
  - Balancing Patient and Personal Safety
  - Decision making

Armed Intruder and Active Shooter in the Long Term Care Environment

Questions and Comments

Thank You....

**Stan Szpytek, President
Fire and Life Safety, Inc.**

Firemarshal10@aol.com

708.707/6363

Armed Intruder and Active Shooter in the
Long Term Care Environment:
Plan… Respond… and *Survive* the Unthinkable

CMS Emergency Preparedness Rule: Resources at Your Fingertips

Published October 18, 2016
Updated February 3, 2017

Introduction

The Centers for Medicare & Medicaid Services (CMS) issued the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule to establish consistent emergency preparedness requirements for healthcare providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters. The U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR) worked closely with CMS in the development of the rule. This document provides links to numerous related resources applicable to a variety of providers and suppliers.

The rule was **published on September 16, 2016** and is **effective as of November 15, 2016**. The regulations must be **implemented by affected entities by November 15, 2017**.

This rule applies to 17 provider and supplier types as a condition of participation for CMS. The providers/suppliers are required to meet **four core elements** (with specific requirements adjusted based on the individual characteristics of each provider and supplier):

1. <u>Emergency plan</u>—Develop an emergency plan based on a risk assessment and using an "all-hazards" approach, which will provide an integrated system for emergency planning that focuses on capacities and capabilities.
2. <u>Policies and procedures</u>—Develop and implement policies and procedures based on the emergency plan and risk assessment that are reviewed and updated at least annually. For hospitals, Critical Access Hospitals (CAHs), and Long-Term Care (LTC) facilities, the policies and procedures must address the provision of subsistence needs, such as food, water and medical supplies, for staff and residents, whether they evacuate or shelter in place.
3. <u>Communication plan</u>—Develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Patient care must be coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management systems to protect patient health and safety in the event of a disaster.
4. <u>A training and testing program</u>—Develop and maintain training and testing programs, including initial training in policies and procedures. Facility staff will have to demonstrate knowledge of emergency procedures and provide training at least annually. Facilities must

T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

conduct drills and exercises to test the emergency plan or participate in an actual incident that tests the plan.

A quick reference chart was developed by CMS that highlights the requirements by provider type. Please note: This quick reference chart is not meant to be an exhaustive list of requirements nor should it serve as a substitute for the regulatory text. The 17 provider and supplier types are listed below and categorized based on whether they are inpatient or outpatient, as outpatient providers are not required to provide subsistence needs.

Table 1. Affected Provider and Supplier Types

Inpatient		Outpatient	
Facility Type	**Final Rule Reference**	**Facility Type**	**Final Rule Reference**
Critical Access Hospitals (CAHs)	Section II. N	Ambulatory Surgical Centers (ASCs)	Section II. E
Hospices	Section II. F	Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services	Section II. O
Hospitals	Section II. C	Community Mental Health Centers (CMHCs)	Section II. P
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Section II. D	Comprehensive Outpatient Rehabilitation Facilities (CORFs)	Section II. M
Long Term Care (LTC)	Section II. J	End-Stage Renal Disease (ESRD) Facilities	Section II. S
Psychiatric Residential Treatment Facilities (PRTFs)	Section II. G	Home Health Agencies (HHAs)	Section II. L
Religious Nonmedical Healthcare Institutions (RNHCIs)	Section II. D	Hospices	Section II. F
Transplant Centers	Section II. I	Organ Procurement Organizations (OPOs)	Section II. Q
		Programs of All Inclusive Care for the Elderly (PACE)	Section II. H
		Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	Section II. R

New February 3, 2017: The Yale New Haven Center for Emergency Preparedness and Disaster Response Emergency Preparedness has developed and published a CMS Conditions of Participation & Accreditation Organizations Crosswalk in collaboration with a number of national subject matter experts. Emergency and disaster related program, policy, communication, training and exercise elements of regulatory and accreditation standards were mapped to the CMS Emergency Preparedness Conditions of Participation. Every effort was made to ensure that the mapped regulations and accreditation standards matched as closely as possible. However, this document should be used only as a resource for reviewing and updating healthcare emergency preparedness plans and does not replace existing federal, local, or association guidance. Feedback and recommendations related to the crosswalk should be sent to center@ynhh.org.

General Information

The CMS Emergency Preparedness Survey and Certification Page has information on training and technical assistance available from CMS and includes a number of templates and checklists for emergency preparedness.

The ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE) dedicated CMS Rule page contains information and resources on developing plans, policies and procedures, and training and exercises.

Informational Webinars

CMS held a Medicare Learning Network National Call on Wednesday, October 5 to discuss the new rule. ASPR staff participated in the call with CMS to answer questions. The slides, audio recording, and transcript are all available for download on the MLN Emergency Preparedness National Call website.

Frequently Asked Questions (updated February 3, 2017)

CMS has published four rounds of EP Rule Frequently Asked Questions and has published these, along with other technical resource material to the CMS Survey and Certification Emergency Preparedness website.

The interpretive guidance and State Operations Manual is expected to be released by CMS in the spring of 2017.

Healthcare Coalition Information (updated November 2, 2016)

This section has been updated to reflect the relationship between affected provider and supplier types and the Hospital Preparedness Program (HPP) grantees.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Although healthcare coalitions (HCCs) (updated January 5, 2017) themselves are not included in the 17 provider and supplier types covered under the CMS Emergency Preparedness (EP) Rule, the rule offers HCCs and newly engaged providers a tremendous opportunity to achieve greater organizational and community effectiveness and sustainability.

HCCs should be an accessible source of preparedness and response best practices for newly engaged provider types as they adapt to the new requirements. They should also play a role in assisting members with closing planning gaps, as well as assuring integration with core coalition partners. HCCs have an opportunity to enhance their financial sustainability and revenue by providing contracted technical assistance to HCC members to meet the CMS conditions of participation (CoPs).

HPP grantees and their sub-recipients may provide funding to individual hospitals or other health care entities, as long as the funding is used for activities to advance regional, HCC, or health care system-wide priorities, and are in line with ASPR's four health care preparedness and response capabilities. However, though coalitions should support other preparedness efforts, funding to individual health care entities is **not** permitted to be used to meet CMS CoPs, including for the CMS EP Rule.

HCCs should expect covered health care entities to contact them asking for assistance, including the following examples:

- Obtaining copies of the coalition or regionally conducted hazard vulnerability analysis or risk assessments (or to be included in future assessments).

- Identifying examples of plans, policies, and procedures that are frequently used or accepted by other entities within those coalitions.

- Engaging in training and exercises conducted by coalitions or coalition members.

- Exploring participation in or leveraging of shared services, such as communications systems, patient tracking systems, and other jointly used equipment and supplies.

- Providing basic information on emergency preparedness and healthcare system preparedness.

- Providing technical assistance support to help meet conditions of the CMS EP Rule. Though HPP funding may not be provided to individual health care entities to meet these requirements, HCCs can provide technical assistance such as:

  o Developing emergency plans. HCCs are permitted to use HPP funding to develop the staffing capacity and technical expertise to assist their members with this

T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

requirement. An alternative would be to contract or use membership fees from the covered entities to support this capacity and expertise.

- o Developing standard policies and procedures. HCCs are permitted to use HPP funding for the staffing capacity and technical expertise to assist their members with this requirement so long as the HCC can do so and still fulfill the cooperative agreement capabilities.

- o Developing a communication plan that integrates with the HCC's communications policies and procedures. HCCs are permitted to use HPP funding for costs associated with adding new providers and suppliers to their HCC who are seeking to join coalitions to coordinate patient care across providers, public health departments, and emergency systems (e.g., hiring additional staff to coordinate with the new members, providing communications equipment and platforms to new members, conducting communications exercises, securing meeting spaces, etc.). The HCC should carefully consider whether equipment costs directly support the cooperative agreement capabilities and coordination of patient care. Coalitions should carefully weigh the costs and benefits of including new members in communications systems, as well as the sustainability of these commitments. Information sharing systems used for covered partners that do not provide acute/ emergency care may be different than those used with core partners.

- o Plan for and conduct education, trainings, and exercises at the regional or HCC level, but not facility level.

The new CMS EP Rule should prompt HCCs to proactively engage the new provider types and offer assistance. HCCs are encouraged to engage in community activities and provide support to the community response framework. They can serve as a key resource for newly covered providers. However, due to the breadth of the new provider types, coalitions must be deliberate about defining the boundaries of this support under the cooperative agreement. They should also explore opportunities for investment in the coalition by collaborating and working with the newly covered providers (e.g., new membership fees, developing contract agreements for training or exercises).

Emergency Managers and Public Health Preparedness Professionals (Updated January 5, 2017)

Like HCCs, Health Department Preparedness Offices and Emergency Management Agencies are not covered entities under this rule, but should play a role in supporting covered entities.

T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Emergency Managers should be an accessible source of preparedness and response best practices for newly engaged provider types as they adapt to the new requirements. They should also play a role in assisting facilities with closing planning gaps, accessing training, participating in planned community exercises, as well as assuring integration with other community partners.

Emergency Managers should expect covered health care entities to contact them asking for assistance, including the following examples:

- Obtaining copies of the jurisdiction or regional hazard vulnerability analysis or risk assessments (or to be included in future assessments).

- Identifying examples of plans, policies, and procedures that are frequently used or accepted by other entities within the jurisdiction.

- Engaging in training and exercises conducted by the jurisdiction.

- Exploring participation in or leveraging of shared services, such as communications systems, patient tracking systems, and other jointly used equipment and supplies by partners within the jurisdiction.

- Providing basic information on emergency preparedness and healthcare system preparedness.

ASPR TRACIE Resources

ASPR TRACIE has developed a number of general healthcare emergency preparedness and facility-specific resources that can help facilitate compliance with the rule. These resources, along with any new or updated resources, are available on the ASPR TRACIE-dedicated CMS Emergency Preparedness Rule page located at asprtracie.hhs.gov/cmsrule.

General Emergency Management Resources (listed alphabetically)

- Access and Functional Needs Topic Collection
- ASPR TRACIE Evaluation of Hazard Vulnerability Assessment Tools
- CMS Emergency Preparedness Rule General Briefing Slides (updated January 5, 2017)
- Communication Systems Topic Collection
- Continuity of Operations (COOP)/Failure Plan Topic Collection
- Crisis Standards of Care Topic Collection
- Emergency Operations Plans/Emergency Management Program Topic Collection
- Exercise Program Topic Collection
- Hazard Vulnerability/Risk Assessment Topic Collection

- Healthcare Coalition Models and Functions Topic Collection
- Information Sharing Topic Collection
- Incident Management Topic Collection
- Recovery Planning Topic Collection

Provider- and Supplier-Specific Resources

- Ambulatory Care and Federally Qualified Health Centers Topic Collection
- Dialysis Centers Topic Collection
- Homecare Topic Collection
- Long-Term Care Facilities Topic Collection

Hospital-Specific Resources
- Healthcare Facility Evaluation/Sheltering Topic Collection
- Hospital Surge Capacity and Immediate Bed Availability Topic Collection
- Hospital Victim Decontamination Topic Collection

ASPR TRACIE Technical Assistance Requests (updated February 3, 2017)

Since the rule was released on September 8, 2016, ASPR TRACIE has received more than 190 requests for technical assistance on CMS-related issues. Most of the questions asked have been addressed in this document, but Appendix A includes specific TA responses related to preparedness for Federally Qualified Health Centers and Ambulatory Surgical Centers that may be of benefit to ASPR TRACIE stakeholders. The chart below provides a summary of additional TA requests that are available in the ASPR TRACIE Information Exchange (requires a free registration).

Sample #	Summary of Request	Summary of Response
1	Requestor is seeking sample emergency operations plans and policies for a Federally Qualified Health Centers (FQHC). *Included in this document.*	The ASPR TRACIE Team provided resources specific to FQHCs in the following categories: Plans, Tools, and Templates; and Guidance Resources. Related Topic Collections: Emergency Operations Plans/ Emergency Management Program and Ambulatory Care and Federally-Qualified Health Centers.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Sample #	Summary of Request	Summary of Response
2	Requestor asked for Ambulatory Surgical Center (ASC) templates to help her organization develop or update their plans. *Included in this document.*	The ASPR TRACIE Team provided resources specific to ASCs in the following categories: Plans, Tools, and Templates; and Guidance Resources. Related Topic Collections: Emergency Operations Plans/ Emergency Management Program and Ambulatory Care and Federally-Qualified Health Centers.
3	Requestor asked for plans, templates, models, and other resources for multiple, separately certified facilities integrated under a unified emergency preparedness program. *Available on the Information Exchange.*	The ASPR TRACIE Team researched resources related to integrated health systems, including those in the Emergency Operations Plans/ Emergency Management Program Topic Collection. The ASPR TRACIE Team also reached out to several ASPR TRACIE Subject Matter Expert (SME) Cadre members for resources and feedback.
4	Requestor asked for communication plan templates to help her organization begin working on the new CMS EP Rule requirements. *Available on the Information Exchange.*	The ASPR TRACIE Team researched several emergency planning resources related to communications, including the Communication Systems Topic Collection. The resources are categorized as follows: Plans, Tools, and Templates; Guidance Resources; and Other Resources.
5	Requestor is seeking communication plans for hospice organizations, and what is the rule when it comes to HIPAA (Health Insurance Portability and Accountability Act) protection during a disaster. *Available on the Information Exchange.*	The ASPR TRACIE Team researched several emergency planning resources related to communications, as well as homecare/ hospice-specific planning resources. In addition, the ASPR TRACIE Team researched materials related to HIPAA. Additional resources related to these topics can be found in the following Topic Collections: Communication Systems , Emergency Operations Plans/ Emergency Management Program, and the Homecare and Hospice.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Sample #	Summary of Request	Summary of Response
6	Requestor asked for clarification on the difference between a HVA, BIA, and a COOP Plan in response to meeting the new CMS EP Rule requirements (Note: Several questions were asked in this TA). *Available on the Information Exchange.*	ASPR TRACIE provided definitions and clarification on the various terms, and followed up with CMS for a response.
7	Requestor asked for templates and other developed outreach materials, referencing the new CMS EP rule, to encourage new healthcare providers to join their HCC, as well as expand the involvement of current members. *Available on the Information Exchange.*	The ASPR TRACIE Team reached out to several ASPR TRACIE SME Cadre members for feedback and resources on HCC outreach/ recruitment materials.
8	Requestor is seeking Memoranda of Understanding (MOU) templates for various CMS requirements (e.g., alternate treatment sites, child care, elder care, pet care, food supply delivery, alternate sheltering of employees). *Available on the Information Exchange.*	The ASPR TRACIE Team researched and provided several resources for MOUs on various emergency preparedness topics.
9	Requestor is seeking agreement letters, Memoranda of Understanding (MOUs), and other resources for vendors in response to the new CMS EP Rule requirements. *Available on the Information Exchange.*	ASPR TRACIE researched several resources for agreement letters, MOUs, and other templates between vendors and healthcare facilities. We also reached out to CMS for a response.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Quick Links

These links provide the most critical information related to the CMS Emergency Preparedness Rule:

- Federal Register Notice CMS Final Rule
- CMS Survey and Certification Group Emergency Preparedness Program
- ASPR TRACIE CMS Resources
- CMS Emergency Preparedness Rule General Briefing Slides (Updated January 5, 2017)
- CMS At A Glance Chart with High Level Requirements by Provider Type
- 17 Provider and Supplier Type Descriptions
- CMS Frequently Asked Questions – Round 1 (updated November 2, 2016)
- CMS Frequently Asked Questions – Round 2 (updated January 5, 2017)
- CMS Frequently Asked Questions – Round 3 (updated January 5, 2017)
- CMS Frequently Asked Questions – Round 4 (updated February 3, 2017)
- CMS Frequently Asked Questions – Round 4 Definitions (updated February 3, 2017)
- Yale New Haven CMS EP Rule Accreditation Crosswalk (updated February 3, 2017)

NOTICE: ASPR TRACIE developed this Resources at Your Fingertips document to provide easy to understand information and quick references for those affected by the CMS Emergency Preparedness Rule. This document is not meant to be an exhaustive list of requirements nor should it serve as a substitute for the regulatory text, the interpretive guidance, the State Operations Manual, or consultation with State Survey Agencies and CMS.

This document will be updated regularly as new information and resources are developed.

Appendix A: Sample Technical Assistance (TA) Responses for ASCs and FQHCs

ASPR TRACIE Technical Assistance Sample 1

Request:

Requestor is seeking sample emergency operations plans and policies for a Federally Qualified Health Centers (FQHC).

Response:

The ASPR TRACIE Team researched several emergency planning resources related to FQHCs. These materials are provided in the sections below and are categorized as follows: Plans, Tools, and Templates; and Guidance Resources.

The ASPR TRACIE Team also reviewed several completed and in-progress Topic Collections, including the Emergency Operations Plans/ Emergency Management Program Topic Collection and the Ambulatory Care and Federally-Qualified Health Centers Topic Collection. A list of comprehensively developed Topic Collections can be found here: https://asprtracie.hhs.gov/technical-resources/topic-collection.

I.   Plans, Tools, and Templates

California EMS Authority and California Primary Care Association. (2004). Community Clinic and Health Center Emergency Operations Plan. California Clinic Emergency Preparedness Project.

Healthcare emergency planners can use this template to develop or maintain an existing emergency management program. The template includes the language, procedures, policies, and forms needed to create a comprehensive plan. Note: This resource is older than 10 years old, but may still be helpful.

Columbia University School of Nursing, Center for Health Policy, and New York Consortium for Emergency Preparedness Continuing Education. (2007). Emergency Preparedness Toolkit for Community Health Centers & Community Practice Sites. Arizona Alliance for Community Health Centers.

This toolkit is intended to be used by leadership of community practice sites (including community health centers, group practices, and specialty care practices) to assess vulnerability; create an emergency preparedness plan; train staff to the plan; and evaluate the staff's readiness through participation in drill and exercises. It also provides guidance and tools for connecting with local emergency management planners to better

understand how a community practice site's resources and expertise can be used during an emergency response.

Lee County, Florida, Emergency Management. (2014). [CEMP Criteria for Ambulatory Surgery Centers](#).

This checklist contains the required elements for a comprehensive emergency management plan, as well as guidance on the plan format, for ambulatory surgery centers in Florida. It may be used as a reference by other facilities to help develop their plans.

National Healthcare for the Homeless Council. (n.d.). [Community Health Center Emergency Planning Guidelines](#). (Accessed 9/2/2016.)

Emergency management staff can use this template (available in Microsoft Word) to develop community health center plans.

Palm Beach County, Florida. (2014). [Cross-Reference for Comprehensive Emergency Plan Ambulatory Surgical Centers](#).

This checklist was designed to help ambulatory surgical centers confirm that they have all required elements in their emergency operations plans to receive certification by their local emergency management agency. It may be used as a reference by other facilities to help develop their plans.

U.S. Department of Health and Human Services, Health Resources & Services Administration. (2016). [Form 10: Emergency Preparedness Report.](#)

This form, which is also part of the Health Resources & Services Administration's Health Center Program Site Visit Guide, can be used by health centers when preparing their annual emergency preparedness and management reports. The form can also serve as a short checklist of emergency preparedness activities a health center should undertake.

II. Guidance Resources

Bureau of Primary Health Care. (2016). [Draft Health Center Program Compliance Manual](#). Health Resources and Services Administration.

This draft "Compliance Manual" can help health centers understand and demonstrate compliance with Health Center Program requirements.

T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Centers for Medicare & Medicaid Services. (2015). Effective Health Care Provider Emergency Planning.

> This toolkit provides a variety of information and numerous links to resources that can assist healthcare centers in the emergency planning process. Guidance on the Centers for Medicare and Medicaid Survey and Certification Process is also provided (note: new regulations released in 2016).

Mid-Atlantic Association of Community Health Centers. (2014). Health Center Guide to Emergency Preparedness.

> This website provides an overview of, and links to resources specific to, emergency preparedness for health centers. The site also includes a "Preparedness Toolbox," which contains links to helpful resources.

National Association of Community Health Centers. (2007). Emergencies Happen: An In-Depth Guide to Emergency Management for Health Centers.

> This guide provides health centers with information and resources to assist health centers in developing and implementing an all-hazards-focused emergency management component to their established risk management program.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

ASPR TRACIE Technical Assistance Sample 2

Request:

Requestor asked for Ambulatory Surgical Center (ASC) templates to help her organization develop or update their plans.

Response:

The ASPR TRACIE Team researched several emergency planning resources related to ASC. These materials are provided in the sections below and are categorized as follows: Plans, Tools, and Templates; and Guidance Resources.

The ASPR TRACIE Team also reviewed several completed and in-progress Topic Collections, including the Emergency Operations Plans/ Emergency Management Program Topic Collection and the Ambulatory Care and Federally-Qualified Health Centers Topic Collection. A list of comprehensively developed Topic Collections can be found here: https://asprtracie.hhs.gov/technical-resources/topic-collection. https://asprtracie.hhs.gov/technical-resources/topic-collection.

I.   Plans, Tools, and Templates

California EMS Authority and California Primary Care Association. (2004). Community Clinic and Health Center Emergency Operations Plan. California Clinic Emergency Preparedness Project.

Healthcare emergency planners can use this template to develop or maintain an existing emergency management program. The template includes the language, procedures, policies, and forms needed to create a comprehensive plan. Note: This resource is older than 10 years old, but may still be helpful.

Columbia University School of Nursing, Center for Health Policy, and New York Consortium for Emergency Preparedness Continuing Education. (2007). Emergency Preparedness Toolkit for Community Health Centers & Community Practice Sites. Arizona Alliance for Community Health Centers.

This toolkit is intended to be used by leadership of community practice sites (including community health centers, group practices, and specialty care practices) to assess vulnerability; create an emergency preparedness plan; train staff to the plan; and evaluate the staff's readiness through participation in drill and exercises. It also provides guidance and tools for connecting with local emergency management planners to better

understand how a community practice site's resources and expertise can be used during an emergency response.

Lee County, Florida, Emergency Management. (2014). [CEMP Criteria for Ambulatory Surgery Centers](#).

This checklist contains the required elements for a comprehensive emergency management plan, as well as guidance on the plan format, for ambulatory surgery centers in Florida. It may be used as a reference by other facilities to help develop their plans.

National Healthcare for the Homeless Council. (n.d.). [Community Health Center Emergency Planning Guidelines](#). (Accessed 9/2/2016.)

Emergency management staff can use this template (available in Microsoft Word) to develop community health center plans.

Palm Beach County, Florida. (2014). [Cross-Reference for Comprehensive Emergency Plan Ambulatory Surgical Centers](#).

This checklist was designed to help ambulatory surgical centers confirm that they have all required elements in their emergency operations plans to receive certification by their local emergency management agency. It may be used as a reference by other facilities to help develop their plans.

U.S. Department of Health and Human Services, Health Resources & Services Administration. (2016). [Form 10: Emergency Preparedness Report.](#)

This form, which is also part of the Health Resources & Services Administration's Health Center Program Site Visit Guide, can be used by health centers when preparing their annual emergency preparedness and management reports. The form can also serve as a short checklist of emergency preparedness activities a health center should undertake.

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This draft "Compliance Manual" can help health centers understand and demonstrate compliance with Health Center Program requirements.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Centers for Medicare & Medicaid Services. (2015). Effective Health Care Provider Emergency Planning.

This toolkit provides a variety of information and numerous links to resources that can assist healthcare centers in the emergency planning process. Guidance on the Centers for Medicare and Medicaid Survey and Certification Process is also provided (note: new regulations released in 2016).

Mid-Atlantic Association of Community Health Centers. (2014). Health Center Guide to Emergency Preparedness.

This website provides an overview of, and links to resources specific to, emergency preparedness for health centers. The site also includes a "Preparedness Toolbox," which contains links to helpful resources.

National Association of Community Health Centers. (2007). Emergencies Happen: An In-Depth Guide to Emergency Management for Health Centers.

This guide provides health centers with information and resources to assist health centers in developing and implementing an all-hazards-focused emergency management component to their established risk management program.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements by Provider Type

Inpatient					
Provider Type	**Emergency Plan**	**Policies and Procedures**	**Communication Plan**	**Training and Testing**	**Additional Requirements**
Hospital	Develop a plan based on a risk assessment using an "all hazards" approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated annually.	Develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which must be reviewed and updated at least annually. System to track on-duty staff & sheltered patients during the emergency.	Develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well-coordinated within the facility, across health care providers and with state and local public health departments and emergency systems. The plan must include contact information for other hospitals and CAHs; method for sharing information and medical documentation for patients.	Develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures and provide training at least annually. Also annually participate in: • A full-scale exercise that is community- or facility-based; • An additional exercise of the facility's choice.	Generators—Develop policies and procedures that address the provision of alternate sources of energy to maintain: (1) temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; (2) emergency lighting; and (3) fire detection, extinguishing, and alarm systems.
Critical Access Hospital	*	*	*	*	Generators
Long Term Care Facility	Must account for missing residents (existing requirement).	Tracking during and **after** the emergency applies to on-duty staff and sheltered residents.	In the event of an evacuation, method to release patient information consistent with the HIPAA Privacy Rule.	*	Generators Share with resident/family/ representative appropriate information from emergency plan.
PRTF	*	Tracking during and **after** the emergency applies to on-duty staff and sheltered residents.	*	*	

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: **This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.**

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements by Provider Type

Inpatient					
Provider Type	**Emergency Plan**	**Policies and Procedures**	**Communication Plan**	**Training and Testing**	**Additional Requirements**
ICF/IID	Must account for missing residents (existing requirement).	Tracking during and after the emergency applies to on-duty staff and sheltered clients.		*(current requirement)	Share with client/family/representative appropriate information from emergency plan.
RNHCI	*	*	Does not include the requirement to coordinate with state or federally designated healthcare professionals.	No requirement to conduct drills.	
Transplant Center	*	*	*	*	Maintain agreement with transplant center & OPO.

Outpatient Providers Outpatient providers are not required to provide subsistence needs for staff and patients.					
Provider Type	**Emergency Plan**	**Policies and Procedures**	**Communication Plan**	**Training and Testing**	**Additional Requirements**
Hospice	*	In home services—inform officials of patients in need of evacuation (additional requirement). Home-based hospices not required to track staff and patients.	In home services—will not need to provide occupancy information.	*	
Ambulatory Surgical Center	*	*	Will not need to provide occupancy information. Not required to develop arrangements with other ASCs and other providers to receive patients in the event of limitations or cessation of operations. Not required to include the names and contact information for "other ASCs" in the communication plan.	Community-based drill not required.	

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: **This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.**

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements by Provider Type

Outpatient Providers					
Outpatient providers are not required to provide subsistence needs for staff and patients.					
Provider Type	Emergency Plan	Policies and Procedures	Communication Plan	Training and Testing	Additional Requirements
PACE	*	Inform officials of patients in need of evacuation (additional requirement). Tracking during and **after** the emergency applies to on-duty staff and sheltered participants.	*	*	
Home Health Agency	*	Will not require shelter in place, provision of care at alternate care sites Inform officials of patients in need of evacuation. HHAs not required to track staff and patients.	Will not need to provide occupancy information. Not required to include the names and contact information for other HHAs in the communication plan. Not required to develop arrangements with other HHAs.	*	HHAs must have policies in place for following up with patients to determine services that are still needed. In addition, they must inform State and local officials of any on-duty staff or patients that they are unable to contact.
CORF	Must develop emergency plan with assistance from fire, safety experts (existing requirement)	Will not need to provide transportation to evacuation locations, or have arrangements with other CORFs to receive patients, and not required to track staff and patients.	Will not need to provide occupancy information.	*	
CMHC	*	Tracking during and **after** the emergency applies to on-duty staff and sheltered clients.	*	*	

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: **This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.**

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements by Provider Type

Outpatient Providers Outpatient providers are not required to provide subsistence needs for staff and patients.					
Provider Type	Emergency Plan	Policies and Procedures	Communication Plan	Training and Testing	Additional Requirements
OPO	Address type of hospitals OPO has agreement (additional requirement).	Needs to have system to track staff during & after emergency and maintain medical documentation (additional requirement).	Does not need to provide occupancy info, method of sharing pt. info, providing info on general condition & location of patients.	Only tabletop exercise	Must maintain agreement with other OPOs & hospitals.
Clinics, Rehabilitation, and Therapy	Must develop emergency plan with assistance from fire, safety experts. Address location, use of alarm systems and signals & methods of containing fire (existing requirements).	*Not required to track staff and patients.	Does not need to provide occupancy information.	*	
RHC/FQHC	*	Does not have to track staff and patients, or have arrangements with other RHCs to receive patients or have alternate care sites.	Does not need to provide occupancy information.	*	

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements by Provider Type

Outpatient Providers					
Outpatient providers are not required to provide subsistence needs for staff and patients.					
Provider Type	Emergency Plan	Policies and Procedures	Communication Plan	Training and Testing	Additional Requirements
ESRD	Must contact local emergency preparedness agency annually to ensure dialysis facility's needs in an emergency (existing requirement).	Policies and procedures must include emergencies regarding fire equipment, power failures, care related emergencies, water supply interruption & natural disasters (existing requirement). Tracking during and **after** the emergency applies to on-duty staff and sheltered patients.	Does not need to provide occupancy information.	Ensure staff demonstrate knowledge of emergency procedures, informing patients what to do, where to go, whom to contact if emergency occurs while patient is not in facility (alternate emergency phone number), how to disconnect themselves from dialysis machine. Staff maintain current CPR certification, nursing staff trained in use of emergency equipment & emergency drugs, patient orientation (existing requirements).	

*Indicates that the requirements are the same as those for hospitals. Exceptions are noted for individual provider/suppliers.

NOTE: This table is an overview of the regulation with key differences summarized. This is not meant to be an exhaustive list of the requirements nor should it serve as substitute for the regulatory text.

LONG TERM CARE

EMERGENCY PREPAREDNESS WORKSHEET

1. DATE OF SURVEY	
2. NAME OF FACILITY	
3. PROVIDER NUMBER	LTC Number
4. SURVEYOR	
5. SURVEYOR ID	

TAG #	TITLE	MET	NOT MET
E - 0001	Establishment of the Emergency Program (EP)		

Reg Text: The LTC facility must comply with all applicable Federal, State and local EP requirements. The LTC facility must establish and maintain a comprehensive EP program that meets the requirements of this section.The EP program must include, but not be limited to, the following elements:

Survey Procdure: Interview facility leadership and ask them to describe the facility's EP program. Ask to see the facility's written policy and documentation on the EP program.   *Pages 5-6* (*also see page 3 for definitions*)

TAG #	TITLE	MET	NOT MET
E - 0004	Develop and Maintain EP Program		

Reg Text: (a) Emergency Plan. The LTC facility must develop and maintain an EP plan that must be reviewed, and updated at least annually.

Survey Procedure: Verify the facility has an emergency plan by asking to see a copy of the plan; Ask facility leadership to identify the hazards that were identified in the facility's risk assessment and how the risk assessment was conducted. Review plan to verify it contains all the required elements. Verify that the plan if reviewed and updated annually.   *Page 8*

TAG #	TITLE	MET	NOT MET
E - 0006	Maintain and Annual EP Updates		

Reg Text: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.

Survey Process: Ask to see the written documentation of the facility's risk assessment and associated strategies; Interview the facility leadership and ask which hazards were included in the risk assessment and why; How was the risk assessment was conducted; Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.   *Pages 10-11*

TAG #	TITLE	MET	NOT MET
E - 0007	EP Program Patient Population		

Reg Text: (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Survey Process: Interview leadership and ask them to describe the following; The facility's patient population that would be at risk in an emergency; Strategies the facility has put in place to address the needs of at risk or vulnerable patient populations; Services that the facility would be able to provide during an emergency; How the facility plans to continue operations during an emergency; and Delegations of authority and succession plans. *Page 12*

TAG #	TITLE	MET	NOT MET
E - 0009	Process for EP Collaboration		

Reg Text: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

Survey Procedure: Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, state and Federal emergency preparedness officials' efforts to ensure an intergrated response during a disaster or emergency situation. Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and coooperative planning efforts. *Pages 15-16*

TAG #	TITLE	MET	NOT MET
E - 0013	Development of EP Policies and Procedures		

Reg Text: (b) Policies and procedures. LTC facilities must develop and implement EP policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

Disclaimer: This is a work sheet to assist the survey process and is not a comprehensive listing of the requirements under the Emergency Planning requirements.

Survey Procedure: Review the written policies and procedures which address the facility's emergency plan and verify: Policies and procedures were developed based on the facility and community based risk assessment and communitcations plan, utilizing and all-hazards approach. Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis. *Pages 18-20*			

TAG #	TITLE	MET	NOT MET
E - 0015	Subsistence needs for staff and patients		

Reg Text: At a minimum, the policies and procedures must address the following:
(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

Survey Procedure: Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to food, water and pharmaceutical supplies for residents and staff by reviewing the plan. Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain: Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; emergency lighting and fire protection, extinguishing and alarm systems. Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal. *Pages 21-24*

TAG #	TITLE	MET	NOT MET
E - 0018	Procedures for Tracking of Staff and Patients		

Reg Text: (2) A system to track the location of on-duty staff and sheltered patients in the LTC facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

Survey Process: Ask the staff to describe and/or demonstrate the tracking system used to document locations of the residents and staff. Verifiy that the tracking system is documented as part of the facilities' emergency plan policies and procedures. *Pages 26-27*

TAG #	TITLE	MET	NOT MET
E - 0020	Policies and Procedures including Evacuation		

Reg Text: Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

Survey Process: Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements. *Pages 29-30*

TAG #	TITLE	MET	NOT MET
E - 0022	Policies and Procedures for Sheltering		

Reg Text: (4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.

Survey Process: Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for residents, staff and volunteers who remain in a facility. Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment. *Pages 32-33*

TAG #	TITLE	MET	NOT MET
E - 0023	Policies and Procedures for Medical Docs.		

Reg Text: (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

Survey Process: Ask to see a copy of the policies and precedures that documents the medical record documentation system the facility has developed to preserve patient information, protects confidentiality of patient information, and secures and maintains availibility of records. *Pages 32-33*

TAG #	TITLE	MET	NOT MET
E - 0024	Policies and Procedures for Volunteers		

Reg Text: (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

Survey Process: Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plans. *Pages 34-35*
(Use of PHS, DOD, NDMS, MRC members as well as ESAR-VHP members.)

Disclaimer: This is a work sheet to assist the survey process and is not a comprehensive listing of the requirements under the Emergency Planning requirements.

TAG #	TITLE	MET	NOT MET
E - 0025	Arrangement with other Facilities		

Reg Text: (7) The development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

Survey Process: Ask to see copies of the arrangements and/or any agreements the facilty has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation. *Pages 36-37*

TAG #	TITLE	MET	NOT MET
E - 0026	Roles under a Waiver Declared by Secretary		

Reg Text: (8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

Survey Process: Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate sites under an 1135 wavier. *Pages 36-37*

TAG #	TITLE	MET	NOT MET
E - 0029	Development of Communication Plan		

Reg Text: (c) The LTC facility must develop and maintain an EP communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.

Survey Process: Verify that the facility has a written communications plan by asking to see the plan. Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis. *Page 40-41*

TAG #	TITLE	MET	NOT MET
E - 0030	Names and Contact Information		

Reg Text: The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Residents' physicians
(iv) Other LTC facilities.
(v) Volunteers.

Survey Process: Verify that all required contacts are included in the communications plan by asking to see a list of the contacts with their contact information. Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review. *Pages 43-44*

TAG #	TITLE	MET	NOT MET
E - 0031	Emergency Officials Contact Information		

Reg Text: (2) Contact information for the following: (i)
Federal, State, tribal, regional, or local emergency preparedness staff.
(ii) The State Licensing and Certification Agency.
(iii) The Office of the State Long-Term Care Ombudsman.
(iv) Other sources of assistance.

Survey Process: Verify that all required contacts are included in the communications plan by asking to see a list of the contacts with their contact information. Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review. *Pages 44-45*

TAG #	TITLE	MET	NOT MET
E - 0032	Primary/Alternate Means for Communication		

Reg Text: (3) Primary and alternate means for communicating with the following:
(i) LTC facility's staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

Survey Process: Verify the communications plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal and local emergency management agencies by reviewing the communications plan. Ask to see the communications equipment or communications systems listed in the plan. *Pages 45-46*

Disclaimer: This is a work sheet to assist the survey process and is not a comprehensive listing of the requirements under the Emergency Planning requirements.

TAG #	TITLE	MET	NOT MET
E - 0033	Methods for Sharing Information		

Reg Text: (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health providers to maintain the continuity of care.
(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).
(6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4).

Survey Process: Verify the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity o f care by reviewing the communications plan. Verify the facility has developed policies and procedures that addresss the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communications plan.   *Pages 46-47*

TAG #	TITLE	MET	NOT MET
E - 0034	Sharing Information on Occupancy/Needs		

Reg Text: (7) A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Survey Process: Verify the communications plan includes a means of provicing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdication, the Incident Command Center, or designee by reviewing the communication plan. For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.
Pages 48-50

TAG #	TITLE	MET	NOT MET
E - 0035	LTC and ICF/IID Family Notifications		

Reg Text: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives.

Survey Process: • Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with the residents or clients and their families or representatives. • Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan. • Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.   *Page 50-51*

TAG #	TITLE	MET	NOT MET
E - 0036	Emergency Prep Training and Testing		

Reg Text: (d) Training and testing. The LTC facility must develop and maintain an EP training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

Survey Process: Verify that the facility has a written training and testing program that meets the requirements of the regulation. Verify the program has been reviewed and updated on, at least, an annual basis by asking for coumentation of the annual review as well as any updates made. Verifiy that ICF/IID emergency plans also meet the requirements for evacuaton drills and training at 483.470(i).   *Pages 50-51*

TAG #	TITLE	MET	NOT MET
E - 0037	Emergency Prep Training Program		

Reg Text: (1) Training program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide EP training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

Survey Process: Ask for copies of the facility's initial emergency preparedness, training and annual emergency preparedness training offerings. Interview various staff and ask questions regarding the faccility's initial and annual training course, to verify staff knowledge of emergenccy procedures. Review a sample of staff training files to verify staff have recieved initial and annual emergency preparednesss training.   *Pages 53-56*

Disclaimer: This is a work sheet to assist the survey process and is not a comprehensive listing of the requirements under the Emergency Planning requirements.

TAG #	TITLE	MET	NOT MET
E - 0039	Emergency Prep Testing Requirements		

Reg Text: (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:
(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.

Survey Process: Ask to see ddocumentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise). Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e., date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise). Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.
Pages 59-61

TAG #	TITLE	MET	NOT MET
E - 0041	Hospital CAH and LTC Emergency Power		

Reg Text: (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.
(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99), Life Safety Code (NFPA 101), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.
(e)(2) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.
(e)(3) Emergency generator fuel. LTC facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

Survey Process: Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures.
• Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place?
• For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed
• For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations.
• Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.   *Pages 63-67*

TAG #	TITLE	MET	NOT MET
E - 0042	Integrated Health Systems		

Reg Text: (f) Integrated healthcare systems. If a LTC facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the LTC facility may choose to participate in the healthcare system's coordinated emergency preparedness program.
If elected, the unified and integrated EP program must do all of the following:
(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated EPprogram.
(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated EP program and is in compliance with the program.
(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:
(i) A documented community-based risk assessment, utilizing an all-hazards approach.
(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Survey Process: • Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program. • Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program. • Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates. • Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program). • Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.
Pages: 67-70

E-0001

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

§483.73 Emergency preparedness.

The LTC facility must comply with all applicable Federal, State and local emergency preparedness requirements. The LTC facility must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

Interpretive Guidelines

Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually.

A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning based on the "all-hazards" definition and specific to the location of the facility. For instance, a facility in a large flood zone, or tornado prone region, should have included these elements in their overall planning in order to meet the health, safety, and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, facilities should have an approach to address these challenges during emergency events. The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan.

Survey Procedures

- Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program.
- Ask to see the facility's written policy and documentation on the emergency preparedness program.
- For hospitals and CAHs only: Verify the hospital's or CAH's program was developed based on an all-hazards approach by asking their leadership to describe how the facility used an all-hazards approach when developing its program.

E-0004

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(a) Emergency plan.

The LTC facility must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. The plan must do the following:

Interpretive Guidelines

Facilities are required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the standard. The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion.

An emergency plan is one part of a facility's emergency preparedness program. The plan provides the framework, which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency. In addition, the emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to:

- Natural disasters;
- Man-made disasters;
- Facility-based disasters that include but are not limited to:
  - Care-related emergencies;
  - Equipment and utility failures, including but not limited to power, water, gas, etc.;
  - Interruptions in communication, including cyber-attacks;
  - Loss of all or portion of a facility; and
  - Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable).

When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration.

Survey Procedures

- Verify the facility has an emergency preparedness plan by asking to see a copy of the plan.
- Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted.
- Review the plan to verify it contains all of the required elements.

● Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review.

E-0006

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

Interpretive Guidelines

Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region such as wildfires, tornadoes, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies. Facilities are encouraged to utilize the concepts outlined in the National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ).

"Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency.

Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment.

When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following:

- Identification of all business functions essential to the facility's operations that should be continued during an emergency;
- Identification of all risks or emergencies that the facility may reasonably expect to confront;
- Identification of all contingencies for which the facility should plan;
- Consideration of the facility's location;
- Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and,

- Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

In situations where the facility does not own the structure(s) where care is provided, it is the facility's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted.

For LTC facilities and ICF/IIDs, written plans and the procedures are required to also include missing residents and clients, respectively, within their emergency plans.

Facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency. Facilities will also want to consider evacuation plans. For example, a facility in a large metropolitan city may plan to utilize the support of other large community facilities as alternate care sites for its patients if the facility needs to be evacuated. The facility is also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive patients.

Hospices must include contingencies for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

Survey Procedures

- Ask to see the written documentation of the facility's risk assessments and associated strategies.
- Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
- Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.

E-0007

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Interpretive Guidelines

The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk, except for plans of ASCs, hospices, PACE organizations, HHAs, CORFs, CMHCs, RHCs/FQHCs and ESRD facilities. As defined by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the PAHPA (children, senior citizens, and pregnant women), "at-risk populations" are also individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children.

Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. For outpatient facilities, such as Home Health Agencies (HHAs), the emergency plan is required to ensure that patients with limited mobility are addressed within the plan.

The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility."

In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to

and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

Survey Procedures

Interview leadership and ask them to describe the following:

- The facility's patient populations that would be at risk during an emergency event;
- Strategies the facility (except for an ASC, hospice, PACE organization, HHA, CORF, CMHC, RHC/FQHC and ESRD facility) has put in place to address the needs of at-risk or vulnerable patient populations;
- Services the facility would be able to provide during an emergency;
- How the facility plans to continue operations during an emergency;
- Delegations of authority and succession plans.

Verify that all of the above are included in the written emergency plan.

E-0009

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

Interpretive Guidelines

While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The facility must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources.

For ESRD facilities, §494.120(c)(2) of the ESRD Conditions for Coverage on Special Purpose Dialysis Facilities describes the requirements for ESRD facilities that are set up in an emergency (i.e., an emergency circumstance facility) which are issued a unique CMS Certification Number (CCN). ESRD facilities must incorporate these specific provisions into the coordination requirements under this standard.

Survey Procedures

Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation.

- Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.
- For ESRD facilities, ask to see documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency.

E-0013

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(b) Policies and procedures.

The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

Interpretive Guidelines

Facilities must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program.

We are not specifying where the facility must have the emergency preparedness policies and procedures. A facility may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. However, the facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures) to facilitate review.

Survey Procedures

Review the written policies and procedures which address the facility's emergency plan and verify the following:

- Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach.
- Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.

E-0015

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water, medical, and pharmaceutical supplies

(ii) Alternate sources of energy to maintain the following:

(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(B) Emergency lighting.

(C) Fire detection, extinguishing, and alarm systems.

(D) Sewage and waste disposal.

Interpretive Guidelines

Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter.

Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions.

This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482.15(e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements.

Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source.

If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.

As an example, some ESRD facilities have contracted services with companies who maintain portable emergency generators for the facilities off-site. In the event of an emergency where the facility is unable to reschedule patients or evacuate, the generators are brought to the location in advance to assist in the event of loss of power. Facilities which are not specifically required by the EP Final Rule to have a generator, but are required to meet the provision for alternate sources of energy, may consider this approach for their facility.

Facilities are encouraged to confer with local health department and emergency management officials, as well as healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly.

Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, ESRD facilities under current CfCs at §494.40(a)(4) are also required to have policies and procedures for handling, storage and disposal of potentially infectious waste. We are not specifying any required provisions regarding treatment of sewage and necessary services under this tag; however, facilities are required to follow their current facility-type requirements (e.g., CoPs/CfCs, Requirements) which may address these areas. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

Survey Procedures

- Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan.
- Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:
  - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;
  - Emergency lighting; and,
  - Fire detection, extinguishing, and alarm systems.
- Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal.

E-0018

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

Interpretive Guidelines

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

CMHCs, PRTF's, LTC facilities, ICF/IIDs, PACE organizations and ESRD Facilities are required to track the location of sheltered patients and staff during and after an emergency.

We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages. The tracking systems set up by facilities may want to consider who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation. A number of states already have such tracking systems in place or under development and the systems are available for use by health care providers and suppliers. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients.

Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts.

NOTE: If an ASC is able to cancel surgeries and close (meaning there are no patients or staff in the ASC), this requirement of tracking patients and staff would no longer be applicable. Similarly to ESRD standard practices, if an emergency was imminent and able to be predicted (i.e. inclement weather conditions, etc.) we would expect that ASCs cancel surgeries and cease operations, which would eliminate the need to track patients and staff.

Survey Procedures

- Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff.
- Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

E-0020

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

Interpretive Guidelines

Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. RHCs and FQHCs must also place exit signs to guide patients and staff in the event of an evacuation from the facility.

Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment enroute to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services.

Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations.

Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and not dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch-bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be who (specifically) will be tasked with making triage decisions.

Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching a hard copy of a standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. Another method for communicating this information, a facility could consider color coordination of triage levels (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information.

Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance. For instance, primary methods may be via regular telephone services to contact transportation companies for evacuation or reporting

evacuation needs to emergency officials; whereas alternate means account for loss of power or telephone services in the local area. In this event, alternate means may include satellite phones for contacting evacuation assistance.

Survey Procedures

- Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.
- When surveying an RHC or FQHC, verify that exit signs are placed in the appropriate locations to facilitate a safe evacuation.

E-0022

(4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.

Interpretive Guidelines

Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. In certain disaster situations (such as tornadoes) sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment.

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

Survey Procedures

- Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility.
- Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment.

E-0023

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

Interpretive Guidelines

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

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.

E-0024

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

Interpretive Guidelines

During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals. Facilities are also encouraged to collaborate with State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).

Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.

Survey Procedures

● Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan.

E-0025

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(7) The development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to LTC facility patients.

Interpretive Guidelines

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

For RNHCIs, at §403.748(b)(7), the term "non-medical" is added in order to accommodate the uniqueness of the RNHCI non-medical care.

Survey Procedures

- Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency.
- Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation.

E-0026

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

Interpretive Guidelines

Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.

Policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency. Examples of 1135 waivers include some of the existing CoPs; Licensure for Physicians or others to provide services in the affected State; EMTALA; Medicare Advantage out of network providers and HIPAA.

Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary. For example, if due to a mass casualty incident in a geographic location, an 1135 waiver may be granted to waive licensure for physicians in order for these individuals to assist at a specific facility where they do not normally practice, then the facility should have policies and procedures which outline the responsibilities during the duration of this waiver period. For instance, the policies may establish a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility.

Additionally, facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc.

For additional 1135 Waiver information, refer to the SCG Emergency Preparedness Website.

Survey Procedures

- Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment (except for RNHCI, for care only) at alternate care sites under an 1135 waiver.

E-0029

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

Interpretive Guidelines

Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan.

Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if a facility is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods facilities may consider include satellite phones, radios and short wave radios.

Survey Procedures

● Verify that the facility has a written communication plan by asking to see the plan.
● Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis.

E-0030

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other LTC facilities.

(v) Volunteers.

Interpretive Guidelines

A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. For instance, hospitals should have contact information for other hospitals and CORFs should have contact information for other CORFs, etc. While not required, facilities may also find it prudent to have contact information for other facilities not of the same type. For instance a hospital may find it appropriate to have the contact information of LTC facilities within a reasonable geographic area, which could assist in facilitating patient transfers. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list.

Transplant Centers should be included in the development of the hospitals communication plans. In the case of a Medicare-approved transplant center, a communication plan needs to be developed and disseminated between the hospitals, OPO, and transplant patients. For example, if the transplant program is planning to transfer patients to another transplant center due to an emergency, the communication plan between the hospitals, the OPO, and the patient should include the responsibilities of each of the facility types to ensure continuity of care. During an emergency, should an organ offer become available at the time the patient is at the "transferred hospital," the OPO's emergency preparedness communication plan should address how this information will be communicated to both the OPO and the patient of where their care will be continued.

Survey Procedures

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

E-0031

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(2) Contact information for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) The State Licensing and Certification Agency.

(iii) The Office of the State Long-Term Care Ombudsman.

(iv) Other sources of assistance.

Interpretive Guidelines

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

Survey Procedures

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

E-0032

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(3) Primary and alternate means for communicating with the following:

(i) LTC facility's staff.

(ii) Federal, State, tribal, regional, or local emergency management agencies.

Interpretive Guidelines

Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency.

The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies. For example, if State X local emergency officials use the SHAred RESources (SHARES) High Frequency (HF) Radio program and facility Y is trying to communicate with RACES, it may be prudent to consider if these two alternate communication systems can communicate on the same frequencies.

Facilities may seek information about the National Communication System (NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations.

Survey Procedures

- Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan.
- Ask to see the communications equipment or communication systems listed in the plan.

E-0033

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(4) A method for sharing information and medical documentation for patients under the LTC facility's care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

Interpretive Guidelines

Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information.

Facilities (with the exception of HHAs, RHCs/FQHCs, and CORFs) are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Thus, facilities must have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted under 45 CFR 164.510(b)(4), to family members and others. Facilities have the flexibility to develop and maintain their own system in a manner that best meets its needs.

HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes. Section 164.510 "Uses and disclosures requiring an opportunity for the individual to agree to or to object," is part of the "Standards for Privacy of Individually Identifiable Health Information," commonly known as "The Privacy Rule." HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), "Use and disclosures for disaster relief purposes," establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient's location or general condition.

Survey Procedures

- Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan.
  - For RNCHIs, verify that the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative.
- Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan.

E-0034

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(7) A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Interpretive Guidelines

Facilities, except for transplant centers, must have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy.

Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The facility should consider how its occupancy affects its ability to provide assistance. For example, if the facility's occupancy is close to 100% the facility may not be able to accept patients from nearby facilities.The types of "needs" a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc.

NOTE: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident Command Center or state-wide coordination of the disaster would likely be a fire-related agency.

We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information.

NOTE: As defined by the Federal Emergency Management Administration (FEMA), an Incident Command System (ICS) is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. (FEMA, 2016). The industry, as well as providers/suppliers, use various terms to refer to the same function and we have used the term "Incident Command Center" to mean "Emergency Operations Center" or "Incident Command Post." Local, State, Tribal and Federal emergency preparedness officials, as well as regional healthcare coalitions, can assist facilities in the identification of their Incident Command Centers and reporting requirements dependent on an emergency.

Survey Procedures

- Verify the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan.
- For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.

E-0035

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives.

Interpretive Guidelines

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

Survey Procedures

- Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives.
- Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan.
- Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.

E-0036

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

Interpretive Guidelines

An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location.

Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement.

Survey Procedures

- Verify that the facility has a written training and testing (and for ESRD facilities, a patient orientation) program that meets the requirements of the regulation.
- Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made.
- Verify that ICF/IID emergency plans also meet the requirements for evacuation drills and training at §483.470(i).

E-0037

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(1) Training program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency preparedness training.

(iv) Demonstrate staff knowledge of emergency procedures.

Interpretive Guidelines

Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency.

PACE organizations and CAHs have additional requirements. PACE organizations must also provide initial training to contractors and PACE participants. CAHs must also include initial training on the following: prompt reporting and extinguishing of fires; protection; and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities.

Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location.

Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review.

While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties

during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements.

Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures.

Survey Procedures

- Ask for copies of the facility's initial emergency preparedness training and annual emergency preparedness training offerings.
- Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures.
- Review a sample of staff training files to verify staff have received initial and annual emergency preparedness training.

E-0039

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event:

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.

Interpretive Guidelines

Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available. As the term full-scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community. A full-scale exercise is also an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements. There is also definition for "community" as it is subject to variation based on geographic setting, (e.g. rural, suburban, urban, etc.), state and local agency roles and responsibilities, types of providers in a given area in addition to other factors. In doing so, facilities have the flexibility to participate in and conduct exercises that more realistically reflect the risks and composition of their communities. Facilities are expected to consider their physical location, agency and other facility responsibilities and needs of the community when planning or participating in their exercises. The term could, however, mean entities within a state or multi-state region.

In many areas of the country, State and local agencies (emergency management agencies and health departments) and some regional entities, such as healthcare coalitions may conduct an annual full-scale, community-based exercise in an effort to more broadly assess community-wide emergency planning, potential gaps, and the integration of response capabilities in an emergency. Facilities should actively engage these entities to identify potential opportunities, as appropriate, as they offer the facility the opportunity to not only assess their emergency plan but also better

understand how they can contribute to, coordinate with, and integrate into the broader community's response during an emergency. They also provide a collective forum for assessing their communications plans to ensure they have the appropriate contacts and understand how best to engage and communicate with their state and local public health and emergency management agencies and other relevant partners, such as a local healthcare coalition, during an emergency.

Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. It is also important to note that agencies and or healthcare coalitions conducting these exercises will not have the resources to fulfill individual facility requirements and thus will only serve as a conduit for broader community engagement and coordination prior to, during and after the full-scale community-based exercise. Facilities are responsible for resourcing their participation and ensuring that all requisite documentation is developed and available to demonstrate their compliance with this requirement.

Facilities are encouraged to engage with their area Health Care Coalitions (HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities. Health Care Coalitions (HCCs) are groups of individual health care and response organizations who collaborate to ensure each member has what it needs to respond to emergencies and planned events. HCCs plan and conduct coordinated exercises to assess the health care delivery systems readiness. There is value in participating in HCCs for participating in strategic planning, information sharing and resource coordination. HCC's do not coordinate individual facility exercises, but rather serve as a conduit to provide an opportunity for other provider types to participate in an exercise. HCCs should communicate exercise plans with local and state emergency preparedness agencies and HCCs will benefit the entire community's preparedness. In addition, CMS does not regulate state and local government disaster planning agencies. It is the sole responsibility of the facility to be in compliance.

Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities. Facilities that elect to develop a small community-based exercise have the opportunity to not only assess their own emergency preparedness plans but also better understand the whole community's needs, identify critical interdependencies and or gaps and potentially minimize the financial impact of this requirement. For example, a LTC facility, a hospital, an ESRD facility, and a home health agency, all within a given area, could conduct a small community-based exercise to assess their individual facility plans and identify interdependencies that may impact facility evacuations and or address potential surge scenarios due to a prolonged disruption in dialysis and home health care services. Those that elect to conduct a community-based exercise should make an effort to contact their local/state emergency officials and healthcare coalitions, where appropriate, and offer them the opportunity to attend as they can provide valuable insight into the broader emergency planning and response activities in their given area.

Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment. For example, an inpatient facility might test their policies and procedures for a flood that may require the evacuation of patients to an external site or to an internal safe "shelter-in-place" location (e.g. foyer, cafeteria, etc.) and include requirements for patients with access and functional needs and potential dependencies on life-saving electricity-dependent medical equipment. An outpatient facility, such as a home health provider, might test its policies and procedures for a flood that may require it to rapidly locate its

on-duty staff, assess the acuity of its patients to determine those that may be able to shelter-in-place or require hospital admission, communicate potential evacuation needs to local agencies, and provide medical information to support the patient's continuity of care.

Each facility is responsible for documenting their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years.   Facilities should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program. Facilities may complete an after action review process to help them develop an actionable after action report (AAR). The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine 1) what was supposed to happen; 2) what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement. Lastly, facilities that are a part of a healthcare system, can elect to participate in their system's integrated and unified emergency preparedness program and exercises. However, those that do will still be responsible for documenting and demonstrating their individual facility's compliance with the exercise and training requirements.

Finally, an actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirements and exempts the facility for engaging in the required exercises for one year following the actual event; and facility's must be able to demonstrate this through written documentation.

For additional information and tools, please visit the CMS Survey & Certification Emergency Preparedness website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html or ASPR TRACIE.

Survey Procedures

- Ask to see documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise.
- Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise).
- Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.

E-0041

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(e) Emergency and standby power systems. The LTC facility must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12- 5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

(3) Emergency generator fuel. LTC facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/ federal_register/code_of_federal_ regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

Interpretive Guidelines §483.73(e)

NOTE: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply. **However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance.**

Emergency and standby power systems

CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – Life Safety Code (LSC) and the 2012 edition of the NFPA 99 – Health Care Facilities Code in accordance with the Final Rule (CMS–3277–F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator. (**NOTE:** LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM). In addition, NFPA 99 identifies the 2010 edition of NFPA 110 – Standard for Emergency and Standby Power Systems as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements.

In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are not limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.

NFPA 99 contains emergency power requirements for emergency lighting, fire detection systems, extinguishing systems, and alarm systems. But, NFPA 99 does not specify emergency power requirements for maintaining supplies, and facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. In addition, NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room(s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated. Therefore, EES in Hospitals, CAHs and LTC facilities should include consideration for design to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies and procedures, unless the facility's emergency plans, policies and procedures required under paragraph (a) and paragraph (b)(1)(i) and (ii) of this section determine

that the hospital, CAH or LTC facility will relocate patients internally or evacuate in the event of an emergency. Facilities may plan to evacuate all patients, or choose to relocate internally only patients located in certain locations of the facility based on the ability to meet emergency power requirements in certain locations. For example, a hospital that has the ability to maintain temperature requirements in 50 percent of the inpatient locations during a power outage, may develop an emergency plan that includes bringing in alternate power, heating and/or cooling capabilities, and the partial relocation or evacuation of patients during a power outage instead of installing additional power sources to maintain temperatures in all inpatient locations. Or a LTC facility may decide to relocate residents to a part of the facility, such as a dining or activities room, where the facility can maintain the proper temperature requirements rather than the maintaining temperature within the entire facility. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Emergency generator location

NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location. NFPA 110 requires that EPSS equipment, including generators, to be designed and located to minimize damage (e.g., flooding). NFPA 110 requires emergency power supply systems to be permanently attached, therefore portable and mobile generators would not be permitted as an option to provide or supplement emergency power to Hospitals, CAHs or LTC facilities.

Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the EPSS equipment is in a location to minimize damage.

Emergency generator inspection and testing

NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8.

Emergency generator fuel

NFPA 110 permits fuel sources for generators to be liquid petroleum products (e.g., gas, diesel), liquefied petroleum gas (e.g., propane) and natural or synthetic gas (e.g., natural gas). Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being "other time, in hours, as required by application, code or user." However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site (e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel source sufficient to allow full output of the ESS for the specified class.

The Emergency Preparedness Final Rule requires Hospitals, CAHs and LTC facilities that maintain onsite fuel sources (e.g., gas, diesel, propane) to have a plan to keep the EES operational

for the duration of emergencies as defined by the facilities emergency plan, policy and procedures, unless it evacuates. This would include maintaining fuel onsite to maintain generator operation or it could include making arrangements for fuel delivery for an emergency event. If fuel is to be delivered during an emergency event, planning should consider limitations and delays that may impact fuel delivery during an event. In addition, planning should ensure that arranged fuel supply sources will not be limited by other community demands during the same emergency event. In instances when a facility maintains onsite fuel sources and plans to evacuate during an emergency, a sufficient amount of onsite fuel should be maintained to keep the EES operational until such time the building is evacuated.

Survey Procedures

- Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures
- Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place?
- For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed

For hospitals, CAHs and LTC facilities with generators:

- For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations.
- Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

E-0042

(Rev. 169, Issued: 06-09-17, Effective: 06-09-17, Implementation: 06-09-17)

(f) Integrated healthcare systems. If a LTC facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the LTC facility may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Interpretive Guidelines

Healthcare systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the healthcare system instead of each facility developing a separate emergency preparedness program. If an integrated healthcare system chooses this option, each certified facility in the system may elect to participate in the system's unified and integrated emergency program or develop its own separate emergency preparedness program. It is important to understand that healthcare systems are not required to develop a unified and integrated emergency program. Rather it is a permissible option. In addition, the separately certified facilities within the healthcare system are not required to participate in the unified and integrated emergency preparedness program. It is simply an option for each facility. If this option is taken, the healthcare system's unified emergency preparedness program should be updated each time a facility enters or leaves the healthcare system's program.

If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program. Therefore, each facility should designate personnel who will collaborate with the healthcare system to develop the plan. The unified and integrated plan should include

documentation that verifies each facility participated in the development of the plan. This could include the names of personnel at each facility who assisted in the development of the plan and the minutes from planning meetings. All components of the emergency preparedness program that are required to be reviewed and updated at least annually must include all participating facilities. Again, each facility must be able to prove that it was involved in the annual reviews and updates of the program. The healthcare system and each facility must document each facility's active involvement with the reviews and updates, as applicable.

A unified program must be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered at each facility participating in the integrated program. For example, for a unified plan covering both a hospital and a LTC facility, the emergency plan must account for the residents in the LTC facility as well as those patients within a hospital, while taking into consideration the difference in services that are provided at a LTC facility and a hospital. The unique circumstances that should be addressed at each facility would include anything that would impact operations during an emergency, such as the location of the facility, resources such as the availability of staffing, medical supplies, subsistence, patients' and residents' varying acuity and mobility at the different types of facilities in a unified healthcare system, etc.

Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency preparedness program and demonstrate compliance with all emergency preparedness requirements at the individual facility level. Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility.

The unified emergency preparedness program must include a documented community–based risk assessment and an individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. This is especially important if the facilities in a healthcare system are located across a large geographic area with differing weather conditions.

Lastly, the unified program must have a coordinated communication plan and training and testing program. For example, if the unified emergency program incorporates a central point of contact at the "system" level who assists in coordination and outlined within its individual plan.

This type of integrated healthcare system emergency program should focus the training and exercises to ensure communication plans and reporting mechanisms are seamless to the emergency management officials at state and local levels to avoid potential miscommunications between the system and the multiple facilities under its control.

The training and testing program in a unified emergency preparedness program must be developed considering all of the requirements of each facility type. For example, if a healthcare system includes, hospitals, LTC facilities, ESRD facilities and ASCs, then the unified training and testing programs must meet all of the specific regulatory requirements for each of these facility types.

Because of the many different configurations of healthcare systems, from the different types of facilities in the system, to the varied locations of the facilities, it is not possible to specify how unified training and testing programs should be developed. There is no "one size fits all" model that can be prescribed. However, if the system decides to develop a unified and integrated training and testing program, the training and testing must be developed based on the community and facility based hazards assessments at each facility that is participating in the unified emergency preparedness program. Each facility must maintain individual training records of staff and records of all required training exercises.

Survey Procedures

- Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program.
- Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program.
- Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates.
- Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).
- Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.

FLS

HOW TO RESPOND
TO AN ACTIVE SHOOTER IN THE FACILITY

QUICKLY DETERMINE THE MOST REASONABLE WAY TO PROTECT YOUR OWN LIFE. PATIENTS, RESIDENTS AND VISITORS ARE LIKELY TO FOLLOW THE LEAD OF EMPLOYEES AND MANAGERS DURING AN ACTIVE SHOOTER SITUATION.

1. GET OUT	2. HIDE OUT	3. KEEP OUT	4. TAKE OUT
• *Exit quickly as possible*	• *Inconspicuous places*	• *Locks / deadbolts*	• *Use as last resort*
• *Leave belongings behind*	• *Cover yourself*	• *Big, heavy things*	• *Commit to the act*
• *Encourage others to go*	• *Call 9-1-1 is possible*	• *Lots of smaller things*	• *Act with aggression*
• *Stay focused*	• *Stay focused*	• *Once secure, call 9-1-1*	• *Focus on survival*
• *When safe, call 9-1-1*	• *Remain still*		

WHEN LAW ENFORCEMENT ARRIVES:

1. HOW YOU SHOULD REACT WHEN LAW ENFORCEMENT ARRIVES:

• *Remain calm, follow instructions*

• *Keep hands over head, fingers spread*

• *Keep hands visible at all times*

• *Avoid yelling, screaming or pointing*

• *Do not attempt to talk to officers or ask questions*

• *Do not make any quick movements towards officers*

2. INFORMATION TO PROVIDE TO LAW ENFORCEMENT OR 9-1-1 OPERATOR:

• *Location of facility name and address*

• *Location of shooter*

• *Number of shooters, if known*

• *Number of victims, if known*

• *Your name*

• *Number and types of weapons shooter has*

• *Clothing description of shooter(s)*

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0001	Establishment of the Emergency Program (EP)	§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.22, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12	The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The facility must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.	Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually. A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning based on the "all-hazards" definition and specific to the location of the facility. For instance, a facility in a large flood zone, or tornado prone region, should have included these elements in their overall planning in order to meet the health, safety, and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, facilities should have an approach to address these challenges during emergency events. The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan. Survey Procedures • Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program. • Ask to see the facility's written policy and documentation on the emergency preparedness program.

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0004	Develop and Maintain EP Program	§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.22(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).	The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The facility must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	Facilities are required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the standard. The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion. An emergency plan is one part of a facility's emergency preparedness program. The plan provides the framework, which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency. In addition, the emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to: • Natural disasters • Man-made disasters, • Facility-based disasters that include but are not limited to: o Care-related emergencies; o Equipment and utility failures, including but not limited to power, water, gas, etc.; o Interruptions in communication, including cyber-attacks; o Loss of all or portion of a facility; and o Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable). When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration. Survey Procedures • Verify the facility has an emergency preparedness plan by asking to see a copy of the plan. • Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted. • Review the plan to verify it contains all of the required elements. • Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review.

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0006	Maintain and Annual EP Updates	§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.22(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)	[(a) Emergency Plan. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.	Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region such as wildfires, tornados, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies. Facilities are encouraged to utilize the concepts outlined in the National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ). "Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency. Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment. When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following: • Identification of all business functions essential to the facility's operations that should be continued during an emergency; • Identification of all risks or emergencies that the facility may reasonably expect to confront; • Identification of all contingencies for which the facility should plan; • Consideration of the facility's location; • Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and, • Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

| 0006 | | | | In situations where the facility does not own the structure(s) where care is provided, it is the facility's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted.

For LTC facilities and ICF/IIDs, written plans and the procedures are required to also include missing residents and clients, respectively, within their emergency plans.

Facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency. Facilities will also want to consider evacuation plans. For example, a facility in a large metropolitan city may plan to utilize the support of other large community facilities as alternate care sites for its patients if the facility needs to be evacuated. The facility is also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive patients

Survey Procedures
• Ask to see the written documentation of the facility's risk assessments and associated strategies.
• Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
• Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards. |

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0007	EP Program Patient Population	§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.22(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).	[(a) Emergency Plan. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk, except for plans of ASCs, hospices, PACE organizations, HHAs, CORFs, CMHCs, RHCs, FQHCs and ESRD facilities. As defined by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the PAHPA (children, senior citizens, and pregnant women), "at-risk populations" are also individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children. Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. For outpatient facilities, such as Home Health Agencies (HHAs), the emergency plan is required to ensure that patients with limited mobility are addressed within the plan. The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility." In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection,

0007				alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations. Survey Procedures Interview leadership and ask them to describe the following: • The facility's patient populations that would be at risk during an emergency event; • Strategies the facility (except for an ASC, hospice, PACE organization, HHA, CORF, CMHC, RHC, FQHC and ESRD facility) has put in place to address the needs of at-risk or vulnerable patient populations; • Services the facility would be able to provide during an emergency; • How the facility plans to continue operations during an emergency; • Delegations of authority and succession plans. Verify that all of the above are included in the written emergency plan.

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0009	Process for EP Collaboration	§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.22(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)	[(a) Emergency Plan. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. **	While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The facility must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources. Survey Procedures Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. • Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

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0013	Development of EP Policies and Procedures	§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.22(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).	(b) Policies and procedures. Facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	Facilities must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program. We are not specifying where the facility must have the emergency preparedness policies and procedures. A facility may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. However, the facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures) to facilitate review. Survey Procedures Review the written policies and procedures which address the facility's emergency plan and verify the following: • Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. • Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.

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0015	Subsistence needs for staff and patients	§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)	[(b) Policies and procedures. Facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter. Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions. This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482.15(e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements. Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source. If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent

| 0015 | | | | generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.

As an example, some ESRD facilities have contracted services with companies who maintain portable emergency generators for the facilities off-site. In the event of an emergency where the facility is unable to reschedule patients or evacuate, the generators are brought to the location in advance to assist in the event of loss of power. Facilities who are not specifically required by the EP Final Rule to have a generator, but are required to meet provision for an alternate sources of energy, may consider this approach for their facility.

Facilities are encouraged to confer with local health department and emergency management officials, as well as and healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly.

Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, ESRD facilities under current CfCs at §494.40(a)(4) are also required to have policies and procedures for handling, storage and disposal of potentially infectious waste. We are not specifying any required provisions regarding treatment of sewage and necessary services under this tag; however, facilities are required to follow their current facility-type requirements (e.g., CoPs/CfCs, Requirements) which may address these areas. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

Survey Procedures
• Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan.
• Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:
o Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; |
|---|---|---|---|---|

0015				o Emergency lighting; and, o Fire detection, extinguishing, and alarm systems. • Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0018	Procedures for Tracking of Staff and Patients	§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).	(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or	Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency. CMHCs, PRTF's, LTC facilities, ICF/IIDs, PACE organizations and ESRD Facilities are required to track the location of sheltered patients and staff during and after an emergency. We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages. The tracking systems set up by facilities may want to consider who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation. A number of states already have such tracking systems in place or under development and the systems are available for use by health care providers and suppliers. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients. Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts. Survey Procedures • Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. • Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

0018			other location.	
			Interpretive Guidelines applies to: §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).	

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0020	Policies and Procedures including Evacuation	§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)	[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment enroute to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services. Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations. Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch-bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be who (specifically) will be tasked with making triage decisions. Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching hard copy of standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. On the same method for communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients,

0020				etc.). Additionally, this hard copy could include family member/representative contact information.

Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance. For instance, primarily methods may be considered via regular telephone services to contact transportation companies for evacuation or reporting evacuation needs to emergency officials; whereas alternate means account for loss of power or telephone services in the local area. In this event, alternate means may include satellite phones for contacting evacuation assistance.

Survey Procedures
• Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.

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0022	Policies and Procedures for Sheltering	§403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).	(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.	Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. . In certain disaster situations (such as tornadoes) , sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment. Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff. Survey Procedures • Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility. • Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment.

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0023	Policies and Procedures for Medical Documents	§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.22(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).	[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. This requirement does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this standard adds to such policies and procedures. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information. 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 information, protects confidentiality of patient information, and secures and maintains availability of records.

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0024	Policies and Procedures for Volunteers	§403.748(b)(6), §416.54(b)(5), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.22(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).	[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section.

The policies and procedures must be reviewed and updated at least annually.

At a minimum, the policies and procedures must address the following:

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. | During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals. Facilities are also encouraged to integrate State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).

Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.

Survey Procedures
• Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan. |

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0025	Arrangement with other Facilities	§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).	[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

At a minimum, the policies and procedures must address the following:]

*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. | Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.
Facilities should consider all needed arrangements for the transfer of patients during an evacuation. For example, if a CAH is required to evacuate, policies and procedures should address what facilities are nearby and outside the area of disaster which could accept the CAH's patients. Additionally, the policies and procedures and facility agreements should include pre-arranged agreements for transportation between the facilities. The arrangements should be in writing, such as Memorandums of Understanding (MOUs) and Transfer Agreements, in order to demonstrate compliance.

Survey Procedures
• Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency.
• Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation. |

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0026	Roles under a Waiver Declared by Secretary	§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7) §494.62(b)(7).	[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted. Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency Examples of 1135 waivers include some of the existing CoPs; Licensure for Physicians or others to provide services in the affected State; EMTALA; Medicare Advantage out of network providers and HIPAA. Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary. For example, if due to a mass casualty incident in a geographic location, an 1135 waiver may be granted to waive licensure for physicians in order for these individuals to assist at a specific facility where they do not normally practice, then the facility should have policies and procedures which outline the responsibilities during the duration of this waiver period. For instance, the policies may establish a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility. Additionally, facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc. For additional 1135 Waiver information, the SCG Emergency Preparedness Website has resources. Survey Procedures • Verify the facility has included policies and procedures in its emergency plan

				describing the facility's role in providing care and treatment (except for RNHCI, for care only) at alternate care sites under an 1135 waiver.

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0029	Development of Communication Plan	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.22(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).	(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.	Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan.

Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if a facility is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods facilities may consider include satellite phones, radios and short wave radios.

Survey Procedures
• Verify that the facility has a written communication plan by asking to see the plan.
• Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis. |

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0030	Names and Contact Information	§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.22(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. For instance, hospitals should have contact information for other hospitals and CORFs should have contact information for other CORFs, etc. While not required, facilities may also find it prudent to have contact information for other facilities not of the same type. For instance a hospital may find it appropriate to have the contact information of LTC facilities within a reasonable geographic area, which could assist in facilitating patient transfers. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list. Survey Procedures • Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

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0031	Emergency Officials Contact Information	§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.22(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	A facility must have the contact information for those individuals and entities outlined within the standard. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event. Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible. All contact information must be reviewed and updated at least annually. Survey Procedures • Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

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0032	Primary/Alternate Means for Communication	§403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.22(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency. The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies. For example, if State X local emergency officials use the SHAred RESources (SHARES) High Frequency (HF) Radio program and facility Y is trying to communicate with RACES, it may be prudent to consider if these two alternate communication systems can communicate on the same frequencies. Facilities may seek information about the National Communication System (NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations. Survey Procedures • Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan. • Ask to see the communications equipment or communication systems listed in the plan.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0033	Methods for Sharing Information	§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.22(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).	(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information. Facilities (with the exception of HHAs, RHCs, FQHCs, and CORFs) are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Thus, facilities must have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted under 45 CFR 164.510(b)(4), to family members and others. Facilities have the flexibility to develop and maintain their own system in a manner that best meets its needs. HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes. Section 164.510 "Uses and disclosures requiring an opportunity for the individual to agree to or to object," is part of the "Standards for Privacy of Individually Identifiable Health Information," commonly known as "The Privacy Rule." HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), "Use and disclosures for disaster relief purposes," establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient's location or general condition. Survey Procedures • Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's

0033				care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan. o For RNCHIs, verify that the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative. • Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan

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0034	Sharing Information on Occupancy/Needs	§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.22(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	Facilities, except for transplant centers, must have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy. Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The facility should consider how its occupancy affects its ability to provide assistance. For example, if the facility's occupancy is close to 100% the facility may not be able to accept patients from nearby facilities. The types of "needs" a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc. Note: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident Command Center or state-wide coordination of the disaster would likely be a fire-related agency. We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information. Note: As defined by the Federal Emergency Management Administration (FEMA), an Incident Command System (ICS) is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. (FEMA, 2016). The industry, as well as providers/suppliers, use various terms to refer to the same function and we have used the term "Incident Command Center" to mean "Emergency Operations Center" or "Incident Command Post." Local, State, Tribal and Federal emergency preparedness officials, as well as regional healthcare coalitions, can assist facilities in the identification of their Incident Command Centers and reporting requirements dependent on an emergency. Survey Procedures • Verify the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan. • For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0035	LTC and ICF/IID Family Notifications	§483.73(c)(8); §483.475(c)(8)	[(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.	LTC facilities are required to share emergency preparedness plans and policies with family members and resident representative s or client representatives, respectively. Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated. While we are not requiring facilities take specific steps or utilize specific strategies to share this information with residents or clients and their families or representatives, we would recommend that facilities provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which may highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility's check-in procedures. The facility may provide this information to the surveyor during the survey to demonstrate compliance with the requirement. Survey Procedures • Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives. • Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan. • Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0036	Emergency Prep Training and Testing	§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.22(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).	(d) Training and testing. The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location. Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement. Survey Procedures • Verify that the facility has a written training and testing program that meets the requirements of the regulation. • Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made.

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0037	Emergency Prep Training Program	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.22(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).	(1) Training program. The facility, must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency. Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location. Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review. While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements. Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities

0037				have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures.
				Survey Procedures
				• Ask for copies of the facility's initial emergency preparedness training and annual emergency preparedness training offerings.
				• Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures.
				• Review a sample of staff training files to verify staff have received initial and annual emergency preparedness training.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0039	Emergency Prep Testing Requirements	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.22(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	(2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available. As the term full-scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community. There is also definition for "community" as it is subject to variation based on geographic setting, (e.g. rural, suburban, urban, etc.), state and local agency roles and responsibilities, types of providers in a given area in addition to other factors. In doing so, facilities have the flexibility to participate in and conduct exercises that more realistically reflect the risks and composition of their communities. Facilities are expected to consider their physical location, agency and other facility responsibilities and needs of the community when planning or participating in their exercises. The term could, however, mean entities within a state or multi-state region. In many areas of the country, State and local agencies (emergency management agencies and health departments) and some regional entities, such as healthcare coalitions may conduct an annual full-scale, community-based exercise in an effort to more broadly assess community-wide emergency planning, potential gaps, and the integration of response capabilities in an emergency. Facilities should actively engage these entities to identify potential opportunities, as appropriate, as they offer the facility the opportunity to not only assess their emergency plan but also better understand how they can contribute to, coordinate with, and integrate into the broader community's response during an emergency. They also provide a collective forum for assessing their communications plans to ensure they have the appropriate contacts and understand how best to engage and communicate with their state and local public health and emergency management agencies and other relevant partners, such as a local healthcare coalition, during an emergency. Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. It is also important to note that agencies and or healthcare coalitions conducting these exercises will not have the resources to fulfill individual facility requirements and thus will only serve as a conduit for broader community engagement and coordination prior to, during and after the full-scale community-

| 0039 | | | | based exercise. Facilities are responsible for resourcing their participation and ensuring that all requisite documentation is developed and available to demonstrate their compliance with this requirement.

Facilities are encouraged to engage with their area Health Care Coalitions (HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities. Health Care Coalitions (HCCs) are groups of individual health care and response organizations who collaborate to ensure each member has what it needs to respond to emergencies and planned events. HCCs plan and conduct coordinated exercises to assess the health care delivery systems readiness. There is value in participating in HCCs for participating in strategic planning, information sharing and resource coordination. HCC's do not coordinate individual facility exercises, but rather serve as a conduit to provide an opportunity for other provider types to participate in an exercise. HCCs should communicate exercise plans with local and state emergency preparedness agencies and HCCs will benefit the entire community's preparedness. In addition, CMS does not regulate state and local government disaster planning agencies. It is the sole responsibility of the facility to be in compliance.

Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities. Facilities that elect to develop a small community-based exercise have the opportunity to not only assess their own emergency preparedness plans but also better understand the whole community's needs, identify critical interdependencies and or gaps and potentially minimize the financial impact of this requirement. For example, a LTC facility, a hospital, an ESRD facility, and a home health agency, all within a given area, could conduct a small community-based exercise to assess their individual facility plans and identify interdependencies that may impact facility evacuations and or address potential surge scenarios due to a prolonged disruption in dialysis and home health care services. Those that elect to conduct a community-based exercise should make an effort to contact their local/state emergency officials and healthcare coalitions, where appropriate, and offer them the opportunity to attend as they can provide valuable insight into the broader emergency planning and response activities in their given area.

Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment. For example, an inpatient facility might test their policies and procedures for a flood that may require the evacuation of patients to an external site or to an internal safe "shelter-in-place" location (e.g. foyer, cafeteria, etc.) and include requirements for patients with access and functional needs and potential dependencies on life-saving electricity-dependent medical equipment. An outpatient facility, such as a home health provider, might test its policies and |

| 0039 | | | | procedures for a flood that may require it to rapidly locate its on-duty staff, assess the acuity of its patients to determine those that may be able to shelter-in-place or require hospital admission, communicate potential evacuation needs to local agencies, and provide medical information to support the patient's continuity of care.

Each facility is responsible for documenting their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years. Facilities should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program. Facilities may complete an after action review process to help them develop an actionable after action report (AAR). The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine 1) what was supposed to happen; 2) what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement. Lastly, facilities that are a part of a healthcare system, can elect to participate in their system's integrated and unified emergency preparedness program and exercises. However, those that do will still be responsible for documenting and demonstrating their individual facility's compliance with the exercise and training requirements.

Finally, an actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirements and exempts the facility for engaging in the required exercises for one year following the actual event; and facility's must be able to demonstrate this through written documentation.

For additional information and tools, please visit the CMS Survey & Certification Emergency Preparedness website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html or ASPR TRACIE.

Survey Procedures
• Ask to see documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise.
• Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise).
• Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis. |

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0041	LTC Emergency Power	482.15(e), §485.625(e), §483.73(e).	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The LTC facility must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency	Note: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply. However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance. Emergency and standby power systems CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – Life Safety Code (LSC) and the 2012 edition of the NFPA 99 – Health Care Facilities Code in accordance with the Final Rule (CMS–3277–F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator. (Note: LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM). In addition, NFPA 99 identifies the 2010 edition of NFPA 110 – Standard for Emergency and Standby Power Systems as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements. In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are not limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste

| 0041 | | | generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.
If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.
(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.
(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.
(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.
(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.
(iv) TIA 12–4 to NFPA 99, issued | disposal.

NFPA 99 contains emergency power requirements for emergency lighting, fire detection systems, extinguishing systems, and alarm systems. But, NFPA 99 does not specify emergency power requirements for maintaining supplies, and facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. In addition, NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room(s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated. Therefore, EES in Hospitals, CAHs and LTC facilities should include consideration for design to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies and procedures, unless the facility's emergency plans, policies and procedures required under paragraph (a) and paragraph (b)(1)(i) and (ii) of this section determine that the hospital, CAH or LTC facility will relocate patients internally or evacuate in the event of an emergency. Facilities may plan to evacuate all patients, or choose to relocate internally only patients located in certain locations of the facility based on the ability to meet emergency power requirements in certain locations. For example, a hospital that has the ability to maintain temperature requirements in 50 percent of the inpatient locations during a power outage, may develop an emergency plan that includes bringing in alternate power, heating and/or cooling capabilities, and the partial relocation or evacuation of patients during a power outage instead of installing additional power sources to maintain temperatures in all inpatient locations. Or a LTC facility may decide to relocate residents to a part of the facility, such as a dining or activities room, where the facility can maintain the proper temperature requirements rather than the maintaining temperature within the entire facility. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Emergency generator location

NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location. NFPA 110 requires that EPSS equipment, including generators, to be designed and located to minimize damage (e.g., flooding). NFPA 110 requires emergency power supply systems to be permanently attached, therefore portable and mobile generators would not be permitted as an option to provide or supplement emergency power to Hospitals, CAHs or LTC facilities.

Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and |

| 0041 | | | March 7, 2013.
(v) TIA 12–5 to NFPA 99, issued August 1, 2013.
(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.
(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.
(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.
(x) TIA 12–3 to NFPA 101, issued October 22, 2013.
(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.
(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. | NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the EPSS equipment is in a location to minimize damage.

Emergency generator inspection and testing

NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8.

Emergency generator fuel

NFPA 110 permits fuel sources for generators to be liquid petroleum products (e.g., gas, diesel), liquefied petroleum gas (e.g., propane) and natural or synthetic gas (e.g., natural gas). Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being "other time, in hours, as required by application, code or user." However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site (e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel source sufficient to allow full output of the ESS for the specified class.

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

Survey Procedures
• Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan |

0041				and corresponding policies and procedures • Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place? • For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed For hospitals, CAHs and LTC facilities with generators: • For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations. • Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

E-Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM https://www.careproviders.org/members/2017/Survey_and_Cert_Letter_17_29.pdf
0042	Integrated Health Systems	§416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e).	(e) [or (f) Integrated healthcare systems. If a facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- do all of the following: (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the	Healthcare systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the healthcare system instead of each facility developing a separate emergency preparedness program. If an integrated healthcare system chooses this option, each certified facility in the system may elect to participate in the system's unified and integrated emergency program or develop its own separate emergency preparedness program. It is important to understand that healthcare systems are not required to develop a unified and integrated emergency program. Rather it is a permissible option. In addition, the separately certified facilities within the healthcare system are not required to participate in the unified and integrated emergency preparedness program. It is simply an option for each facility. If this option is taken, the healthcare system's unified emergency preparedness program should be updated each time a facility enters or leaves the healthcare system's program. If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program. Therefore, each facility should designate personnel who will collaborate with the healthcare system to develop the plan. The unified and integrated plan should include documentation that verifies each facility participated in the development of the plan. This could include the names of personnel at each facility who assisted in the development of the plan and the minutes from planning meetings. All components of the emergency preparedness program that are required to be reviewed and updated at least annually must include all participating facilities. Again, each facility must be able to prove that it was involved in the annual reviews and updates of the program. The healthcare system and each facility must document each facility's active involvement with the reviews and updates, as applicable. A unified program must be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered at each facility participating in the integrated program. For example, for a unified plan covering both a hospital and a LTC facility, the emergency plan must account for the residents in the LTC facility as well as those patients within a hospital, while taking into consideration the difference in services that are provided at a LTC facility and a hospital. The unique circumstances that should be addressed at each facility would include anything that would impact operations during an emergency, such as the location of the facility, resources such as the availability of staffing, medical supplies, subsistence, patients' and residents' varying acuity and mobility at the different types of facilities in a unified healthcare system, etc.

| 0042 | | | | following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Interpretive Guidelines Applies to: §482.15(f), §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.78(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). | Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency preparedness program and demonstrate compliance with all emergency preparedness requirements at the individual facility level. Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility.

The unified emergency preparedness program must include a documented community–based risk assessment and an individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. This is especially important if the facilities in a healthcare system are located across a large geographic area with differing weather conditions.

Lastly, the unified program must have a coordinated communication plan and training and testing program. For example, if the unified emergency program incorporates a central point of contact at the "system" level who assists in coordination and communication, such as during an evacuation, each facility must have this information outlined within its individual plan.

This type of integrated healthcare system emergency program should focus the training and exercises to ensure communication plans and reporting mechanisms are seamless to the emergency management officials at state and local levels to avoid potential miscommunications between the system and the multiple facilities under its control.

The training and testing program in a unified emergency preparedness program must be developed considering all of the requirements of each facility type. For example, if a healthcare system includes, hospitals, LTC facilities, ESRD facilities and ASCs, then the unified training and testing programs must meet all of the specific regulatory requirements for each of these facility types.

Because of the many different configurations of healthcare systems, from the different types of facilities in the system, to the varied locations of the facilities, it is not possible to specify how unified training and testing programs should be developed. There is no "one size fits all" model that can be prescribed. However, if the system decides to develop a unified and integrated training and testing program, the training and testing must be developed based on the community and facility based hazards assessments at each facility that is participating in the unified emergency preparedness program. Each facility must maintain individual training records of staff and records of all required training exercises.

Survey Procedures

• Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program.
• Ask to see documentation that verifies the facility within the system was actively |

0042				involved in the development of the unified emergency preparedness program. • Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates. • Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program). • Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.

ALL HAZARDS

Purpose

The purpose of this Incident Planning Guide (IPG) is to identify issues that should be considered when planning for emergencies and unforeseen situations that may impact your nursing home. This IPG identifies planning considerations to assist the nursing home in 4 important areas:

- Mitigation
- Preparedness
- Immediate and Intermediate Response
- Extended Response and System Recovery

This is an "all hazards" IPG and the issues presented will apply to many different types of emergencies. It is not uncommon for one emergency to lead to another, e.g., a fire may trigger evacuation procedures, or an extended utility failure may warrant a response to cold or heat exposure.

Nursing homes are encouraged to customize this IPG to meet their specific requirements which should take into account the vulnerabilities and risks identified in your nursing home's Hazard Vulnerability Analysis (HVA). It is also advised to consult with local emergency management officials to understand the hazards specific to the community.

INCIDENT PLANNING GUIDE
ALL HAZARDS

	Does your nursing home…
	MITIGATION
1.	Address local threats and the impact of those threats in the annual Hazard Vulnerability Analysis, including the identification of mitigation strategies and tactics?
2.	Participate in pre-incident local response planning with public safety officials (e.g., emergency medical services, fire, and law enforcement), local emergency management officials, other area nursing homes, regional healthcare coalition coordinators , and other appropriate public and private organizations, including meetings and conference calls to plan and share status?
3.	Have a cache of basic <u>emergency supplies</u>, including flashlights, headlamps, batteries, protective gear (work gloves, safety goggles, masks, and helmets), first aid supplies, sealing tape, food and water, and emergency lighting? Is this cache maintained in working condition and routinely inspected? Is the location of the cache known and is it easily deployable to assigned personnel?
4.	Have a plan for reminding staff about personal and home emergency preparedness and the importance of exercising it annually?
5.	Maintain a fire defensible space that includes all buildings on site?
6.	Ensure all fire detection systems are routinely tested, reviewed by the local fire service, and procedures are in compliance with regulatory and accreditation standards?
7.	Update and maintain accessible maps which note the location of all on-site fire hydrants, stand pipes, sprinkler systems, dry suppression systems, hose bibs, and other fire suppression systems? Are maps readily available in the Nursing Home Command Center?
8.	Have systems to connect to <u>alternate water sources</u> to support fire suppression, wastewater, and cooling systems if needed?
9.	Have a procedure for <u>rationing</u> water and other utilities, if necessary?
10.	Have a plan to address flooding on the grounds and measures to prevent water from flowing into the facility (sandbags, pumps, etc.)?
11.	Conduct utility inspections, testing, and maintenance for: ☐ Generator (fixed, emergency, and deployable)? ☐ Power system? ☐ Water? ☐ Sewage? ☐ Natural gas? ☐ Medical gas?
12.	Have a plan to initiate pre-incident nursing home hardening actions (e.g., test backup generators, protect high risk areas, top off fuel tanks, etc.)?

	Does your nursing home…
13.	Have utility contractors or service vendors for emergency repairs and immediate response?
14.	Agreements or contracts for provision of potable water, generator fuel, and repairs?
15.	Procedures to rapidly replace utility system components such as air filters (e.g., high-efficiency particulate absorption [HEPA]) within the heating, ventilation, and air conditioning systems?
16.	Clearly identified valve controls to the main and area supply valves and area shutoff valves for piped utilities such as medical gases and vacuum systems accessible?
17.	Maintain a cache of spare phones and a communication directory? Is the Communication plan updated annually?
18.	Maintain pre-incident standardized messages for communicating risks and recommendations to the public and media?
19.	Undergo building evaluations to identify mitigation activities that would prevent or reduce damage when an earthquake occurs?
20.	Utilize earthquake shelving or other means to prevent objects from falling during an earthquake? This may include securing of cabinets, bolting large storage carts and shelving, moving objects off of high shelves, etc.
21.	Routinely ensure that all entry and exit points in both clinical and nonclinical areas are kept free of obstruction? Are potential entry and exit points for the nursing home contained in a single document or file for rapid access?
22.	Have panic and automated door intrusion alarms installed in all buildings? Are the alarms routinely tested?
23.	Enforce a staff photo identification badge policy and procedure?
24.	Have a visitor policy that provides visible identification and tracking of all visitors, vendors, and others who may be on site?
25.	Maintain hazardous materials in a safe and secure area of the nursing home? Is the inventory routinely checked?
26.	Maintain potentially explosive and combustible materials (e.g., oxygen, propane, acetylene) in a safe and secure environment? Are the sites routinely observed? Is there a policy or procedure in place if materials are tampered with or missing?
27.	Have a security system to ensure residents with altered mental capacity (e.g., dementia) cannot wander from assigned areas or units?

	Does your nursing home…
28.	Have security technology (closed circuit television [CCT] or video cameras and surveillance recording capabilities [digital or tape] in the nursing home and campus) to assist law enforcement in collecting information and controlling building access?
29.	Have deployable equipment to restrict access to pedestrian and vehicle traffic?
30.	Provide information and education to staff on infection control precautions, personal protective equipment, and exposure prophylaxis?
31.	Have a plan to limit access to the nursing home to prevent exposure of residents, staff, and facilities?
32.	Use expert information sources (e.g., Infectious Disease Society, in-house infectious disease clinician, Centers for Disease Control and Prevention website, city or county health departments) when planning for infectious disease incidents, evaluation, and treatment?
33.	Identify and train staff to continually monitor: ☐ Pre-incident weather forecasts and projections? ☐ Directions from public safety officials? ☐ Other intelligence sources to maintain current situational awareness of an event?
	PREPAREDNESS
1.	Have an Emergency Operations Plan (EOP) that designates who has the authority to activate the: ☐ EOP? ☐ Nursing Home Command Center? ☐ Emergency response procedures (i.e., Evacuation, Shelter-in-place, Fire, Missing Resident, Infectious Disease, etc.)? ☐ What are the criteria/triggers for activation?
2.	Have on hand the supplies needed for daily operations as well as a surge in occupancy for up to 96 hours of self-sustainment?
3.	Identify and train sufficient depth in personnel for staffing the Incident Management Team (IMT) positions if there are absences due to staff injury or illness?
4.	Exercise its emergency procedures annually and revise it as needed?
5.	Use standardized emergency codes? Are staff trained on their responsibilities when codes are activated?
6.	Conduct annual fire safety training and education, including fire response and evacuation procedures, in conjunction with local fire service?

	Does your nursing home…
7.	Train staff on the evacuation policy and procedures, including the use of evacuation assist devices, safety considerations, primary and secondary evacuation routes, and prioritization of residents?
8.	Participate in community evacuation exercises?
9.	Have the technology (e.g., TV, internet, radio) and policies in place to monitor events?
10.	Have established search procedures for a missing resident, including the following: ☐ Tracking systems to ensure all areas have been searched? ☐ Nursing home and campus floor plans, maps, and evacuation routes? ☐ Search grids and restriction of movement? ☐ Communication equipment to relay results to the Incident Management Team (IMT) and law enforcement?
11.	Tailor training to specific units, resident populations, or job functions?
12.	Maintain <u>shelter-in-place</u> and <u>evacuation procedures</u> with escape procedures and route assignments (e.g., floor plans, safe areas, reunification sites)?

13.	Have <u>evacuation procedures</u> that detail:
	
	☐ Criteria to evacuate all or sections of the nursing home based on damage assessments?
	☐ Evacuation routes, tracking tools, necessary supplies and equipment, and a secondary site?
	☐ Protocols that define:
	   o Planned versus immediate evacuation?
	   o Immediate versus delayed evacuation?
	   o Vertical versus lateral evacuation?
	   o Partial versus complete evacuation?
	☐ Equipment for bariatric residents, residents with access and functional needs, and residents with disabilities?
	☐ The process to facilitate the transfer of individual resident information, medications, and valuables with the resident?
	☐ Personnel roles in the evacuation including training for nonclinical staff to assist?
	☐ The process to reassign staff to alternate sites and staging areas, and other nursing homes?
	☐ Identify routes of egress?
	☐ Coordination with ambulances and other transportation providers, including:
	   o Additional out of area medical transportation?
	   o Nonmedical transportation providers (school buses, other types of buses, etc.)?

14.	Have Business Continuity Plans that include use of computerized resident and billing records from another adequately secured location?

Does your nursing home…	
15.	Have a plan to expand resident care capabilities in the face of a rapid outbreak of infectious residents that includes: ☐ Rapid identification, triage, and isolation practices in the facility? ☐ Expanding isolation capability (cohorting, portable HEPA filtration, etc.)? ☐ Staff PPE and use of fit-tested personnel? ☐ Integration with other local nursing homes, clinics, public health, and emergency management?
16.	Have a plan for alternate care sites including set up, equipment, staffing, and signage?
17.	Have a plan to manage dispensing prophylactic medications to staff and for administering vaccines when available?
18.	Have a process in place to determine appropriate amounts of personal protective equipment and hand hygiene supplies required for incident response? Is there a process in place to procure additional supplies?
19.	Have a plan to increase the capability to perform specific screening tests for designated pathogens and safely package, identify, and transfer laboratory specimens to external testing sites, including local, state, and federal labs? Relay laboratory results to internal clinical sites and external partners?
20.	Have a procedure to regularly inventory antiviral and medication supplies, personal protective equipment, and other required supplies?
21.	Have a plan to monitor the health status of staff who participate in triage and treatment activities and to provide appropriate medical follow-up?
22.	Have a staffing plan that includes: ☐ Procedures to evaluate the need for additional staff including contingency staff utilization and support? ☐ An established list of backup or relief staff that need to be in the nursing home or relocation site before or after the incident to continue resident care, if applicable? ☐ A list of nonessential staff that may be used in alternate roles? ☐ A plan to modify staffing and work hours?
23.	Have a plan for contacting personnel (i.e., staff call back lists) and a backup system if primary systems fail?
24.	Have a plan to send a representative to the local emergency operations center (EOC)?

	Does your nursing home…
25.	Assess the need and plan for sheltering staff and families including: ☐ Provisions for dependent elders, children, and pets? ☐ Location of rest and hygiene facilities for staff, visitors, and families? ☐ Sufficient supplies for hygiene, food and water, sleeping, and recreation? ☐ Policy for pet sheltering that addresses identification, vaccines, medicines, bedding, and litter? ☐ Orientation to the site including safety and security, hours of operations, and feeding options?
26.	Maintain a <u>communication plan</u> that includes: ☐ Pre-incident standardized messages for communicating the risks associated with different types of incidents? ☐ Distribution of radios, auxiliary phones, and flashlights to appropriate people and areas? ☐ Rapid communication of weather status (watch, warning)? ☐ A protocol to notify local emergency management, the public health department, emergency medical services, ambulance providers, and other area nursing homes of the situation and possible need to evacuate? ☐ Procedures for establishing a media staging area and for providing regular media briefings regarding nursing home status? ☐ Procedures to communicate situations and safety information to residents, staff, and family/guardians, including relocation if evacuation ordered? ☐ Procedures for establishing redundant communications with public safety and local emergency management officials if normal communications are damaged?
27.	Maintain <u>utility failure procedures</u> which address: ☐ Damage to the nursing home structure and infrastructure, including damaged water and sewer lines, electrical and information systems, fuel sources, communications, medical gases, alarm systems, waste and hazardous materials? ☐ Loss of heating, ventilation, or air conditioning systems? ☐ Alternative sources and systems if any utility fails? (e.g., battery powered lights, flashlights, etc. for loss of lighting)? ☐ Communication to staff that only essential equipment is plugged into emergency power outlets throughout the nursing home and other utility conservation measures as needed? ☐ Communication with the utility company's operations center to ascertain scope and length of service interruption? ☐ Verification that emergency generators are assuming the power load as designed? ☐ Verification that exhaust fans and air handlers supplied by emergency power are operational? ☐ Acquisition of generator fuel and repairs to maintain emergency power? ☐ Evaluation of the power system for load shedding potential?
28.	Have criteria to initiate, and the capability to, shut down air intakes to prevent smoke from entering the nursing home?

	Does your nursing home...
29.	Identify, document, and test redundant contact information for vendors, suppliers, response partners, and key stakeholders?
30.	Have a protocol to assess resident conditions and prioritize those most at risk for exposure to heat and cold?
31.	Maintain lockdown procedures (full and zoned lockdown capabilities)? Have all staff been trained in the nursing home and campus lockdown procedures and the impact on operations?
32.	Have emergency call boxes within parking lots, garages, and other remote locations?
33.	Provide training and reporting procedures that differentiate between an armed suspect, a barricaded suspect, a hostage situation, and an active shooter?
34.	Have a process for staff or residents to alert the nursing home of any restraining orders or other restrictive court orders?
35.	Have procedures to maintain sanitation systems throughout the nursing home, including providing personal hygiene and sanitation supplies (e.g., hand wipes, portable toilets, potable water)?
36.	Have procedures and forms to track cost expenditures and provide reports?
37.	Have plans to protect or recover lost data or wet/damaged documents?
38.	Have mutual aid agreements with emergency medical services and with other nursing homes when your nursing home has to be evacuated or abandoned?
IMMEDIATE AND INTERMEDIATE RESPONSE	
1.	Have a plan to secure and maintain security at the nursing home including a policy to secure the immediate area and to restrict entrance or exit of non-essential personnel?
2.	Have sufficient staff to enforce perimeter security and safety? Can this staff be rapidly augmented?
3.	Maintain contact information for all potential daily vehicle traffic (e.g., vendors, deliveries, transport vans, etc.) in the Nursing Home Command Center/
4.	Have protocols to assess, treat and document resident, visitor, and staff injuries?
5.	Have a plan to provide rest and sleep areas, nutrition, and hydration to staff?
6.	Have a procedure to quickly deploy equipment, supplies, and medications?
7.	Have a plan to maintain continuity of operations including trash, food, linen, laundry, etc.?

Does your nursing home…

8.	Have procedures to monitor environmental issues and biohazardous waste disposal during and after the incident for an extended period?
9.	Have criteria and a process to determine the need for complete or partial <u>evacuation</u> of the nursing home?

10.	Have a plan to rapidly initiate <u>shelter-in-place</u>, including procedures to:
	
	☐ Shutdown heating, ventilation, and air-conditioning systems?
	☐ Secure and limit access to the nursing home to designated secure screening points for staff and visitors entering the facility?
	☐ Regularly re-evaluate shelter-in-place vs. evacuation and coordinate decision making with local officials?
	☐ Establish priorities for the nursing home?
	☐ Initiate assembly area and holding area operations, including the provision of adequate staff and equipment?
	☐ Facilitate the transfer and tracking of individual resident information, medications, and valuables with the resident?
	☐ Transport critical residents, coordinate with ambulances and other transportation providers, including:
	     o Additional out of area medical transportation?
	     o Nonmedical transportation providers (school buses, other types of buses, etc.)?

11.	Have multiple methods and equipment for evacuating residents (e.g., chairs, stretchers, backboards, sled type devices, blanket drag, single person carry, multiple person carry)?
12.	Maintain a <u>communication plan</u> that includes procedures to: ☐ Obtain situation reports and utility status updates from the local emergency management agency and utility providers? ☐ Notify the family members of residents regarding the situation? ☐ Provide accurate and timely briefings to staff, residents, family members/guardians, and area nursing homes during extended operations? ☐ Collect and maintain current contact numbers for all external authorities in the Nursing Home Command Center and at the switchboard?
13.	Use social media to disseminate information during and after the event? ☐ Are all messages approved through the incident's Liaison/Public Information Officer (Liaison/PIO) and the Incident Commander prior to release? ☐ Is information coordinated within the Joint Information Center in cooperation with local, regional, and state emergency management partners?

INCIDENT PLANNING GUIDE
ALL HAZARDS

	Does your nursing home…
14.	Have <u>fatality management procedures</u> that address: ☐ Integration with local or state medical examiner or coroner? ☐ Preservation of evidence and chain of custody? ☐ Religious and cultural concerns? ☐ Management of contaminated decedents? ☐ Family/Guardian notification procedures? ☐ Behavioral health support for family and staff? ☐ Documentation?
15.	Have a process to: ☐ Reassess the status of the nursing home, resident care, and staffing and adjust the Incident Action Plan and operations accordingly? ☐ Assess current nursing home surge capacity and initiate discharge procedures?
16.	Have procedures to notify and engage appropriate internal and external experts including: ☐ Security? ☐ Safety? ☐ Decontamination teams? ☐ Respiratory? ☐ Infection control? ☐ Engineering, facilities, and plant operations? ☐ Toxicologist or chemical expert
17.	Have a policy and procedure to access the status of the community to ensure the safety of discharged residents?
18.	Have a mechanism to regularly evaluate the performance of the following: ☐ Electrical systems? ☐ Phones? ☐ Water? ☐ Natural gas? ☐ Medical gas? ☐ Alarms? ☐ Fire sprinkler systems?
19.	Have a plan for prioritizing emergency power allocation to critical infrastructure (e.g., heating, ventilation, and air conditioning units, morgue, elevators, ventilators, information technology, and other systems) during an extended activation?
20.	Have a process for safe <u>shutdown</u> of the nursing home, including: ☐ Computers ‑and other electrical equipment? ☐ Heating, ventilation, and air conditioning?

	Does your nursing home…
	☐ Power, water, gas, and medical gases? ☐ Methods to protect paper records not being evacuated? ☐ Maintaining nursing home security in all areas during and after closure? ☐ Securing or movement of hazardous materials?
21.	Maintain a plan to conduct regular media briefings, in collaboration with the local emergency management agency, local emergency operations center, and the Joint Information Center?
22.	Have a plan to supplement staffing through call backs or requesting resources from local emergency management, local emergency operations center, emergency medical services, fire, law enforcement, and regional medical resources?
23.	Have a process to provide accurate and continuous incident documentation, computerized or manual, including: ☐ Resident care? ☐ Incident management (Incident Action Plan, NHICS forms, etc.)? ☐ Actions, decisions, and activities and to track response expenses
24.	Maintain supplies and plans to address <u>extreme heat</u>, including: ☐ Cooling measures (fans, ice, cold packs)? ☐ Cold water and fluids for hydration? ☐ Medications for sunburn, heat exhaustion, and heat stroke?
25.	Maintain supplies and plans to address <u>extreme cold</u>, including: ☐ Warm blankets? ☐ Warm IV fluids? ☐ Warm liquids for hydration? ☐ Medications for hypothermia and frostbite?
26.	Identify criteria and procedures to modify the resident visitation policy during an incident?
27.	Have a plan to protect or recover lost data or damaged documents?
28.	Have procedures for decontamination and clean-up of the nursing home including bacteriological surveillance and potable water supply sanitation?
29.	Have <u>hazardous material response procedures</u> that include: ☐ Initial actions: Recognize, Avoid, Isolate, Notify (RAIN)? ☐ Search procedures for personnel? ☐ Internal notification procedures for staff, residents and visitors? ☐ External notification procedures including addressing the use of the Liaison/PIO role to coordinate response and recovery with law enforcement ☐ Hazardous and explosive materials inventory?

INCIDENT PLANNING GUIDE
ALL HAZARDS

Does your nursing home…	
	☐ Search grids? ☐ Nursing home and campus floor plans, maps, and evacuation routes? ☐ Alternate communications technology? ☐ Procedures for immediate and planned evacuation or shelter-in-place of the nursing home? ☐ Restriction of movement? ☐ Restriction of pedestrian and vehicle movement on campus? ☐ Evidence preservation measures in cooperation with law enforcement?
EXTENDED RESPONSE AND SYSTEM RECOVERY	
1.	Maintain a Business Continuity Plan for longer term events?
2.	Have position depth to support extended operations of the Incident Management Team?
3.	Have procedures for <u>repatriation</u> of residents and staff, including: ☐ Managing resident repatriation? ☐ Resident transportation coordination with sending nursing homes? ☐ Medical records management? ☐ Room assignments?
4.	Have a policy and procedure to assess damage post incident and initiate repairs and report this to the Nursing Home Command Center?
5.	Have a process to: ☐ Salvage equipment remaining onsite? ☐ Secure kitchen and laundry areas? ☐ Secure diagnostic areas and medications? ☐ Maintain traffic control on campus, as needed? ☐ Determine nursing home cleaning needs, including the use of contract service assistance? ☐ Ensure equipment, medications, and supplies are reordered to replace stock supplies? ☐ Ensure all necessary equipment is usable and safety checked, and equipment and supplies are reordered, repaired, and replaced as warranted? ☐ Prioritize service restoration activities? ☐ Monitor contractor services (work quality, costs, etc.)? ☐ Return borrowed equipment after proper cleaning and replenishment of supplies?
6.	Maintain procedures for restoring normal nursing home visitation and non-essential service operations?
7.	Have a policy and procedure to return non-traditional areas used in operational support (resident care, rest areas, pet shelters) to pre-incident status?
8.	Have a plan to provide behavioral health support to residents, staff, and families, including obtaining services of local or regional resources?

	Does your nursing home…
9.	Have a policy and the technology in place to notify all residents, staff, and stakeholders of the conclusion of the incident?
10.	Have a dedicated space for long term operations of outside response agencies, including law enforcement?
11.	Maintain demobilization procedures that include criteria for deactivation of positions, reactivation of services, and the return to normal operations?
12.	Have a continuing process to capture all costs and expenditures related to operations? Does it include addressing insurance reporting requirements?
13.	Have a process for documenting and submitting costs for disaster reimbursement from insurance carriers, as well as local, state, and Federal Emergency Management Agency (FEMA) disaster relief?
15.	Have a policy and procedure to address line-of-duty death?
16.	Have procedures to debrief residents, staff, and community partners on the activation?
17.	Have procedures to collect and collate incident documentation and formulate an After Action Report and Corrective Action and Improvement Plan?

NHICS FORMS

200 Incident Action Plan (IAP) Quick Start

201 Incident Briefing

202 Incident Objectives

203 Organization Assignment List

204 Assignment List

205 Communicaitons List

206 Staff Medical Plan

207 Incident Management Team Chart

214 Activity Log

215A Incident Action Plan Safety Analysis

251 Facility System Status Report

252 Section Personnel Timesheet

253 Volunteer Registration

254 Emergency Admit Tracking

255 Master Resident Evacuation Tracking

257 Resource Accounting Record

258 Facility Resource Directory

259 Facility Casualty/Fatality Report

260 Resident Evacuation Tracking

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INCIDENT ACTION PLAN (IAP) QUICK START

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

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

3. SITUATION SUMMARY	-- NHICS 201 --

4. WEATHER/ENVIRONMENTAL IMPLICATIONS FOR PERIOD (INCLUDES AS APPROPRIATE: FORECAST, DAYLIGHT)
1.
2.
3.
4.

PURPOSE: COMBINES NHICS FORMS 201+202+203+204+215A
ORIGINATION: INCIDENT COMMANDER OR PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 200
PAGE ___ of ___
REV. 2017

INCIDENT ACTION PLAN (IAP) QUICK START

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

5. CURRENT ORGANIZATION
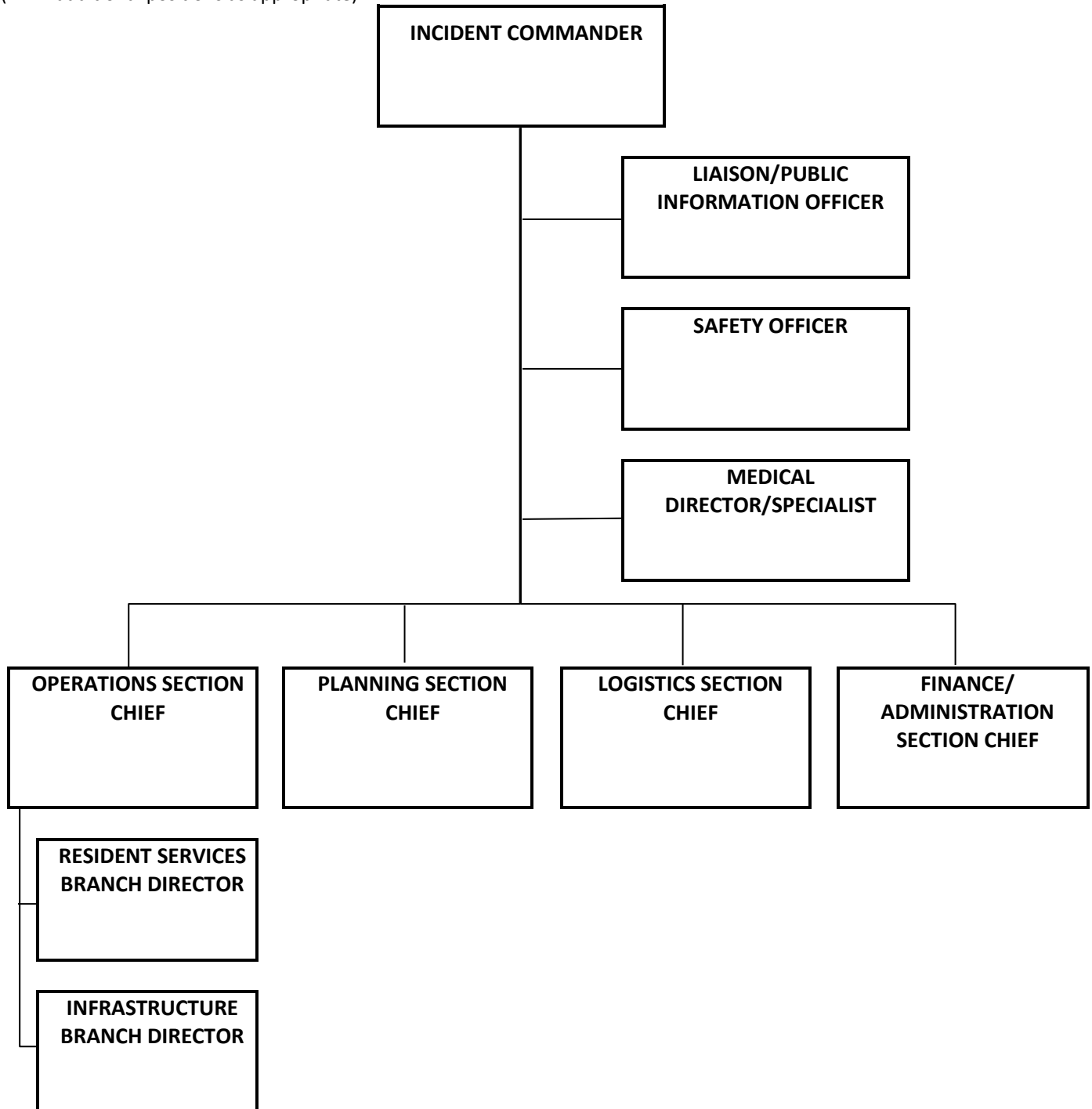
(Fill in additional positions as appropriate)

```
                        INCIDENT COMMANDER


                                    LIAISON/PUBLIC
                                    INFORMATION OFFICER


                                    SAFETY OFFICER


                                    MEDICAL
                                    DIRECTOR/SPECIALIST


  OPERATIONS      PLANNING        LOGISTICS        FINANCE/
  SECTION CHIEF   SECTION CHIEF   SECTION CHIEF    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 200
PAGE ___ of ___
REV. 2017

INCIDENT ACTION PLAN (IAP) QUICK START

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

NHICS
Nursing Home Incident Command System

6. INCIDENT OBJECTIVES			-- NHICS 202, 204--
6a. OBJECTIVES	**6b. STRATEGIES/ TACTICS**	**6c. RESOURCES REQUIRED**	**6d. ASSIGNED TO**

7. HEALTH AND SAFETY BRIEFING IDENTIFY POTENTIAL INCIDENT HEALTH AND SAFETY HAZARDS AND DEVELOP NECESSARY MEASURES (REMOVE HAZARD, PROVIDE PERSONAL PROTECTIVE EQUIPMENT, WARN PEOPLE OF THE HAZARD)   -- NHICS 202, 215A-- TO PROTECT RESPONDERS FROM THOSE HAZARDS

1.

2.

3.

4.

8. ATTACHMENTS (MARK IF EXTRA DOCUMENTATION IS ATTACHED)

☐ NHICS 251: FACILITY SYSTEM STATUS REPORT

☐ NHICS 254: EMERGENCY ADMIT TRACKING

☐ NHICS 255: MASTER RESIDENT EVACUATION TRACKING

☐ NHICS 215A: INCIDENT ACTION PLAN (IAP) SAFETY ANALYSIS

☐ TRAFFIC PLAN

☐ INCIDENT MAP

☐ OTHER: _____

9. PREPARED BY

PRINT NAME: _____   SIGNATURE: _____

DATE/TIME: _____   FACILITY: _____

PURPOSE: COMBINES NHICS FORMS 201+202+203+204+215A
ORIGINATION: INCIDENT COMMANDER OR PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 200
PAGE ___ of ___
REV. 2017

INCIDENT ACTION PLAN (IAP) QUICK START

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

INSTRUCTIONS

PURPOSE: Provides a faster approach to developing the IAP by combining NHICS Forms 201, 202, 203, 204 and 215A. You may use the IAP Quick Start during the early stage of an incident or if it is expected to be a short duration incident or it meets the needs of the incident at any time. If the full complement of NHICS Forms are needed, transition to their individual use.

ORIGINATION: Incident Commander or Planning Section Chief

COPIES TO: All IMT staff

NOTES: If additional pages are needed for any form page, use a blank NHICS IAP Quick Start and repaginate as needed. Additions may be made to the form to meet the organization's needs.

* Three versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF, Visio and Microsoft Word.

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	Situation Summary	Enter brief situation summary.
4	Weather/Environmental Implications for period	Enter forecast information.
5	Current Organization	Enter the names of the individuals assigned to each position on the Incident Management Team chart. Modify the chart as necessary.
6	Incident Objectives	
	6.a Objectives	Enter each objective separately. Adjust objectives for each operational period as needed.
	6.b Strategies/Tactics	For each objective, document the strategy/tactic to accomplish that objective.
	6.c Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	6.d Assigned to	For each strategy/tactic, document the Section or Branch assigned to that objective.
7	Health and Safety Briefing	Summary of health and safety issues and instructions.
8	Attachments	Attach additional NHICS forms and supporting documents as needed.
9	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.

PURPOSE: COMBINES NHICS FORMS 201+202+203+204+215A
ORIGINATION: INCIDENT COMMANDER OR PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 200
PAGE ___ of ___
REV. 2017

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 201
PAGE __ of __
REV. 2017

NHICS 201 | INCIDENT BRIEFING

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

NHICS 201
PAGE __ of __
REV. 2017

NHICS 201 | INCIDENT BRIEFING

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

7. INCIDENT OBJECTIVES

8. SUMMARY OF CURRENT AND PLANNED ACTIONS	
TIME	ACTIONS

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

NHICS 201
PAGE ___ of ___
REV. 2017

NHICS 201 | INCIDENT BRIEFING

9. SUMMARY OF RESOURCES REQUESTED AND ASSIGNED

RESOURCE	DATE/TIME ORDERED	ETA	DATE/TIME ARRIVED	NOTES (LOCATION/ ASSIGNMENT/ STATUS)

10. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

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

NHICS 201
PAGE __ of __
REV. 2017

NHICS 201 | INCIDENT BRIEFING

INSTRUCTIONS

PURPOSE: Provides the Incident Management Team (IMT) with basic information regarding the incident, current situation, and the resources allocated to the response.

ORIGINATION: Incident Commander (or designee) for presentation to the staff or later to the incoming Incident Commander along with a detailed oral briefing.

COPIES TO: All IMT staff

NOTES: If additional pages are needed for any form page, use a blank NHICS 201 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

*Three versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF, Visio and Microsoft Word.

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	Situation Summary	Concise statement of the status and information regarding the current situation.
4	Health and Safety Briefing	Enter the summary of health and safety issues and instructions.
5	Map / Sketch	Attach as necessary: floor plans, maps, sketches of impacted area, or response diagrams. North should be at the top of the page unless noted otherwise.
6	Current Organization	Enter the names of the individuals assigned to each position directly onto the Incident Management Team (IMT) chart.
7	Incident Objectives	Enter the objectives used for the incident.
8	Summary of Current and Planned Actions	Enter the current and planned actions and time (24-hour clock) they may or did occur. If additional pages are needed, use a blank sheet or another NHICS 201, and adjust page numbers accordingly.
9	Summary of Resources Requested and Assigned	Enter information about the resources allocated to the incident. If additional pages are needed, use a blank sheet or another NHICS 201 (page 4), and adjust page numbers accordingly.

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

NHICS 201
PAGE __ of __
REV. 2017

NHICS 201 | INCIDENT BRIEFING

NUMBER	TITLE	INSTRUCTIONS
	Resource	Enter the number and category, kind, or type of resource ordered.
	Date / Time Ordered	Enter the date (m/d/y) and time (24-hour clock) the resource was ordered.
	ETA	Enter the estimated time of arrival (ETA) to the incident (24-hour clock).
	Date / Time Arrived	Enter the date (m/d/y) and time (24-hour clock) the resource arrived.
	Notes	Enter notes such as the assigned location of the resource and/or the actual assignment and status.
10	**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.

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

NHICS 201
PAGE ___ of ___
REV. 2017

NHICS 202 | INCIDENT OBJECTIVES

		2. OPERATIONAL PERIOD		
1. INCIDENT NAME		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 202
PAGE ___ of ___
REV. 2017

NHICS 202 | INCIDENT OBJECTIVES

INSTRUCTIONS

PURPOSE:	Describes the basic incident strategy, incident objectives, command priorities, and safety considerations for use during the next operational period.
ORIGINATION:	Planning Section Chief for each operational period as part of the Incident Action Plan (IAP).
COPIES TO:	May be reproduced with the IAP and given to Command Staff, Section Chiefs, and all supervisory personnel at the Section and Branch level.
NOTES:	If additional pages are needed, use a blank NHICS 202 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Incident Objectives**	Enter clear, concise statements of the objectives for managing the response. Ideally, these objectives will be listed in priority order. These objectives are for the incident response for this operational period as well as for the duration of the incident. Include alternative and/or specific tactical objectives as applicable.
4	**Factors to Consider**	Enter considerations for the operational period, which may include tactical priorities or a general situational awareness for the operational period. It may be a sequence of events or order of events to address. General situational awareness may include a weather forecast, incident conditions, and/or a general safety message. If a safety message is included here, it should be provided by the Safety Officer.
5	**NHICS 215A or Site Safety Plan Required**	Safety Officer should check whether or not a Site Safety Plan is required for this incident.
	Approved Site Safety Plan Locations	Enter the locations of the approved Site Safety Plan.
6	**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.
7	**Approved by**	If additional Incident Commander signatures are required, attach a blank page. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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

NHICS 202
PAGE __ of __
REV. 2017

NHICS 203 | ORGANIZATION ASSIGNMENT LIST

NHICS
Nursing Home Incident Command System

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

POSITION	NAME / AGENCY	CONTACT INFO (PHONE, CELL)
3. INCIDENT COMMANDER AND STAFF		
INCIDENT COMMANDER		
LIAISON/PUBLIC INFORMATION OFFICER		
SAFETY OFFICER		
MEDICAL DIRECTOR/SPECIALIST		
4. OPERATIONS SECTION		
CHIEF		
RESIDENT SERVICES BRANCH		
INFRASTRUCTURE BRANCH		
5. PLANNING SECTION		
CHIEF		
6. LOGISTICS SECTION		
CHIEF		
7. FINANCE/ADMINISTRATION SECTION		
CHIEF		

8. AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)		
AGENCY	NAME	CONTACT INFO (PHONE, CELL)

9. EXTERNAL AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)		
EXTERNAL LOCATION	NAME	CONTACT INFO (PHONE, CELL)

10. PREPARED BY	PRINT NAME:	SIGNATURE:
	DATE/TIME:	FACILITY:

PURPOSE: DOCUMENT STAFFING
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 203
PAGE 1 of 1
REV. 2017

NHICS 203 | ORGANIZATION ASSIGNMENT LIST

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

INSTRUCTIONS

PURPOSE: Provides the Incident Management Team (IMT) personnel with information on the positions currently activated and the names of personnel staffing each position.

ORIGINATION: Planning Section Chief

COPIES TO: All IMT staff

NOTES: If assigned, document Assistants / Deputies to Command Staff as needed or resources allow. If additional pages are needed for any form page, use a blank NHICS 203 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Incident Commander and Command Staff**	Enter the names and contact information.
4	**Operations Section**	Enter the names and contact information.
5	**Planning Section**	Enter the names and contact information.
6	**Logistics Section**	Enter the names and contact information.
7	**Finance / Administration Section**	Enter the names and contact information.
8	**Agency Executive**	Enter the name and contact information of the executive (e.g., Chief Executive Officer) with whom the Incident Commander interfaces.
9	**External Agency Representative**	Enter the external agency/organization names present in the Nursing Home Command Center and the names of their representatives.
10	**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.

PURPOSE: DOCUMENT STAFFING
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: All IMT STAFF

NHICS 203
PAGE _ of _
REV. 2017

NHICS 204 | ASSIGNMENT LIST

NHICS
Nursing Home Incident Command System

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

3. SECTION		4. BRANCH (if applicable)	
SECTION CHIEF		BRANCH DIRECTOR	

5a. SECTION / BRANCH OBJECTIVES	5b. STRATEGIES / TACTICS	5c. RESOURCES REQUIRED	5d. SECTION / BRANCH ASSIGNED TO

PURPOSE: DOCUMENTS STRATEGIES/TACTICS OF EACH SECTION OR BRANCH, RESOURCES TO ACCOMPLISH THEM AND THE COMPOSITION OF THE SECTION/BRANCH ASSIGNED
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 204 | ASSIGNMENT LIST

NHICS
Nursing Home Incident Command System

6.	ASSIGNED TO THIS OPERATIONAL PERIOD	
NAME	**SECTION / BRANCH TITLE**	**SECTION / BRANCH LOCATION**

7.	SPECIAL INFORMATION / CONSIDERATIONS

8.	PREPARED BY PLANNING SECTION CHIEF	PRINT NAME: _____ DATE/TIME: _____	SIGNATURE: _____ FACILITY: _____

PURPOSE: DOCUMENTS STRATEGIES/TACTICS OF EACH SECTION OR BRANCH, RESOURCES TO ACCOMPLISH THEM AND THE COMPOSITION OF THE SECTION/BRANCH ASSIGNED

ORIGINATION: PLANNING SECTION CHIEF

COPIES TO: ALL IMT STAFF

NHICS 204
PAGE __ of __
REV. 2017

NHICS 204 | ASSIGNMENT LIST

NHICS
Nursing Home Incident Command System

INSTRUCTIONS

PURPOSE: Documents the strategies and tactics of each (activated) Section or Branch, resources required, and the composition of the Section or Branch assigned.

ORIGINATION: Planning Section Chief

COPIES TO: All IMT staff. Duplicate and attach as part of the IAP if not using the IAP Quick Start.

NOTES: An abbreviated NHICS 204 is included in the IAP Quick Start. Additions may be made to the form to meet the organization's needs.

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	**Section**	Enter the name of the Section and Section Chief.
4	**Branch (if applicable)**	Enter the name of the Branch and Branch Director, if the form is for a specific Branch.
5	**5a. Section/Branch Objectives**	Utilizing the Incident Objectives (NHICS 202), develop objectives as they relate to the Section/Branch. Enter objectives to focus on for the designated operational period.
	5b. Strategies / Tactics	For each objective, document the strategies/tactics to accomplish that objective.
	5c. Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	5d. Section/Branch Assigned to	For each strategy/tactic, document the Section/Branch assigned to that strategy/tactic.
6	**Assigned this Operational Period**	Enter the names, titles of staff activated and location of the Section/Branch
7	**Special Information /Considerations**	Enter a statement noting any safety problems, specific precautions to be exercised, drop-off or pick-up points, or other information.
8	**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.

PURPOSE: DOCUMENTS STRATEGIES/TACTICS OF EACH SECTION OR BRANCH, RESOURCES TO ACCOMPLISH THEM AND THE COMPOSITION OF THE SECTION/BRANCH ASSIGNED
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF

NHICS 204
PAGE __ of __
REV. 2017

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NHICS 205 | COMMUNICATIONS LIST

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

3. INTERNAL CONTACTS

NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS

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 205
PAGE __ of __
REV. 2017

NHICS 205 | COMMUNICATIONS LIST

3. INTERNAL CONTACTS (CONTINUED...)						
NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS

4. EXTERNAL CONTACTS						
NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS

5. SPECIAL INSTRUCTIONS	

6. PREPARED BY LOGISTICS SECTION CHIEF	PRINT NAME: _____ SIGNATURE: _____ DATE/TIME: _____ FACILITY: _____

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 205
PAGE __ of __
REV. 2017

NHICS 205 | COMMUNICATIONS LIST

INSTRUCTIONS

PURPOSE: Provides information on all telephone and other communication assignments for each operational period.

ORIGINATION: Logistics Section Chief and given to the Planning Section Chief for inclusion in the Incident Action Plan (IAP).

COPIES TO: All IMT staff.

NOTES: If additional pages are needed, use a blank NHICS 205 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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 (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Internal Contacts	Enter the appropriate contact information for internal contacts, hospital personnel, those in an activated Incident Management Team (IMT) position, and other key staff.
4	External Contacts	Enter the appropriate contact information for external agencies, organizations, key contacts.
5	Special Instructions	Enter any special instructions (e.g., using repeaters, secure-voice, private line [PL] tones, etc.) or other emergency communications. If needed, also include any special instructions for alternate communication plans.
6	Prepared by Logistics Section Chief	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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 205
PAGE __ of __
REV. 2017

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NHICS 206 | STAFF MEDICAL PLAN

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

3. TREATMENT AREAS

AREA NAME	LOCATION	TEAM LEADER & ALTERNATE CONTACT NUMBER

4. RESOURCES ON HAND (numbers)

STAFF	TRANSPORTATION DEVICES	MEDICATION	SUPPLIES
MD/DO	LITTERS		
PA/NP	PORTABLE BEDS		
RN/LPN	GURNEYS		
TECHNICIANS	WHEELCHAIRS		
ANCILLARY/OTHER	EVAC. ASSIST DEVICES		

5. TREATMENT RESOURCES (EXTERNAL)

NAME	PHONE	ADDRESS
MD/DO		
NEAREST HOSPITAL/EMERGENCY ROOM		

PURPOSE: PROVIDES INFORMATION ON STAFF TREATMENT AREAS
ORIGINATION: SAFETY OFFICER
COPIES TO: ALL IMT STAFF

NHICS 206
PAGE ___ of ___
REV. 2017

NHICS 206 | STAFF MEDICAL PLAN

TREATMENT RESOURCES (**EXTERNAL**) continued…		
NAME	**PHONE**	**ADDRESS**
ALTERNATE HOSPITAL/EMERGENCY ROOM		
OCCUPATIONAL HEALTH CLINIC		

6. TRANSPORTATION

AMBULANCE, BUS, VAN, PRIVATE VEHCILE, AIR	LOCATION	CONTACT NUMBER	LEVEL OF SERVICE
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS

7. ALTERNATE CARE SITE(S)

FACILTIY NAME	ADDRESS	CONTACT NUMBER	SPECIALTY CARE (SPECIFY)

8. SPECIAL INSTRUCTIONS	

9. PREPARED BY SAFETY OFFICER	PRINT NAME: _____ SIGNATURE: _____ DATE/TIME: _____ FACILITY: _____
10. APPROVED BY	PRINT NAME: _____ SIGNATURE: _____ DATE/TIME: _____ FACILITY: _____

PURPOSE: PROVIDES INFORMATION ON STAFF TREATMENT AREAS

ORIGINATION: SAFETY OFFICER

COPIES TO: ALL IMT STAFF

NHICS 206

PAGE ___ of ___

REV. 2017

NHICS 206 | STAFF MEDICAL PLAN

INSTRUCTIONS

PURPOSE: Addresses the treatment plan for injured or ill staff members and / or volunteers. The NHICS 206 provides information on staff treatment areas, resources (external), transportation services, and special instructions.

ORIGINATION: Safety Officer

COPIES TO: All IMT staff

NOTES: If additional pages are needed, use a blank NHICS 206 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Treatment Areas**	Enter the name of the treatment area, the location, and the contact numbers.
4	**Resources On Hand**	Enter the number of listed resources that are available and assigned to the treatment areas.
5	**Treatment Resources (External)**	Enter the contact information for external treatment resources.
6	**Transportation**	Enter the information for transportation services available to the incident.
7	**Alternate Care Site(s)**	Enter the information for alternate care sites that could serve this incident.
8	**Special Instructions**	Note any special emergency instructions for use by incident personnel, including who should be contacted, how should they be contacted; and who manages an incident within an incident due to a rescue, accident, etc.
9	**Prepared by Safety Officer**	Enter the name and signature of the person preparing the form, typically the Safety Officer. Enter date (m/d/y), time prepared (24-hour clock), and facility.
10	**Approved by**	Enter the name of the person who approved the plan. Enter date (m/d/y), time reviewed (24-hour clock), and facility.

PURPOSE: PROVIDES INFORMATION ON STAFF TREATMENT AREAS
ORIGINATION: SAFETY OFFICER
COPIES TO: ALL IMT STAFF

NHICS 206
PAGE __ of __
REV. 2017

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NHICS 207 | INCIDENT MANGEMENT TEAM CHART

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

3. CURRENT ORGANIZATION

(Fill in additional positions as appropriate)

```
                          INCIDENT COMMANDER

                                      LIAISON/PUBLIC
                                      INFORMATION OFFICER

                                      SAFETY OFFICER

                                      MEDICAL
                                      DIRECTOR/SPECIALIST

  OPERATIONS SECTION    PLANNING SECTION    LOGISTICS SECTION    FINANCE/
  CHIEF                 CHIEF               CHIEF                ADMINISTRATION
                                                                SECTION CHIEF

     RESIDENT SERVICES
     BRANCH DIRECTOR

     INFRASTRUCTURE
     BRANCH DIRECTOR
```

PURPOSE: DISPLAY POSITIONS ASSIGNED TO THE INCIDENT MANAGEMENT TEAM
ORIGINATION: INCIDENT COMMANDER OR DESIGNEE
COPIES TO: ALL IMT STAFF AND POSTED IN THE NURSING HOME COMMAND CENTER

NHICS 207
PAGE __ of __
REV. 2017

NHICS 207 | INCIDENT MANGEMENT TEAM CHART

INSTRUCTIONS

PURPOSE: Provides a visual display of personnel assigned to the IMT positions.

ORIGINATION: Incident Commander or designee at the incident onset and continually updated throughout an incident.

COPIES TO: All IMT staff.

NOTES: Additions may be made to the form to meet the organization's needs. Two versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF and Visio for customization.

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	**Current Organization**	Enter the names of the individuals assigned to each position on the Incident Management Team (IMT) chart. Modify the chart as necessary, and add any lines/spaces needed for Command Staff assistants, agency representatives, and the organization of each of the General Staff sections.

PURPOSE: DISPLAY POSITIONS ASSIGNED TO THE INCIDENT MANAGEMENT TEAM
ORIGINATION: INCIDENT COMMANDER OR DESIGNEE
COPIES TO: ALL IMT STAFF

NHICS 207
PAGE __ of __
REV. 2017

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

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
PAGE ___ of ___
REV. 2017

NHICS 214 | ACTIVITY LOG

INSTRUCTIONS

PURPOSE: Records details of notable activities for any Incident Management Team (IMT) position. Provide basic documentation of incident activity, and a reference for any After Action Report (AAR). Personnel should document how relevant incident activities are occurring and progressing, actions taken and decisions made.

ORIGINATION: All IMT staff

COPIES TO: Planning Section Chief. Individuals may retain a copy for their own records.

NOTES: Multiple pages can be used if needed. If additional pages are needed, use a blank NHICS 214 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Name**	Print the name of the person for whom the activities are being documented.
4	**IMT Position**	Enter the Incident Management Team (IMT) position for which the activities are being documented.
5	**Activity Log**	Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date (m/d/y), as well as if the operational period covers more than one day. Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, information received, etc.
6	**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.

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

NHICS 214
PAGE __ of __
REV. 2016

NHICS 215A| INCIDENT ACTION PLAN SAFETY ANALYSIS

NHICS
Nursing Home Incident Command System

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

3. HAZARD MITIGATION

3a. POTENTIAL/ACTUAL HAZARDS (BIOHAZARDS, STRUCTURAL, UTILITY, ETC.)	3b. AFFECTED SECTION OR BRANCH & LOCATION	3c. MITIGATIONS (E.G., PPE, BUDDY SYSTEM, ESCAPE ROUTES)	3d. MITIGATION COMPLETED (INITIALS/DATE/TIME)

4. PREPARED BY SAFETY OFFICER	PRINT NAME:	SIGNATURE:
	DATE/TIME:	FACILITY:

5. APPROVED BY INCIDENT COMMANDER	PRINT NAME:	SIGNATURE:
	DATE/TIME:	FACILITY:

PURPOSE: OPERATIONAL RISK ASSESSMENT TO PRIORITIZE HAZARDS, SAFETY AND HEALTH ISSUES, AND TO ASSIGN MITIGATION ACTIONS
ORIGINATION: SAFETY OFFICER
COPIES TO: PLANNING SECTION CHIEF FOR INCIDENT ACTION PLAN (IAP)

NHICS 215A| INCIDENT ACTION PLAN SAFETY ANALYSIS

INSTRUCTIONS

PURPOSE: Records the findings of the Safety Officer after completing an operational risk assessment and to identify and resolve hazard, safety, and health issues. When the safety analysis is completed, the form is used to prepare the Operations Briefing.

ORIGINATION: Safety Officer during the IAP cycle.

COPIES TO: Planning Section Chief. Duplicate and attach as part of the IAP.

NOTES: Issues identified should be reviewed and updated each operational period. If additional pages are needed, use a blank NHICS 215A and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Hazard Mitigation**	
	3a. Potential / Actual Hazards	List the types of hazards and/or risks likely to be encountered by personnel or resources at the incident area relevant to the work assignment.
	3b. Affected Section / Branch and Location	Reference the affected sections, branches, and the location of the hazards.
	3c. Mitigations	List actions taken to reduce risk for each hazard indicated (e.g., restricting access, proper PPE for identified risk).
	3d. Mitigation Completed	Enter the initials, date, and time when the mitigation is implemented or the hazard no longer exists.
4	**Prepared by Safety Officer**	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.
5	**Approved by Incident Commander**	Enter the name and signature of the person approving the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

PURPOSE: OPERATIONAL RISK ASSESSMENT TO PRIORITIZE HAZARDS, SAFETY AND HEALTH ISSUES, AND TO ASSIGN
MITIGATION ACTIONS
ORIGINATION: SAFETY OFFICER
COPIES TO: PLANNING SECTION CHIEF FOR INCIDENT ACTION PLAN (IAP)

NHICS 215A
PAGE __ of __
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

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

3. SYSTEM	4. STATUS	5. COMMENTS (If not fully functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
COMMUNICATIONS		
FAX	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/ PATIENT RECORDS/TIME CARD SYSTEM)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NURSE CALL SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
PAGING – PUBLIC ADDRESS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
TELEPHONE SYSTEM – CELL	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
VIDEO-TELEVISION-INTERNET-CABLE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER (SATELLITE PHONES, RADIO EQUIPMENT, ETC)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

INFRASTRUCTURE		
SYSTEM	**STATUS**	**COMMENTS**
CAMPUS ACCESS (ROADWAYS, BRIDGES, SIDEWALKS)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FIRE DETECTION SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FIRE SUPPRESSION SYSTEM	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FOOD PREPARATION EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ICE MACHINES	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
LAUNDRY/LINEN SERVICE EQUIPMENT	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

RESIDENT CARE

SYSTEM	STATUS	COMMENTS
PHARMACY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
DIETARY SERVICES	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

SECURITY SYSTEM

SYSTEM	STATUS	COMMENTS
DOOR LOCKDOWN SYSTEMS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
SURVEILLANCE CAMERAS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
CAMPUS SECURITY (LIGHTING, TRAFFIC CONTROLS)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

UTILITIES, EXTERNAL SYSTEM		
SYSTEM	**STATUS**	**COMMENTS**
ELECTRICAL POWER- PRIMARY SERVICE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
SANITATION SYSTEMS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
WATER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
NATURAL GAS	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
OTHER	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

UTILITIES, INTERNAL SYSTEM		
SYSTEM	**STATUS**	**COMMENTS**
AIR COMPRESSOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
ELECTRICAL POWER, BACKUP GENERATOR	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	
FUEL STORAGE	☐ FULLY FUNCTIONAL ☐ PARTIALLY FUNCTIONAL ☐ NONFUNCTIONAL ☐ NA	

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

UTILITIES, INTERNAL SYSTEM (CONTINUED….)

SYSTEM	STATUS	COMMENTS
ELEVATORS/ESCALATORS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
HAZARDOUS WASTE CONTAINMENT SYSTEM	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
OXYGEN	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	(NOTE BULK, H-TANKS, RESERVE SUPPLY STATUS)
PNEUMATIC TUBE	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
STEAM BOILER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
SUMP PUMP	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
WELL WATER SYSTEM	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
VACCUM (FOR PATIENT USE)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

UTILITIES, INTERNAL SYSTEM (CONTINUED…)		
SYSTEM	**STATUS**	**COMMENTS**
WATER HEATER AND CIRCULATORS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
EXTERNAL LIGHTING	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
EXTERNAL STORAGE (EQUIPMENT)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
EXTERNAL STORAGE (VEHICLES)	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	
PARKING LOTS	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	(POWER, PANIC ALARMS, ACCESS, EGRESS, LIGHTING)
OTHER	☐ **FULLY FUNCTIONAL** ☐ **PARTIALLY FUNCTIONAL** ☐ **NONFUNCTIONAL** ☐ **NA**	

6.   REMARKS (CRACKED WALLS, BROKEN GLASS, FALLING LIGHT FIXTURES, ETC.)

7. PREPARED BY	**PRINT NAME:** _____ **SIGNATURE:** _____ **DATE/TIME:** _____ **FACILITY:** _____

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

NHICS 251 | FACILITY SYSTEM STATUS REPORT

INSTRUCTIONS

PURPOSE: Records the status of various critical facility systems and infrastructure. Provides the Planning and Operations Sections with information about current and potential system failures or limitations that may affect incident response and recovery.

ORIGINATION: Infrastructure Branch Director with input from facility personnel.

COPIES TO: Planning Section Chief, Operations Section Chief, Safety Officer, and Liaison/Public Information Officer

NOTES: The Infrastructure Branch conducts the survey and correlates results. Individual department managers may also be tasked to complete an assessment of their areas and provide the information to the Infrastructure Branch. If additional pages are needed, use a blank NHICS 251 and repaginate as needed. Additions and deletions may be made to the form to meet the organization's needs.

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	**System**	System type listed in form.
4	**Status**	**Fully functional:** 100% operable with no limitations **Partially functional:** Operable or somewhat operable with limitations **Nonfunctional:** Out of commission **N/A:** Not applicable, do not have
5	**Comments**	Comment on location, reason, and estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.
6	**Remarks**	Note any overall facility-wide assessments or future potential issues such as skilled staffing issues, fuel duration, plans for repairs, etc.
7	**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.

PURPOSE: DETERMINE FACILITY OPERATING STATUS
ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR
COPIES TO: SAFETY OFFICER, OPERATIONS SECTION CHIEF, PLANNING SECTION CHIEF & LIAISON/PIO

NHICS 251
PAGE _ of _
REV. 2017

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NHICS 252 | SECTION PERSONNEL TIME SHEET

NHICS
Nursing Home Incident Command System

		2. OPERATIONAL PERIOD	
1. INCIDENT NAME		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

NHICS 252 | SECTION PERSONNEL TIME SHEET

NHICS
Nursing Home Incident Command System

INSTRUCTIONS

PURPOSE: Records each section's personnel time and activities.

ORIGINATION: Section Chiefs are responsible for ensuring that personnel complete the form.

COPIES TO: Finance/Administration Section Chief every 12 hours or every operational period.

NOTES: If additional pages are needed, use a blank NHICS 252 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	Time Record	
	Employee (E) / Volunteer (V) Name (Print)	Print the full name of the personnel assigned.
	E / V	Enter employee (E) or volunteer (V).
	Employee Number	If employee of the organization, fill in employee
	NHICS Assignment	Enter assignment being assumed.
	Date / Time In	Enter time started in assignment.
	Date / Time Out	Enter time ended in assignment.
	Total Hours	Enter total number of hours in assignment.
	Signature	Employee/volunteer signature verifying that times are correct.
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.

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
PAGE __ of __
REV. 2017

NHICS 253 | VOLUNTEER REGISTRATION

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

3. REGISTRATION INFORMATION

NAME (LAST NAME, FIRST NAME)	CERTIFICATION/ LICENSURE & NUMBER	ID NUMBER (DRIVERS LICENSE OR SSN)	ADDRESS (CITY, STATE, ZIP)	CONTACT INFO (PHONE, CELL)	REFERENCE CHECK	SIGNATURE

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

PURPOSE: TO DOCUMENT VOLUNTEER INFORMATION FOR EACH OPERATIONAL PERIOD
ORIGINATION: LOGISTICS SECTION CHIEF OR DESIGNEE
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF AND PLANNING SECTION CHIEF

NHICS 253
PAGE __ of __
REV. 2017

NHICS 253 | VOLUNTEER REGISTRATION

INSTRUCTIONS

PURPOSE: Documents volunteer sign in and sign out for each Operational Period.

ORIGINATION: Logistics Section Chief or designee

COPIES TO: Planning Section Chief and Finance/Administration Section Chief

NOTES: If additional pages are needed, use a blank NHICS 253 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	Registration Information	
	Name	Enter the full name of volunteer.
	Certification / License and Number	If volunteer holds a certification or license, enter type and number.
	ID Number	Enter a Driver's License number or Social Security Number.
	Address	Enter address.
	Contact Info	Enter phone number.
	Reference Check	References contacted, yes or no.
	Signature	Signature of volunteer verifying that information is correct.
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.

PURPOSE: TO DOCUMENT VOLUNTEER INFORMATION FOR EACH OPERATIONAL PERIOD
ORIGINATION: LOGISTICS SECTION CHIEF OR DESIGNEE
COPIES TO: FINANCE ADMINISTRATION SECTION CHIEF AND PLANNING SECTION CHIEF

NHICS 253
PAGE __ of __
REV. 2017

NHICS 254 | EMERGENCY ADMIT TRACKING

NHICS
Nursing Home Incident Command System

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

3. AREA

TRIAGE TAG OR MEDICAL RECORD #	NAME (LAST, FIRST)	SEX	DOB/AGE	ADMITTED FROM	ADMITTED TO	TIME

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

PURPOSE: ACCOUNT FOR EMERGENCY ADMITS OR OTHERS SEEKING TEMPORARY SHELTER
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: PLANNING AND OPERATIONS SECTION CHIEF

NHICS 254 | EMERGENCY ADMIT TRACKING

INSTRUCTIONS

PURPOSE: Records the triage, treatment, and disposition of emergency admits seeking medical attention or transfer from an impacted facility.

ORIGINATION: Resident Services Branch Director or team members

COPIES TO: Planning Section Chief and Operations Section Chief

NOTES: Completed upon arrival of the first emergency admission and updated periodically. Copies are sent to the Planning Section Chief each hour and at the end of each operational period until disposition of the last victim(s) are known. If additional pages are needed, use a blank NHICS 254 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Area**	Enter the triage or specific treatment area (e.g., Triage, Immediate Treatment Area).
	Triage Tag or Medical Record Number	Enter triage tag number or medical record number if available.
	Name	Enter the full name of victim.
	Sex	Enter sex: M for male/F for female.
	DOB / Age	Enter date of birth and age.
	Admitted from	Enter the name of the sending facility/location
	Admitted to	Enter the name of the facility accepting the admit
	Time	Enter the time of admission
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.

PURPOSE: ACCOUNT FOR EMERGENCY ADMITS OR OTHERS SEEKING TEMPORARY SHELTER
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: PLANNING AND OPERATIONS SECTION CHIEF

NHICS 254
PAGE __ of __
REV. 2017

NHICS 255 | MASTER RESIDENT EVACUATION TRACKING

NHICS
Nursing Home Incident Command System

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 ☐ FACILITY TRANSFER ☐ 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 ☐ FACILITY TRANSFER ☐ 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 ☐ FACILITY TRANSFER ☐ 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

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.

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

NHICS 255
PAGE __ of __
REV. 2017

NHICS 257 | RESOURCE ACCOUNTING RECORD

NHICS
Nursing Home Incident Command System

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

3. RESOURCE RECORD

TIME	ITEM/FACILITY TRACKING ID#	CONDITION	RECEIVED FROM	DISPENSED (TO/TIME)	RETURNED (DATE/TIME)	CONDITION (OR INDICATED IF NON-RECOVERABLE)	INITIALS

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

PURPOSE: RECORDS THE REQUEST, DISTRIBUTION, RETURN AND CONDITION OF EQUIPMENT AND RESOURCES
ORIGINATION: IMT PERSONNEL AS DIRECTED BY SECTION CHIEFS
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF, LOGISTICS SECTION CHIEF, ORIGINATOR AND PLANNING SECTION CHIEF

NHICS 257 | RESOURCE ACCOUNTING RECORD

NHICS
Nursing Home Incident Command System

INSTRUCTIONS

PURPOSE: Documents the request, distribution for use, return, and condition of equipment and resources used to respond to the incident.

ORIGINATION: Logistics Section Chief and/or by Incident Management Team (IMT) staff

COPIES TO: Finance/Administration Section Chief, the Logistics Section Chief, the original requester of the resource, and the Planning Section Chief

NOTES: If additional pages are needed, use a blank NHICS 257 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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	**Resource Record**	
	Time	Enter the time (24-hour clock) and the request received.
	Item / Facility Tracking Identification Number	Enter the item and the facility tracking identification number.
	Condition	Enter the condition of the item when it was received.
	Received From	Enter whom the item was received from.
	Dispensed	Enter whom the item was dispensed to and the time (24-hour
	Returned	Enter the date (m/d/y) and time (24-hour clock) the item was
	Condition	Enter the condition the item was in when returned or indicate if non- recoverable.
	Initials	Enter initials of person processing item.
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.

PURPOSE: RECORDS THE REQUEST, DISTRIBUTION, RETURN AND CONDITION OF EQUIPMENT AND RESOURCES
ORIGINATION: MAY BE COMPLETED BY THE LOGISTICS SECTION CHIEF AND/OR IMT STAFF
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF, LOGISTICS SECTION CHIEF, ORIGINATOR AND PLANNING SECTION CHIEF

NHICS 257
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

NHICS
Nursing Home Incident Command System

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

3. CONTACT INFORMATION

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Agency for Toxic Substances and Disease Registry (ATSDR)					
Ambulance/EMS					
American Red Cross					
Biohazard Waste Company					
Buses					
Cab, City					
Emergency Management Agency					
CDC					
Clinics					
Coroner/Medical Examiner					
Dispatcher - 911					
Emergency Operations Center (EOC), Local					
Emergency Operations Center (EOC), State					
Engineers:					
HVAC					
Mechanical					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Seismic					
Structural					
Environmental Protection Agency (EPA)					
Epidemiologist					
Family/Guardian	*SEE FAMILY/GUARDIAN CONTACT LIST*				
Fire Department					
Food Service					
Fuel distributor					
Fuel trucks					
Funeral Homes/Mortuary Services					
Generators					
HazMat Team					
Health Department, Local					
Heavy Equipment (e.g., Backhoes, etc.)					
Home Repair/Construction Supplies:					
Hospitals:					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Hotel/motel					
Housing, Temporary					
Ice, Commercial					
Laboratory Response Network					
Laundry/Linen Service					
Law Enforcement:					
City Police					
County Sherriff					
Highway Patrol					
Licensing & Certification District Office					
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:					
Media:					
Print					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Radio					
Radio					
TV					
TV					
TV					
Medical Gases:					
Medical Supply:					
Medication, Distributor:					
Moving Company:					
Pharmacy, Commercial:					
Poison Control Center					
Portable Toilets					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Radios:					
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds					
Biomedical Devices					
Gardeners/landscapers					
Glass					
Medical Equipment					
Oxygen Devices					
Radios					
Roadways/sidewalks					
Restoration Services (e.g., Service Master)					
Road Conditions	*CALTRANS*	*1-800-427-7623*			
Salvation Army					
Shelter Sites					
Staff	*SEE STAFF CONTACT LIST*				
Surge Facilities					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Traffic Control/Department of Transportation					
Trucks:					
Refrigeration					
Towing					
Utilities:					
Gas/Electricity					
Power					
Sewage					
Telephone					
Water, municipal					
Ventilators					
Water Vendor - Potable					
Water; non-potable					
Other:					
Other:					
Other:					

4. DATE LAST UPDATED	

5. PREPARED BY PLANNING SECTION CHIEF	PRINT NAME: _____ SIGNATURE: _____ DATE/TIME: _____ FACILITY: _____

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

NHICS 258 | FACILITY RESOURCE DIRECTORY

INSTRUCTIONS

PURPOSE: Lists all methods of contact for nursing home resources for an incident.

ORIGINATION: Planning Section Chief

COPIES TO: All IMT staff, and posted as necessary.

NOTES: If this form contains sensitive information such as cell phone numbers, it should be clearly marked in the header that it contains sensitive information and is not for public release. If additional pages are needed, use a blank NHICS 258 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	**Contact Information**	
	Company / Agency	Type of company or agency.
	Company / Agency / Name	List the name of the company/agency. List the name of the point of contact if available.
	Telephone	Enter the telephone number.
	Alternate Telephone	Enter the alternate telephone number.
	Email	Enter the email, if available.
	Fax / Website	Enter the fax number and/or website.
4	**Date Last Updated**	If the document is completed prior to an incident, the last update should be entered (m/d/y). The directory should be updated at least annually.
5	**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.

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258
PAGE __ of __
REV. 2017

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NHICS 259 | FACILITY CASUALTY/FATALITY REPORT

1. INCIDENT NAME		2. OPERATIONAL PERIOD		
		DATE: FROM:		TO:
		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 259
PAGE __ of __
REV. 2017

NHICS 259 | FACILITY CASUALTY/FATALITY REPORT

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

INSTRUCTIONS

PURPOSE: Records the number of residents injured and expired for each operational period.

ORIGINATION: Resident Services Branch Director or team

COPIES TO: Command Staff and General Staff

NOTES: If additional pages are needed, use a blank NHICS 259 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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 (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Reported Casualty/Fatality**	
	Resident Name	Enter the full name of the casualty/fatality.
	Medical Record #	Enter the medical record number.
	Injury	Describe the injury.
	Transfer Date/Time	Enter the transfer date and time.
	Receiving Facility	Enter the name of the facility accepting the casualty/fatality.
	Expired Date/Time	Enter the expiration date and time of the fatality.
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.

PURPOSE: DOCUMENT THE NUMBER OF INJURIES AND FATALITIES
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: COMMAND STAFF AND GENERAL STAFF

NHICS 259
PAGE __ of __
REV. 2017

NHICS 260 | RESIDENT EVACUATION TRACKING FORM

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

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
☐ GURNEY
☐ WHEEL CHAIR
☐ AMBULATORY
☐ SPECIAL MATTRESS

☐ IV PUMPS
☐ OXYGEN
☐ VENTILATOR
☐ BLOOD GLUCOSE MONITOR
☐ RESPIRATORY EQUIPMENT

☐ SERVICE ANIMAL
☐ G TUBE PUMP
☐ MONITOR
☐ FOLEY CATHETER
☐ OTHER

List "OTHER" below:
_____
_____

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 ☐ LEFT IN ROOM ☐ NONE
VALUABLES	☐ WITH RESIDENT ☐ LEFT IN ROOM ☐ NONE
MEDICATIONS	☐ WITH RESIDENT ☐ LEFT IN ROOM ☐ 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 ☐ NO
VALUABLES RECEIVED	☐ YES ☐ NO
MEDICATIONS RECEIVED	☐ YES ☐ 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

NHICS 260
PAGE __ of __
REV. 2017

NHICS 260 | RESIDENT EVACUATION TRACKING FORM

NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

INSTRUCTIONS

PURPOSE: Documents and accounts for residents transferred to another facility.

ORIGINATION: Resident Services Branch Director, Operations Section Chief and/or IMT staff as appropriate

COPIES TO: Planning Section Chief and the evacuating clinical location. Original is kept with the resident.

NOTES: The information on this form may be used to complete NHICS 255, Master Resident Evacuation Tracking Form. Additions or deletions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Date	Enter the date of the evacuation.
2	Facility Name	Enter the Facility Name the resident is leaving from.
3	Resident Name	Enter the resident's full name.
4	Age	Enter the resident's age.
5	Medical Record #	Enter the resident's medical record number.
6	Significant Medical History	Enter significant medical history.
7	Attending Physician	Enter the name of the resident's attending physician.
8	Family/Guardian Notified	Check yes or no; enter family/guardian contact information.
9	Transportation Equipment	Identify type of transportation equipment (e.g., wheelchair, gurney) needed.
10	Accompanying Equipment	Check appropriate boxes for any equipment being transferred with the resident.
11	Special Needs	Indicate if the resident has special needs, assistance, or requirements.
12	Isolation	Indicate if isolation is required, the type, and the reason.
13	Evacuating Location	Fill in information and check boxes to indicate originating room and what was sent with the resident (records, medications, and belongings).
14	Arriving Location	Fill in information and check boxes to indicate resident's arrival at new location and whether materials sent with the resident were received.
15	Transferring to another Facility/ Location	Document arrival and departure from the staging area, confirmation of ID band, and mode of transportation used.
16	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.

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING

NHICS 260
PAGE __ of __
REV. 2017

Nursing Home Incident Command System (NHICS)

2017

GUIDEBOOK

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Acknowledgements

In partnership with the California Association of Health Facilities (CAHF), the California Department of Public Health directed federal grant-funded resources to revise the Nursing Home Incident Command System (NHICS) initially published in 2009. The 2017 NHICS revision parallels relevant changes contained in the 2014 Hospital Incident Command System (HICS) update. Most significantly, the 2017 NHICS represents a "streamlining" of the prior NHICS and HICS versions with a goal of making the system easier to use for nursing homes and other long-term care facilities.

The 2017 NHICS relies upon many sources of information, including previous versions of NHICS and HICS that specifically focus on healthcare facilities; the National Incident Management System (NIMS), and other documents in the public domain relevant to emergency management.

Disclaimers

The 2017 Nursing Home Incident Command System (NHICS) was developed under contract by the California Department of Public Health (CDPH) and the California Association of Health Facilities (CAHF) and is exclusively intended to provide information and guidance. This material does not contain or constitute legal advice in any form and does not make any assurance or representation that the information and guidance contained herein will be determined to be accurate or appropriate to your institution or constitute compliance with state or federal law, regulation, or guidance. The decision to adopt and utilize (or modify) the material contained herein is a decision that must be made by each facility.

CAHF, CDPH and the various authors of included content are not responsible for any errors or omissions contained in the NHICS material and assume no responsibility for the misuse or erroneous interpretation of its contents.

Source Imagery

Disaster icons included in the 2017 NHICS are freely available humanitarian symbols offered by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). The symbols have been slightly altered for use in this document.

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Major Changes in NHICS 2017

- Streamlined the Guidebook and Toolkit materials to make the system easier to use.

Incident Management Team (IMT)

- Streamlined the Incident Management Team (IMT) to better reflect the needs of nursing homes and long-term care facilities. In NHICS 2017, there are 11 IMT positions that are described (vs. 28 in the previous 2009 version). In addition to the 10 IMT positions shown below, there is also provision for a Scribe/Runner, who may be assigned to any section but is most commonly assigned to the Planning/Intelligence section. In the Operations Section, two branches are provided (Resident Services and Infrastructure Services). Because of staffing limitations and the need to prioritize resident care, the more expansive organizational structures seen in ICS and HICS have been "rolled up" in NHICS.

- The Liaison Officer and Public Information Officer have been combined into one position.

NEW IMT CHART IN NHICS 2017
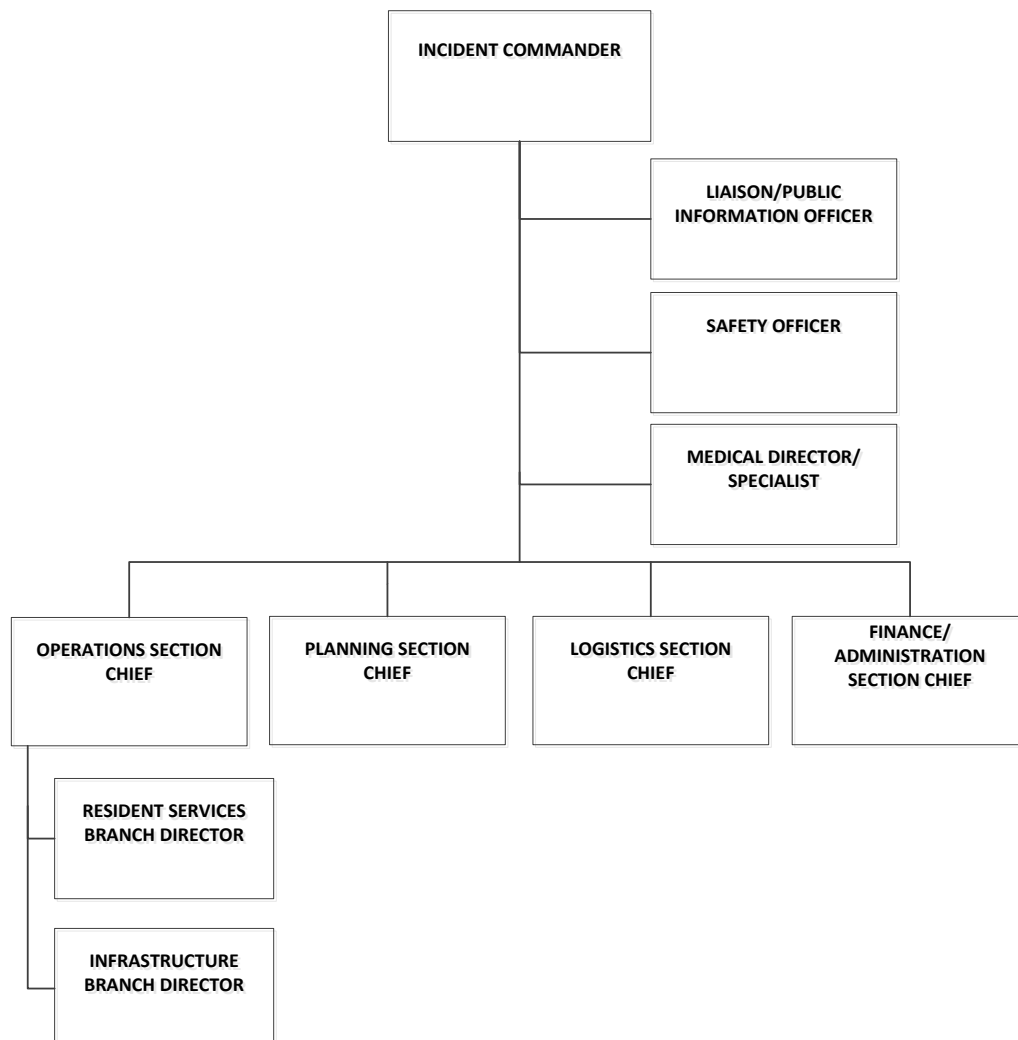
Job Action Sheets (JASs)

- Rolled up position-level tasks from eliminated Branches and Units
- Job Actions Sheets have been streamlined from 20 to 11, one for each IMT position
- Added an optional "Scribe/Runner"

Incident Response Guides (IRGs)

- Added five new Incident Response Guides (IRGs):

IRGs in NHICS 2017	Previous IRGs
Earthquake	Earthquake
Fire - External	Internal Fire
Infectious Disease	Infectious Disease
Flood	Internal Flooding
Utility Failure	Loss of Power
Severe Weather – Cold or Heat	Severe Weather
Hazardous Material/Waste	
Missing Resident	
Evacuation	
Shelter-in-Place	
Active Shooter	

- A "Rapid Response Checklist" has been inserted into the IRGs before the "Immediate Response (0-2 hours) period.
- The tasks identified in the IRGs are now directly assigned to IMT positions.
- The Security tasks that previously fell under the Operations Section's Physical Plant/Security Unit Leader are now assigned to the Safety Officer
- Mental/behavioral health falls under the Resident Services Branch Director (Intermediate and Extended response) and Operations Section Chief (Demobilization).

Incident Planning Guides (IPGs)

- Three new Incident Planning Guides have been added to NHICS 2017.
- A narrative "Scenario" has been added to the IPGs which are now subdivided into sections based on Mitigation, Preparedness, Immediate and Intermediate Response, and Extended Response and System Recovery.

IPGs in NHICS 2017	Previous IPGs
Earthquake	Earthquake
Fire - External	Internal Fire
Infectious Disease	Infectious Disease
Flood	Internal Flooding
Utility Failure	Loss of Power

IPGs in NHICS 2017	Previous IPGs
Severe Weather – Cold or Heat	Severe Weather
Hazardous Material/Waste	
Missing Resident	
Evacuation	
Shelter-in-Place	
Active Shooter	

NHICS Forms

- New! Created an Incident Action Plan (IAP) Quick Start.
- New! Added a NHICS 204 Assignment List for the Planning Section Chief (use is optional).
- Added a one-page instruction sheet at the end of each NHICS form that describes the purpose, who completes the form, and additional information.
- Created a customizable IMT chart in Microsoft Visio.
- Eliminated NHICS 213 - Incident Message Form and NHICS 256 - Procurement Summary.
- Forms are available in fillable Microsoft Word and Adobe PDF format. The Word-based forms may be customized by turning off document protection. To turn off document protection in Word: 1) Select the "Developer" tab, 2) Find the "Protect" group and Select "Restrict Editing", and 3) Click the button for "Stop Protection"

The table below summarizes the new NHICS 2017 Forms compared to the previous NHICS Forms.

NHICS 2017	2011 NHICS
200 Incident Action Plan (IAP) Quick Start	(Previous IAP required a combination of completed NHICS forms)
201 Incident Briefing	201 Incident Briefing & Operational Log
202 Incident Objectives	202 Incident Objectives
203 Organization Assignment List	203 Organization Assignment List
204 Assignment List	n/a
205 Communications List	205 Incident Communications Plan
206 Staff Medical Plan	206 Staff Injury Plan
207 Incident Management Team Chart	207 Organization Chart
Eliminated	213 Incident Message Form
214 Activity Log	214 Unit Log
251 Facility System Status Report	251 Facility System Status Report
252 Section Personnel Time Sheet	252 Section Personnel Time Sheet
253 Volunteer Registration	253 Volunteer Staff Registration
254 Emergency Admit Tracking	254 Master Emergency Admit Tracking Form
255 Master Resident Evacuation Tracking	255 Master Resident Evacuation Tracking Form

NHICS 2017	2011 NHICS
Eliminated	256 Procurement Summary Report
257 Resource Accounting Record	257 Resource Accounting Record
258 Facility Resource Directory	258 Facility Resource Directory
259 Facility Casualty Fatality Report	259 Master Facility Casualty Fatality Report
260 Resident Evacuation Tracking	260 Resident Evacuation Tracking Form
215A Incident Action Plan (IAP) Safety Analysis	261 Incident Action Plan Safety Analysis

The table below summarizes the IMT personnel assigned to complete each NHICS Form and whether the form is Recommended or Optional. A total of 10 forms are recommended.

NHICS 2017	Completed by	Recommended or Optional
Incident Action Plan (IAP) Quick Start	Incident Commander or Planning Section Chief	Recommended
201 Incident Briefing	Incident Commander or designee	Optional
202 Incident Objectives	Planning Section Chief	Optional
203 Organization Assignment List	Planning Section Chief	Optional. Has IMT contact information. If not maintained somewhere else, use this form.
204 Assignment List	Planning Section Chief	Optional full form. Abbreviated in IAP Quick Start
205 Communications List	Logistics Section Chief	Optional full form. Abbreviated in IAP Quick Start
206 Staff Medical Plan	Safety Officer	Optional full form. Abbreviated in IAP Quick Start
207 Incident Management Team Chart	Incident Commander or designee	Optional. Included in Quick Start IAP
214 Activity Log	All IMT Personnel	Recommended
215a Incident Action Plan (IAP) Safety Analysis	Safety Officer	Recommended full form. Abbreviated in IAP Quick Start
251 Facility System Status Report	Infrastructure Branch Director	Recommended
252 Section Personnel Time Sheet	All IMT Personnel	Recommended
253 Volunteer Registration	Logistics Section Chief	Optional, may use own tracking system
254 Emergency Admit Tracking	Resident Services Branch Director	Recommended
255 Master Resident Evacuation Tracking	Resident Services Branch Director	Recommended

NHICS 2017	Completed by	Recommended or Optional
257 Resource Accounting Record	All IMT Personnel; included under Logistics Section Chief JAS	Optional, may use own tracking system
258 Facility Resource Directory	Planning Section Chief	Recommended
259 Facility Casualty Fatality Report	Resident Services Branch Director	Recommended
260 Resident Evacuation Tracking	Resident Services Branch Director	Recommended

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NHICS GUIDEBOOK

TABLE OF CONTENTS

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I.   INTRODUCTION

Nursing homes provide essential services that must be protected at all times, including those extraordinary occasions we call *emergencies* or *disasters*. Yet it is difficult to predict when an incident may occur that threatens the ability of a nursing home to safely care for its residents, staff and visitors; or conduct normal operations that maintain the facility's business viability (continuity of operations).

In 2016, the Centers for Medicare and Medicaid Services (CMS) expanded the emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers.[1] In so doing, CMS defines an emergency or disaster as:

> *"An event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional or national level by an authorized public official such as a Governor, the Secretary of HHS, or the President of the United States. It also includes events that can affect the facility internally."*

In addition, the President is authorized to issue "emergency" or "major disaster" declarations before or after catastrophes occur. In general, a major disaster declaration triggers broader authority for federal agencies to provide supplemental assistance to state and local governments, families and individuals, and certain nonprofit organizations recovering from the incident.

All nursing homes should be prepared for and exhibit resiliency when faced with any type of incident, ranging from an internal emergency that affects only one facility to a large, regional disaster that simultaneously affects many healthcare facilities and the community. The **Incident Command System (ICS)** provides a practical, proven approach to disaster management that is an integral part of the National Incident Management System (NIMS). ICS is utilized for incident management throughout the public and private sectors.

ICS can be used by anyone who understands the basic functional requirements necessary for establishing goals and objectives to meet the operational needs of an incident.

A note about terminology: **The Incident Command System originated with the fire service in the 1970's and is used throughout the U.S. in both the public and private sectors. Why has ICS become so universally adopted? The answer is because it is the most successful approach to managing emergencies/disasters (incidents) that require a coordinated response beyond typical day-to-day challenges. For some public safety agencies, ICS is routinely used on a daily basis.**

In the healthcare environment, hospitals and nursing homes have adapted ICS to fit their specific needs, leading to the Hospital Incident Command System (HICS) and the Nursing Home Incident Command System (NHICS). The adoption of these systems allows healthcare facilities to effectively integrate into the emergency management structure, and by so doing, maximize positive outcomes.

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[1] Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule; U.S. Department of Health and Human Services; Centers for Medicare & Medicaid Services; 81 Federal Register 180 (16 September 2016); p 63865.

To simplify for a moment, let's consider a "disaster" to be a really big problem that you didn't expect. Examples: your facility lost power and the backup generators failed; a tornado ripped away part of your building; there is an active shooter in your facility. With all of these situations, a number of problems are created and response priorities must be identified (as an example, it would be a priority to safely evacuate residents from a structurally damaged building). ICS enables you to create an organizational structure and road map to optimally manage the incident relative to the situational circumstances.

Why isn't the normal, day-to-day organizational system used by each nursing home sufficient to manage a disaster? The answer is that disasters are not "business as usual"; they are, by definition, extraordinary events that place highly unusual stresses on the facility, including the management team and staff that work at the facility. **Effectively responding to a disaster requires additional skills that must be acquired <u>before</u> the disaster occurs.** If this document conveys only one important point, it is that each facility should commit to preparing in advance for such an event.

ICS, like all well established and tested systems, utilizes a standardized organizational structure and terminology (we recommend sticking with the structure and terminology for reasons we'll discuss in more detail later). While ICS's fundamental principles are carved in stone, there is great flexibility in how ICS is applied in a specific setting, including nursing homes, for any given incident. The streamlined approach presented in this Guidebook and Toolkit reflects the need to prioritize resident care and acknowledges the staffing limitations faced by many facilities. However, it is important to recognize that there are certain unalterable tasks that must occur when responding to any emergency; these NHICS documents provide a road map for accomplishing those essential tasks. NHICS provides standardization that can markedly improve the ability of an organization to successfully respond to a disaster.

The purpose of this document is to provide the information necessary for nursing home administrators and staff to understand the principles of NHICS and embrace its implementation before it's needed.

> **The Nursing Home Incident Command System (NHICS) is both <u>functional</u> and <u>flexible</u>. Whenever an emergency/disaster (incident) occurs, ICS provides a structure and organizational approach to support incident goals and objectives (we'll talk more about "incident goals and objectives" later).**

NHICS recognizes that the following <u>essential responsibilities</u> must be met to successfully manage an incident:

- People that **LEAD/MANAGE** all of the activities necessary to support incident goals and objectives;
- People that **DO** stuff to support incident goals and objectives;
- People that **GET** stuff to support incident goals and objectives;
- People that **COLLECT RELEVANT INFORMATION, ANALYZE and PLAN** to support incident goals and objectives; and
- People that take care of **FINANCE/ADMINISTRATIVE/CLERICAL SUPPORT** to support incident goals and objectives.

These essential responsibilities relate to NHICS functions as follows:

ESSENTIAL RESPONSIBILITIES	NHICS FUNCTIONS
Lead/Manage	Incident Command
Do Stuff	Operations
Get Stuff	Logistics
Collect Information, Analyze and Plan	Planning
Finance, Administration and Clerical Support	Finance and Administration

This simple table illustrates how the responsibilities necessary to successfully manage an incident are reflected in the five NHICS functions. All five functions within NHICS – Command, Operations, Planning, Logistics, and Finance and Administration – must be covered for each incident.

For a small incident, the activities of all NHICS sections may be managed effectively by one person, the Incident Commander. For larger incidents, more people are almost certainly needed. NHICS is very specific on how the NHICS organizational structure grows as incidents become larger and more complex.

> **Note: Let's pause for a moment to discuss what is meant when we say NHICS is "flexible". It does not mean that the five functional roles in NHICS change; it means that the number of people required to fulfill those roles may range from one person (the "Incident Commander") to many people in a large disaster. If ONE PERSON can effectively lead/manage the incident; do what is necessary; get the resources needed; plan, collect and analyze relevant information; and provide the necessary finance, administrative and clerical support to manage the incident, then NHICS has been successfully applied!**

II.   NHICS FUNCTIONS

Each of the five NHICS functions -- Command, Operations, Planning, Logistics, and Finance and Administration – are responsible for the following activities:

A)   INCIDENT COMMAND ("Leader")

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

The Incident Commander is responsible for the following:

- Establishes the use of NHICS to manage the incident

- Establishes the initial objectives for managing the incident
- Identifies the supporting NHICS staff necessary to respond to the incident (also known as incident "*size up*"[2])
- Recruits assistance as needed
- Keeps senior administration informed
- Coordinates with other response partners as necessary, e.g., EMS, fire, law enforcement, public health

There are three additional members of the Command Staff that report to the Incident Commander. These functions must always be addressed; although in a small incident, the Incident Commander may be able to handle these responsibilities.

The **Safety Officer** is responsible for the overall safety of the response actions, including modifying or suspending operations if conditions are unsafe to continue. For example, a nursing home may be forced to evacuate all or part of the facility due to an earthquake. The Safety Officer should evaluate the site to which residents are relocated to ensure the location is free of hazards or risk.

The **Liaison/Public Information Officer** serves as the communication link between the nursing home and external partners. This position provides information to external response agencies such as public health authorities, emergency management officials, law enforcement and other agencies that have been identified by the facility as key community partners that may be involved in response. This position also communicates with the media.

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

B)   OPERATIONS ("Doers")

The Operations Section coordinates all tactical activities. Under the direction of an Operations Section Chief, these people implement actions that are consistent with the objectives initially identified by the Incident Commander and further identified in the Incident Action Plan (IAP).

The oversight of the Operations Section is provided by an **Operations Section Chief**. Additional positions, if necessary, may include a **Resident Services Branch Director** and an **Infrastructure Branch Director.**

The **Operations Section Chief** oversees all tactical operations carried out within the response. He/she will activate the additional positions based on the needs of the event, as well as the availability of

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[2] "Size up" is the ability to assess the current emergency management needs imposed by the incident in addition to the anticipated needs expected in the near term. Proper "size up" leads to correct IMT staffing.

qualified personnel to fill the positions. Remember that if a position is needed but there is insufficient staffing to fill that position, the functions of that position are assumed by the highest position activated in that section.

The **Resident Services Branch Director** is responsible for the continuation of resident services as well as the provision of care to residents, staff and visitors who are injured or become ill due to the incident. Responsibilities include ensuring the continuation of resident services, e.g., rehabilitation and vocational services as provided by the facility; ensuring that residents are accounted for and tracked; medical records; and that services needed to sustain operations are identified and provided.

The following functions are managed within the Resident Service Branch:

- Admit/Transfer and Discharge
- Nursing
- Medical Records
- Psychosocial

The following functions are managed within Infrastructure Branch:

- Dietary
- Physical Plant/Security
- Environmental

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

C)   LOGISTICS ("Getters")

The **Logistics Section** is considered the "getters" for the response. Logistics provides the necessary services and support to sustain operations during the emergency response. This section identifies and inventories current resources including supplies, equipment, and personnel, and obtains any additional items needed to support operations. Logistics basically obtains **"staff, stuff and space"** to support the ability of the IMT to perform its duties and operationally respond to the incident.

This section's responsibilities include personnel/manpower, supplies, equipment, pharmaceuticals, and vehicles. The Logistics Section works closely with the Operations Section, responding to supply requests and their acquisition based on the needs of the response. During pre-event planning, a staging area (or areas) should be established and identified in the Emergency Operations Plan (EOP). The staging area will be a central location, large enough to allow for the collection of personnel, vehicles, and equipment/supplies that may be needed for the response. The Logistics Section Chief provides oversight and direction at the staging area(s), maintaining an inventory of those supplies.

Logistics ensures the preservation of essential services including communications and information technology. Logistics organizes and maintains the facility's supplies, equipment, transportation and labor pool in support of the residents, staff, and staff dependents in accordance with facility policy. It must account for those resources used and requested for operations.

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

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

The type of support Logistics provides may include the following:

- Food and Water
- Shelter
- Medical Supplies
- Transportation
- Communications and IT
- Specialized Personnel Resources

D)   PLANNING ("Planners")

The **Planning Section** (also known as **Planning and Intelligence**) is overseen by the Planning Section Chief and is responsible for collecting and analyzing relevant situational information, creating plans that support the success of the NHICS process, and maintaining documents or displays that show the current status of relevant resources (e.g., what resources such as staff, heaters, generators, etc.) are assigned where. The Planning Section provides up-to-date and accurate information regarding residents, staff, supplies and equipment and projects the ability to sustain operations. An important duty assigned to the Planning Section is the development of the **Incident Action Plan (IAP)**; the Planning Section also keeps careful track of personnel who report to the IMT (this process is called "Check In").

The Planning Section will take the lead in coordinating documentation efforts by working with other members of the IMT to document the incident, typically using NHICS Forms. This section is also responsible for archiving the documents created during the response.

E)   FINANCE AND ADMINISTRATION ("Supporters")

The **Finance and Administrative Section** may lack glamour but it is vitally important to incident response. It is responsible for all purchasing related to the management of the incident; in addition to tracking and reporting all financial and administrative information, including records management, payroll, and the overall incident budget. Long after the Operations, Planning and Logistics Sections have demobilized, the Finance and Administration Section is still sorting out paperwork, bills due, payroll issues, and tallying response costs. In some cases, it may be possible for private entities to recoup some of their disaster-

related response costs, although detailed record keeping is an absolute requirement.

The **Finance and Administration Section Chief** oversees the costs and expenditures incurred by the response actions, including the purchasing of supplies and equipment. The Finance and Administration Section must also account for lost revenue associated with the response and recovery and ensure thorough investigation and documentation of incident-related claims.

> **Note: Most disciplines, including emergency management, like to use memory tricks to keep track of the essentials. One way to remember the essential NHICS Sections is to use the acronym "FLOP" – Finance & Admin, Logistics, Operations and Planning. Of course, don't forget the Command Function in addition to FLOP. The FLOP Section Chiefs report to the Incident Commander. If you are ever the Incident Commander, or any FLOP Section Chief, be sure to add this to your qualifications!**

III.   NHICS FLEXIBILITY

Regarding flexibility, emergencies/disasters come in all shapes and sizes. Consider the need to fully evacuate your facility. A critical factor is whether the evacuation must occur as quickly as possible (*emergent* evacuation) or could be planned and executed over a more extended time period, e.g., 2-3 days (*planned* evacuation). Either situation is highly unusual and could be considered an emergency (under the assumption that your facility is the only one impacted) or even a larger, community disaster (under the assumption that a number of healthcare facilities in an affected area must evacuate simultaneously, placing considerable stress on the EMS transport system).

The type of incident, magnitude of impact to your facility or the larger community and many other factors will dictate the size of your Incident Management Team (IMT). A determining factor is called "span-of-control", i.e., the number of people that can effectively manage the incident is determined by the size and complexity of the incident; no person should manage more people than he or she can do so effectively. In NHICS, the range for span-of-control is 3 to 7 people, but typically no more than 5. If activities cannot easily be managed by the existing IMT, it's time to expand the IMT. Remember that the entire IMT may be a single person – the Incident Commander, assuming this person can successfully complete all of the required activities to manage the incident.

IV.   BUILDING THE INCIDENT MANAGEMENT TEAM (IMT)

Once an emergency has occurred (or is eminent), how do you decide who, and how many personnel, should become involved in managing the incident? The people assigned to managing the incident are called the "Incident Management Team" or IMT.

There are a number of factors that will determine the size and composition of your IMT, including who is available; the demands created by the incident; etc.

If an incident occurs without notice, the senior person on site should assume the role of Incident Commander unless your facility's disaster plan has pre-established who the immediate on-site Incident Commander should be. This person should continue in the role of Incident Commander until relieved by another person designated by your facility's disaster plan or appointed by the senior facility executive. To

account for staff turnover and unavailability, the disaster plan should list a sequence of Incident Commanders in case the initial choice(s) are unavailable or delayed. If NHICS is activated for a planned event, the Incident Commander should be specified in the facility's disaster plan.

As previously stated, the one IMT position <u>always</u> activated is the Incident Commander. If this person can handle all five of the essential functions of incident response – Command, Operations, Planning, Logistics, and Finance and Administration – then the IMT may be exactly one person. As soon as the Incident Commander recognizes that there is a need to expand the IMT to successfully manage these five essential functions, then the IMT should expand at that point as necessary.

The person in the role of Incident Commander should be a knowledgeable and steady hand, not easily prone to being rattled by a pressured and possibly chaotic situation, and trusted by management. The ability of an Incident Commander to "size up" the incident and plan to add the appropriate IMT members is essential to effective leadership. Proper "size up" of an incident requires a quick understanding of current needs coupled with the ability to project needs in the near term. It is very difficult to manage an emergency if the response organization is constantly playing "catch up".

As soon as the Incident Commander recognizes the need for additional IMT members to successfully manage the five NHICS functions throughout the duration of the incident, he or she should expand the organization in a standardized fashion. This means that it is built from the "top down", i.e., the Incident Commander may recognize the need to activate other members of the Command Staff (Liaison/Public Information Officer, Safety Officer or Medical Director/Specialist) and/or one or more Section Chief(s), as needed for the incident. This expansion continues until all five functions are successfully managed; similarly, positions may be de-activated as the incident needs diminish. Every decision to expand or contract the size of the IMT should reflect the basic needs of the incident, keeping in mind the concept of "span-of-control", i.e., no individual should manage more than 3 to 5 individuals.
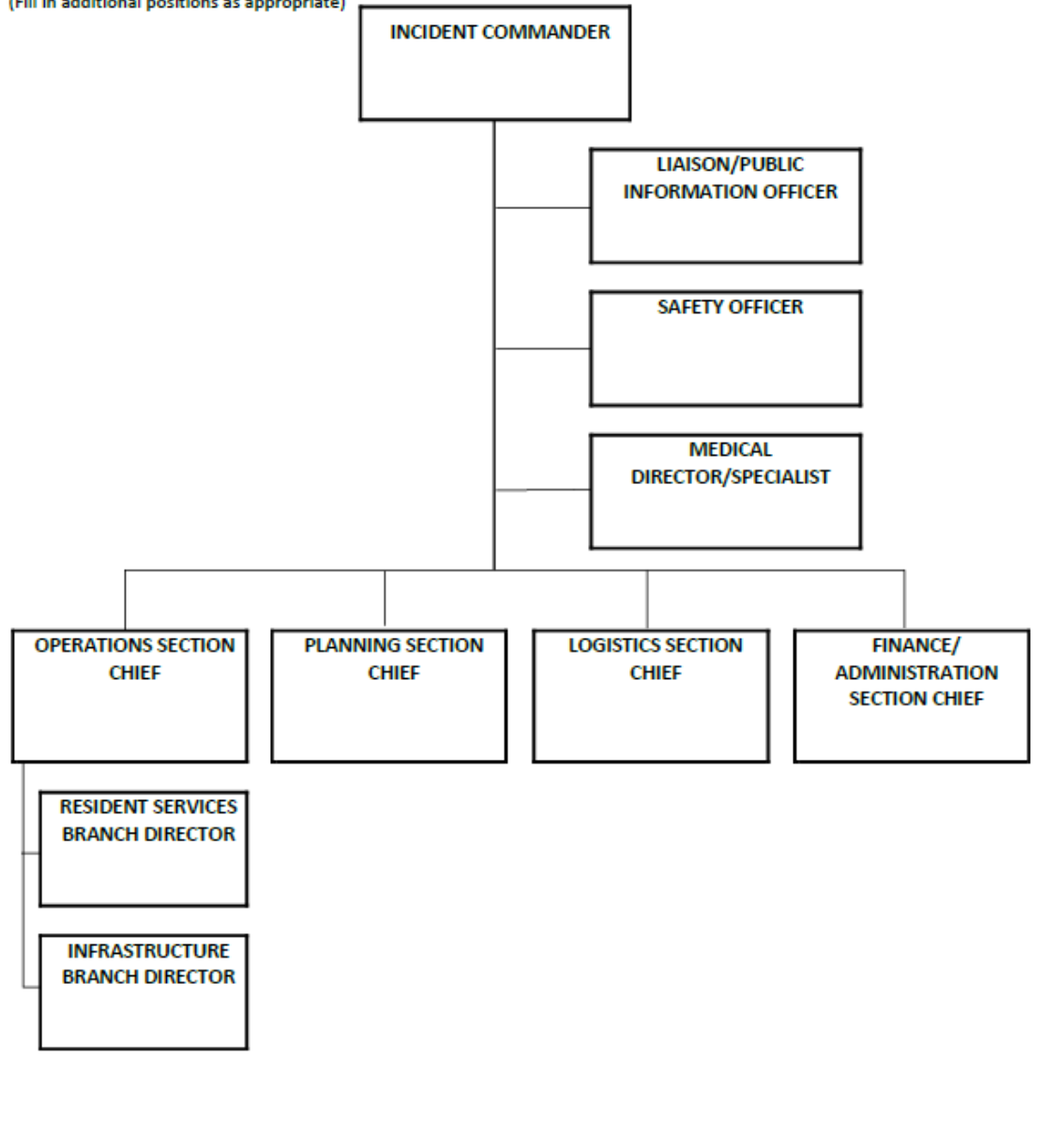
See the next page for a component of the important documentation necessary for managing incident response, the structure of the IMT. This is provided as part of the NHICS Forms package included in the NHICS Response Toolkit. It can be found in the Incident Action Plan (IAP) Quick Start (NHICS 200) or the Incident Briefing (NHICS 201).

NHICS 201 | INCIDENT BRIEFING

6. CURRENT ORGANIZATION

(Fill in additional positions as appropriate)

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                        ┌─────────────────────┐
                        │  INCIDENT COMMANDER  │
                        └─────────────────────┘
                                  │
                        ┌──────────────────────────┐
                        │      LIAISON/PUBLIC       │
                        │   INFORMATION OFFICER     │
                        └──────────────────────────┘

                        ┌──────────────────────────┐
                        │      SAFETY OFFICER       │
                        └──────────────────────────┘

                        ┌──────────────────────────┐
                        │         MEDICAL           │
                        │   DIRECTOR/SPECIALIST     │
                        └──────────────────────────┘

  ┌──────────────┬──────────────┬──────────────┬──────────────┐
  │ OPERATIONS   │  PLANNING    │  LOGISTICS   │  FINANCE/     │
  │ SECTION      │  SECTION     │  SECTION     │  ADMINISTRATION│
  │ CHIEF        │  CHIEF       │  CHIEF       │  SECTION CHIEF │
  └──────────────┴──────────────┴──────────────┴──────────────┘
         │
   ┌───────────────────┐
   │ RESIDENT SERVICES │
   │ BRANCH DIRECTOR   │
   └───────────────────┘

   ┌───────────────────┐
   │  INFRASTRUCTURE   │
   │  BRANCH DIRECTOR  │
   └───────────────────┘
```

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

NHICS 201
PAGE ___ of ___
REV. 2017

If expansion of the IMT is needed, it expands in a standardized fashion. Position titles within the IMT define the role and tasks assigned to that role. Titles identify the hierarchy within the chain of command, which is an important component of the NHICS management system. These titles include, in order of hierarchy:

Incident Commander:	There is only one Incident Commander at any time during the incident response.
Officers:	Officers are part of the Command Section. In NHICS, the Officer roles are the Liaison/Public Information Officer, Medical Director/Specialist and Safety Officer. Each of these positions reports directly to the Incident Commander.
Chiefs:	Oversight for a section is provided by a Section Chief.
Directors:	Branches may be activated under the Sections to maintain the chain-of-command and conduct specific duties identified by the position title. For example, within the Operations Section, there may be a Resident Services Branch and an Infrastructure Branch, with oversight provided by Branch Directors.

Adapting the IMT to Rural or Small Facilities

In the planning stages, nursing home administrators and managers should determine the availability of on-site staff to fill IMT positions. This should include identification of staff on all shifts; those persons readily available to fill positions during the day may not be immediately available during the night or on weekends. Ideally, a pre-designated IMT chart should be kept current and accessible.

For smaller facilities or during off hours for any facility, it may be necessary for administrators/managers who are working and still on-site to initially assume multiple roles until additional personnel arrive. Job Action Sheets (JASs) for each position that an individual completes should be reviewed and used separately or combined into a blended JAS – this should be done as part of the planning process and not during the response.

The use of NHICS and common training conducted by all of the nursing homes in a community will help to insure that facilities can help one another, especially when the problem is isolated to one facility. Those not impacted may be able to share their IMT trained personnel as well as needed equipment and supplies.

Integrating response planning and training with other local response entities (hospitals, public safety, public health, EMS, etc.) can pay remarkable dividends during an actual emergency.

V.   INCIDENT ACTION PLANNING

Incident Action Planning is a core concept of all ICS systems, including NHICS, and must occur regardless of incident size or complexity.

Incident Action Planning involves six essential steps:

1. Understanding the nursing home's policy and direction

The Command and General staff must first understand the facility's purpose and policies in order to develop appropriate response actions. For example, the nursing home may be active in community medical disaster planning and have developed plans to provide first aid services during the emergency. This policy should be established in written policy and be clearly understood by the IMT as a component of an established response action.

2. Assessing the situation

Situational understanding is critical for developing effective response actions and projecting the likely duration of the incident. Nursing homes should have access to established mechanisms and systems within the community (city, county, regional, or state) that can provide and/or verify situational information. Another component of assessing the situation is determining the potential impact on the facility itself, based on current resident and employee status, the status of the building(s) and grounds, and the ability to maintain resident services.

3. Establishing incident objectives

The Incident Commander sets the overall objectives for the response. For example, during an emergency power failure, ensuring the safety of the residents, staff and visitors should be considered the highest priority. The Incident Response Guides (IRGs) provide examples of objectives that apply to the response based on the specific hazard. These IRGs may be helpful to the Incident Action Planning process.

4. Determining appropriate strategies to achieve the objectives

After the Incident Commander has established the overall objectives for the response, the Section Chiefs determine the appropriate strategies and actions to effectuate the response. This provides an action plan for each section that clearly identifies actions and duties. Section objectives should be developed that provide clear direction in terms of what is to be done. For example, assessing the building for structural damage after an earthquake is a clear and easily understood objective.

5. Giving tactical direction and ensuring that it is followed

Tactical directions provide the responders with the actions to be taken and identify the resources needed to complete the task. For example, assessing the facility after an

earthquake will require the necessary tools such as protective equipment, checklists to document the assessment, etc. Actions undertaken should be assessed for their effectiveness, with the objectives and directions adapted if they are unsuccessful.

6. Providing necessary back-up

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

Management by Objectives (MBO)

The foundation of healthcare incident action planning is Management by Objectives (MBO). The Incident Commander sets the overall objectives for response and recovery. By so doing, staff within operations, logistics, and planning are given clear direction to follow and will subsequently develop strategies for their respective sections.

Consider the following example that demonstrates the application of overall response objectives and strategies. A community-wide infectious disease outbreak impacts the nursing home through illness of residents and staff. The outbreak must be contained, and local health authorities advise restrictions on visitations to nursing homes, hospitals, long-term care, and residential facilities.

At the nursing home, the emergency operations plan has been activated as over 50% of the residents and almost 35% of the facility staff are ill. The Incident Commander identifies the objectives for this response as:

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

For the <u>Operations Section</u> (those who provide care to residents and maintain the facility infrastructure), the strategies and tactics that meet the each of these objectives include:

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

   Strategy: Restrict entry of external visitors

   Tactic 1: Notify residents and family members of restricted visitation to prevent possible spread of infectious disease

   Tactic 2: Post signage of restricted visitation

   Tactic 3: Consolidate all entry points into facility to a single ingress/egress portal

2. Objective: Continue essential resident services and the provision of care

   Strategy: Cancel non-essential services in order to utilize available staff for essential resident services

   Tactic: Identify non-essential services that can be cancelled or postponed;

reassign staff to essential services or to an on-site labor pool

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

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

   Strategy: Provide infection control supplies as needed and directed

   Tactic: Inventory all available infection control supplies, including gloves and masks that are currently available. If the amount is inadequate, investigate alternate sources of supply and acquire amount needed.

Documenting the Incident Action Plan (IAP)

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

For ease of use, the standard ICS forms have been modified for use by healthcare facilities including nursing homes and long-term care facilities (NHICS Forms) and hospitals (HICS Forms).

Since Incident Action Planning is so important, an **Incident Action Plan (IAP) – Quick Start** version has been developed for NHICS. This Quick Start IAP consolidates the information contained in five separate forms:

NHICS 201	Incident Briefing
NHICS 202	Incident Objectives
NHICS 203	Organization Assignment List
NHICS 204	Assignment List (for Sections)
NHICS 215A	Incident Action Plan Safety Analysis

The completed IAP should be copied and shared with all IMT staff so that all team members clearly understand the information most relevant to incident response.

Facility Command Center

It is important to designate an area within the nursing home to serve as the Facility or Nursing Home Command Center. This should happen as part of the planning process, not at the time the incident occurs. Conference rooms are often used for this purpose. The room ideally should be in a secure location and suitable in size to accommodate the anticipated number of personnel filling IMT positions who will operate from this area. It is important that there be ready access to phones, computers with internet capability, printers, fax machine, and general

supplies (paper, pencils, etc.). It is often helpful to have a whiteboard on hand for communicating important information (e.g., meeting times) in addition to projection capabilities. Convenient access to bathrooms and food is also important.

Space should be organized so that each Command position has a desk area and access to available technology. Persons assuming a Command or General Staff role should be easily identified through the use of color-coded vests or other suitable clothing item (i.e. hat, armband).

It is often productive to assign staff to serve as assistants to those in charge; they can assist by answering phones and documenting key pieces of information.

GLOSSARY

Activate: To begin the process of mobilizing a response team, or to set in motion an emergency operations (response) or recovery plan, process, or procedure in response to incident or exercise. An activation may be partial (stipulating the components of the EOP to activate, or some indication of the level of commitment to be made by the notified entity) or full (stipulating activation of the notified entity's entire EOP).[1]

After Action Report (AAR): The AAR summarizes key exercise-related evaluation information, including the exercise overview and analysis of objectives and core capabilities. The AAR is usually developed in conjunction with an Improvement Plan (IP).[2]

All-Hazards: Describing an incident, natural or manmade, that warrants action to protect life, property, environment, public health or safety, and minimize disruptions of government, social, or economic activities.[3]

California Governor's Office of Emergency Services (Cal OES) Warning Center: The Cal OES Warning Center monitors events occurring in California and is the official point-of-contact for emergency notifications received from the National Warning System. It also serves as the receiving point for emergency notifications of hazardous material spills and releases from facilities which use, store, or process hazardous materials. A release or spill could potentially impact area nursing homes by occurring onsite (via a spill) or at a neighboring users facility (i.e., industrial site, railroad accident, etc.).

Chain of Command: The orderly line of authority within the ranks of the incident management organization.[3]

Chief: The Nursing Home Incident Command System title for individuals responsible for management of functional Sections: Operations, Planning, Logistics, Finance/Administration, and Planning.

Code Silver: The emergency code used to warn nursing home staff of an active shooter on-site at the facility.

Command: The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, delegated authority.[3]

Command Staff: The staff that report directly to the Incident Commander, including the Liaison/Public Information Officer, Safety Officer, and other positions as required. They may have an assistant or assistants, as needed. [3]

Communication Plan: New CMS Rule. Facilities are required to have contact information for emergency officials and who they should contact in emergency events; maintain an emergency preparedness communication plan that complies with both federal and state law; and be able to demonstrate collaboration through the full-scale exercises. Official "sign-off" from local emergency management officials is not required; however, if the state requires this action, we would expect that facilities comply with their state laws.[4]

Coordinate: To advance an analysis and exchange of information systematically among

principals who have or may have a need to know certain information to carry out specific incident management responsibilities.[3]

Demobilization: The orderly, safe and efficient return of an incident resource to its original location and status.[3]

Department Operations Center (DOC): An emergency operations center specific to a single department or agency. The focus is on internal agency incident management and response. DOCs are usually linked to, and in most cases are physically represented within, a combined agency EOC through authorized representatives for the department or agency.[3]

Director: The NHICS title for individuals responsible for supervision of a Branch (see Operations Section)

Emergency or Disaster: An event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional or national level by an authorized public official such as a Governor, the Secretary of HHS, or the President of the United States. It also includes events that can affect the facility internally.[5]

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or some combination thereof. [3]

Emergency Operations Plan (EOP): An ongoing plan for responding to a wide variety of potential hazards. [3]

Emergency Support Function (ESF) #8: Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential public health and medical emergency.[6]

Evacuation: The organized, phased, and supervised withdrawal, or removal of residents from dangerous or potentially dangerous areas, and their reception and care in safe areas. Evacuation may be partial or full facility evacuation depending on the nature of the emergency.

Finance/Administration Section: The NHICS Section responsible for all administrative and financial considerations surrounding an incident.

First Responders: Refers to individuals who in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). It includes emergency management, public health, clinical care,

public works, and other skilled support personnel (e.g., equipment operators) who provide immediate support services during prevention, response, and recovery operations. [2]

Function: One of the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved (e.g., the planning function). [3]

General Staff: A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief. [3]

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome. [3]

Hazard Vulnerability Analysis (HVA): A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or "vulnerability," is related to both the impact on organizational function and the likely service demands created by the hazard impact. [2]

Healthcare Facility: Any asset where point-of-service medical care is regularly provided or provided during an incident. It includes hospitals, integrated healthcare systems, private physician offices, outpatient clinics, long-term care facilities and other medical care configurations. During an incident response, alternative medical care facilities and sites where definitive medical care is provided by EMS and other field personnel would be included in this definition. [2]

Hospital Incident Command System (HICS): An incident management system that provides an organizational structure for incident management that can be used by any hospital to manage threats, planned events, or emergency incidents. [7]

Incident Action Plan (IAP): An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods. [3]

Incident Action Planning: A core concept for successful response and recovery from any incident. Involves development and use of the Incident Action Plan (IAP) which provides the goals, strategies and tactics to facilitate the Management by Objectives (MBO) an ensure understanding of strategic direction. [7]

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational

structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations. [3]

Incident Commander (IC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. [3]

Incident Management: The broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity. [3]

Incident Management Team (IMT): An Incident Commander and the appropriate Command and General Staff personnel assigned to an incident. [3]

Incident Objectives: Statements of guidance and direction needed to select appropriate strategy(s) and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow strategic and tactical alternatives. [3]

Incident Planning Guides (IPGs) and Incident Response Guides (IRGs): Guidance documents whose purpose is to prompt the healthcare facility to review their own plans relative to incident planning and response. The scenarios and planning/response considerations provided are not meant to be exhaustive; each facility should build and/or modify IPG/IRGs based on their HVA. [7]

Infrastructure Branch: The Nursing Home Incident Command System (NHICS) Branch under the Operations Section responsible for the following functions: Dietary, Physical Plant/Security and Environmental.

Job Action Sheet (JAS): Guidance documents for each NHICS Command and General staff position to assist with describing the position's responsibilities, reporting relationship, needed forms, and potential action steps based on time period.

Joint Information Center (JIC): A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media. Public information officials from all participating agencies should co-locate at the JIC. [3]

Liaison/Public Information Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies or organizations and interfacing with the public and media and/or with other agencies with incident-related information requirements.

Logistics Section: The NHICS Section responsible for providing facilities, services, and material support for the incident.

Management by Objectives (MBO): A management approach that involves a five-step

process for achieving the incident goal. The Management by Objectives approach includes the following: establishing overarching incidents objectives; developing strategies based on overarching incidents objectives; developing and issuing assignments, plans, procedures, and protocols; establishing specific, measurable tactics or tasks for various incident management, functional activities, and directing efforts to attain them, in support of defined strategies; and documenting results to measure performance and facilitate corrective action.[3]

Medical Director/Specialist: A member of the Command staff with specialized expertise in areas such as medical, biological/infectious, and hazmat implications related to an event, who oversees medical services and assists with diagnosis, treatment and medical management of residents and injured staff.

Memorandum of Understanding (MOU): Agreement for providing assistance in the form of personnel, equipment, materials and other associated services. Examples include generator and fuel support, water and sewage services, and medical gas deliveries.

Mitigation: Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.[3]

National Incident Management System (NIMS): Provides a systematic, proactive approach guiding government agencies at all levels, the private sector, and nongovernmental organizations to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.[3]

Nursing Home Command Center: A designated location in nursing homes and long term care facilities prepared to convene and coordinate response activities, resources, and information during an emergency or disaster.

Nursing Home Incident Command System (NHICS): A management system used by nursing homes and long term care facilities to assist with emergency planning and response efforts for all hazards.

Operational Period: The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12-24 hours. [3]

Operations Section: The NHICS Section responsible for all tactical incident operations and implementation of the Incident Action Plan. [3] In NHICS, the Operations Section includes two subordinate Branches: Infrastructure and Resident Services.

Planning Meeting: A meeting held as needed throughout the duration of an incident to select specific strategies and tactics for incident control operations and for service and support planning. For larger incidents, the Planning Meeting is a major element in the development of the Incident Action Plan. [3]

Planning Section: The NHICS Section responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the Incident Action Plan. This Section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Preparedness: A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Within NIMS, preparedness focuses on the following elements: planning; procedures and protocols; training and exercises; personnel qualification and certification; and equipment certification. [3]

Public Information: Processes, procedures, and systems for communicating timely, accurate, accessible information on the incident's cause, size, and current situation; resources committed; and other matters of general interest to the public, responders, and additional stakeholders (both directly affected and indirectly affected).[3]

Recovery: The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.[3]

Reimbursement: A mechanism used to recoup funds expended for incident-specific activities. [3]

R.A.C.E. – Rescue, Alarm, Confine, Extinguish or Evacuate. Technique for rescuing anyone in immediate danger while protecting the safety of rescuing staff during an internal fire.

Resident Services Branch: A Branch under the Operations Section responsible for the following functions: admit/transfer and discharge, nursing, medical records and psychosocial.

Resource Management: A system for identifying available resources at all jurisdictional levels to enable timely, efficient, and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management under the National Incident Management System includes mutual aid agreements and assistance agreements; the use of special Federal, State, tribal, and local teams; and resource mobilization protocols.[3]

Resource Tracking: A standardized, integrated process conducted prior to, during, and after an incident by all emergency management/response personnel and their associated organizations. [3]

Response: Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. [3]

Run, Hide, Fight – Technique for responding to an active shooter situation at the facility. If your life is in imminent danger and you need to fight, be as aggressive as possible.

Safety Officer: A member of the Command Staff responsible for monitoring incident operations and advising the Incident Commander on all matters relating to operational safety, including the health and safety of emergency responder personnel. [3]

Scribe/Runner: A member of the IMT that may be assigned to any section in NHICS but is most commonly assigned to the Planning Section.

Section: The NHICS organizational level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, and Finance/Administration).

Situational Awareness: Is the ability to identify, process, and comprehend the essential information about an incident to inform the decision making process in a continuous and timely cycle and includes the ability to interpret and act upon this information. [7]

Span of Control: The number of resources for which a supervisor is responsible, usually expressed as the ratio of supervisors to individuals. (Under NIMS, an appropriate span of control is between 1:3 and 1:7, with optimal being 1:5.) [3]

Size-up: The information collected at the beginning of a response to an incident to help determine immediate objectives and inform management decisions. Size-up includes the nature and magnitude of the incident, hazards and safety concerns, and initial priorities and immediate resource needs. [8]

State Survey Agency: The Agency with regulatory responsibility for all the nursing homes in the state. In California, the State Survey Agency is California Department of Public Health's Center for Health Quality (CDPH-CHCQ) Licensing & Certification Program.

Shelter-in-Place: A protective action strategy taken to maintain resident care in the facility and to limit the movement of residents, staff and visitors in order to protect people and property from a hazard. [9]

Threat: Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property. [3]

Warning: Dissemination of notification message signaling imminent hazard that may include advice on protective measures. For example, a warning is issued by the National Weather Service to let people know that a severe weather event is already occurring or is imminent, and usually provides direction on protective actions. A "warning" notification for individuals is equivalent to an "activation" notification for response systems. [2]

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