To activate this plan:

- NOTIFY SWITCHBOARD OPERATOR (Dial “0”)  
- State: “This is an EMERGENCY PLAN ALERT”  
- DESCRIBE LOCATION, SITUATION and SPECIFIC ASSISTANCE NEEDED

During an incident, refer directly to the EMERGENCY OPERATIONS PLAN ACTIVATION section, beginning on Page 69. It contains procedures, checklists, and forms that are required for Nursing Home Incident Command System implementation.

Quick Reference:

- Red Borders: Quick-Start Rapid Response Guides  
- White Borders: General Information  
- Pink Borders: Emergency Operations Plan  
- Green Borders: Job Action Sheets  
- Blue Borders: NHICS Forms  

Event-Specific Annexes: Tabbed Section at Back of Book
PROMULGATION DOCUMENT

This Comprehensive Emergency Management Plan (CEMP) has been reviewed and endorsed for use at Rebekah Rehab & Extended Care Center. This plan establishes full compliance with applicable provisions of the CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, Part 483, as effective November 16, 2016; as well as The Joint Commission Nursing Care Center Accreditation Program, Leadership Chapter and Emergency Management Chapter, as effective January 1, 2016. Compliance is additionally established with the 11 National Incident Management System (NIMS) Implementation Objectives for Healthcare Organizations, as well as the National Fire Protection Association (NFPA) Standard 99-12 Health Care Emergency Management and Standard 1600, Standard on Disaster/Emergency Management and Business Continuity Programs.

By their signatures below, senior facility leadership establishes their commitment to, and accountability for, this emergency management program, including all aspects of planning, implementation, effectiveness, and performance improvement.

__________________________
Kenneth T. Gelb
Chief Executive Officer

__________________________
Dr. William Irish-O`Brien
Director of Nursing

__________________________
Jose Hernandez
Facilities Manager
Designated Senior Facility Leader
for Emergency Management Program

__________________________
Dr. Jeffry Gold
Medical Director
INITIAL ACTION QUICK-START GUIDE

1. Any person discovering an unusual or emergency incident calls Switchboard Operator (Dial “0”) to report the situation. "If you see something, say something".

2. Switchboard operator immediately notifies Facility Administrator (business hours) or Nursing Supervisor (all other times)

3. Facility Administrator or Nursing Supervisor determines if incident meets criteria for Emergency Operations Plan (EOP) activation (refer to Appendix B: EOP Activation Matrix [page 62])

4. If Activation Criteria is met, Facility Administrator or Nursing Supervisor:
   a. Activates the EOP
   b. Assumes command / becomes the Incident Commander (IC) [page 62]
   c. Activates the Facility Command Center (FCC) [page 72]

5. Switchboard Operator announces Emergency Plan [page 72] and initiates notifications as directed

6. Each department carries out actions as specified in their Department Emergency Operations Plan (DEOP) [page 72]

7. The IC determines whether the FCC activation is actual or virtual [page 72]

8. Operations proceed as shown below, using the Nursing Home Incident Command System (NHICS) under the direction and control of the Incident Commander
1  RAPID RESPONSE GUIDES

Follow these immediate first steps if you recognize a potential or actual emergency that may threaten or impact:

- the health and safety of occupants (including residents, staff, and visitors),
- the facility’s ability to provide care, or
- the environment or property.

STEP 1
Protect yourself and those in the immediate area from harm. If appropriate, call 9-1-1 for emergency response and sound the facility alarm and/or overhead code if appropriate per the EOP. See Rapid Response Guides for hazard-specific protocols.

STEP 2
Take a deep breath and assess the situation. Gather basic facts:
- Type of incident, including specific hazard/agent,
- Location of incident,
- Number and types of injuries, and
- What you have done so far.
If the situation allows, begin to document your actions.

STEP 3
Contact your immediate supervisor to report the incident and get further instructions. If you are unable to contact your supervisor, activate the Incident Commander (IC) position and the Emergency Operations Plan (EOP). Activate overhead codes or facility emergency alert system as appropriate.

STEP 4
Notify additional authorities if appropriate and indicated by protocols.

STEP 5
Follow facility policy for documenting actions and incident reporting.

CRITICAL PHONE NUMBERS:

<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Primary Telephone</th>
<th>In-House Ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenneth Gelb / CEO</td>
<td>347-996-7864</td>
<td>1100</td>
</tr>
<tr>
<td>Dr. William Irish-O’Brien / DNS</td>
<td>718-490-6028</td>
<td>1147</td>
</tr>
<tr>
<td>Jose Hernandez / Facilities Manager</td>
<td>646-715-4359</td>
<td>1120</td>
</tr>
<tr>
<td>Dr. Jeffrey Gold / Medical Director</td>
<td>914-642-5438</td>
<td>1103</td>
</tr>
<tr>
<td>Iddo Geva / IT</td>
<td>646-296-6565</td>
<td>1117</td>
</tr>
<tr>
<td>Connie Capaldo / Facility Liaison</td>
<td>347-514-1830</td>
<td>1102</td>
</tr>
</tbody>
</table>
1.1 Facility Profile

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Rebekah Rehab &amp; Extended Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Address</td>
<td>1070 Havemeyer Ave</td>
</tr>
<tr>
<td>Facility Location</td>
<td>Cross Bronx Expressway &amp; Havemeyer Ave</td>
</tr>
<tr>
<td>Facility Telephone #</td>
<td>718-863-6200</td>
</tr>
<tr>
<td>Facility Fax #</td>
<td>914-530-2170</td>
</tr>
<tr>
<td>Facility Email</td>
<td><a href="mailto:kgelb@rebekahrehab.org">kgelb@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Facility Web Address</td>
<td><a href="http://www.rebekarehab.org">http://www.rebekarehab.org</a></td>
</tr>
<tr>
<td>Administrator/Phone #</td>
<td>Kenneth T. Gelb / 718-863-6200 x1100</td>
</tr>
<tr>
<td>Emergency Contact Person/Phone #</td>
<td>Dr. William Irish-O’Brien / 718-863-6200 x1147</td>
</tr>
<tr>
<td>Facilities Manager/Phone #</td>
<td>Jose Hernandez / 718-863-6200 x1120</td>
</tr>
<tr>
<td>Year Facility Built</td>
<td>2007</td>
</tr>
<tr>
<td>Fire Alarm System/Contact #</td>
<td>Acme / 718-939-3939</td>
</tr>
<tr>
<td>Security Company/Contact #</td>
<td>Esteem / 718-636-5400</td>
</tr>
<tr>
<td># of Licensed Beds</td>
<td>213 + 2 respite</td>
</tr>
<tr>
<td>Average # of Staff – Days</td>
<td></td>
</tr>
<tr>
<td>Average # of Staff – Nights/Weekends</td>
<td></td>
</tr>
<tr>
<td>Emergency Power Generator Type</td>
<td>1 - Fixed / Automatic Transfer Switch</td>
</tr>
<tr>
<td>Emergency Power Generator Fuel</td>
<td>#6 Diesel</td>
</tr>
<tr>
<td>Emergency Communication System</td>
<td>OEM Radio</td>
</tr>
<tr>
<td>Like-Facility #1 for Resident Evacuation¹ (within 10 miles)/Phone #</td>
<td>Beth Abraham Center for Rehabilitation and Nursing</td>
</tr>
<tr>
<td>Like-Facility #2 for Resident Evacuation (within 10 miles)/Phone #</td>
<td>Bronx Gardens Rehabilitation and Nursing Center</td>
</tr>
<tr>
<td>Like-Facility for Resident Evacuation (beyond 25 miles)/Phone #</td>
<td></td>
</tr>
<tr>
<td>Like-Facility for Resident Evacuation (beyond 25 miles)/Phone #</td>
<td></td>
</tr>
</tbody>
</table>

¹ Our facility has a Memorandum of Understanding (MOU) with at least one nearby facility (within 10 miles) and one out-of-the-immediate-area facility (beyond 25 miles) to accept evacuated residents, if able to do so.
1.2 Emergency Contacts

<table>
<thead>
<tr>
<th>Type</th>
<th>Telephone No. / Email Address</th>
<th>Contact Name (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY FIRE / POLICE / EMS</td>
<td>Call 911</td>
<td></td>
</tr>
<tr>
<td>New York Police Department (43rd precinct)</td>
<td>718-542-0888</td>
<td></td>
</tr>
<tr>
<td>New York City Fire Department (Fire/EMS)</td>
<td>718-430-0264</td>
<td></td>
</tr>
<tr>
<td>New York City Department of Health and Mental Hygiene (NYCDOHMH)</td>
<td>311</td>
<td></td>
</tr>
<tr>
<td>New York City Emergency Management</td>
<td>212-639-9675</td>
<td></td>
</tr>
<tr>
<td>Ambulance Company (Senior Care)</td>
<td>718-430-9700</td>
<td></td>
</tr>
<tr>
<td>Ambulette Company (MAS)</td>
<td>844-666-6270</td>
<td></td>
</tr>
<tr>
<td>Con Edison (Electric Company)</td>
<td>877-427-2255</td>
<td></td>
</tr>
<tr>
<td>Con Edison (Gas Company)</td>
<td>877-427-2255</td>
<td></td>
</tr>
<tr>
<td>Telephone Company (Empire Telecomm)</td>
<td>732-363-9898</td>
<td></td>
</tr>
<tr>
<td>Water System</td>
<td>718-595-7000</td>
<td></td>
</tr>
<tr>
<td>Sewer System</td>
<td>718-595-7000</td>
<td></td>
</tr>
<tr>
<td>Fire Alarm System (Acme)</td>
<td>718-939-3939</td>
<td></td>
</tr>
<tr>
<td>Fire Protection – Sprinkler System (Acme)</td>
<td>718-939-3939</td>
<td></td>
</tr>
<tr>
<td>Emergency Water Supply – Non Potable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Water Supply – Potable (WBMason)</td>
<td>203-996-1882</td>
<td></td>
</tr>
<tr>
<td>Emergency Food Supply (US Foods)</td>
<td>516-662-7868</td>
<td></td>
</tr>
<tr>
<td>Additional Staff - CNA (Towne Agency)</td>
<td>718-998-4660</td>
<td></td>
</tr>
<tr>
<td>Additional Staff - LPN (Merridian)</td>
<td>718-255-5830</td>
<td></td>
</tr>
<tr>
<td>Additional Staff – Rehab (White Glove)</td>
<td>718-828-2666</td>
<td></td>
</tr>
</tbody>
</table>

Note: If used, see NHICS 258 Facility Resource Directory for a full list of Emergency Contacts
The remainder of this section provides specific information on the initial activities that may be undertaken in response to specific types of threats or emergencies (see table below). We recognize that there is no substitute for awareness and good judgment based on the unique circumstances of our facility, including location (proximity to threats), characteristics of our resident population, local agreements and protocols, and the results of our Hazard Vulnerability Analysis (HVA). Initial activities always include vigilance for potential threats that may or may not be identified through our HVA process. The results of our HVA that identify the most relevant threats to our facility have been incorporated into our EOP (See Appendix B – Hazard Vulnerability Analysis).

<table>
<thead>
<tr>
<th>Types of Incidents</th>
<th>See Page</th>
</tr>
</thead>
<tbody>
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<td>1.6 Extreme Weather – Cold</td>
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<td>1.7 Extreme Weather – Heat</td>
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<td>1.8 Fire (External)</td>
<td>15</td>
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<td>1.9 Fire (Internal)</td>
<td>16</td>
</tr>
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<td>1.10 Flood</td>
<td>17</td>
</tr>
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<td>1.11 Hazardous Material/Waste Spill</td>
<td>19</td>
</tr>
<tr>
<td>1.12 Infectious Disease (e.g., Pandemic Influenza)</td>
<td>21</td>
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<tr>
<td>1.13 Missing Resident</td>
<td>22</td>
</tr>
<tr>
<td>1.14 Shelter in Place</td>
<td>23</td>
</tr>
<tr>
<td>1.15 Power Outage</td>
<td>24</td>
</tr>
<tr>
<td>1.16 Workplace Violence, Extreme (e.g., Armed Intruder, Active Shooter, Hostage Situation)</td>
<td>25</td>
</tr>
</tbody>
</table>
1.3 BOMB THREAT

Initial Actions

☐ Call 9-1-1 to report the threat.

☐ Do NOT approach, disturb, or touch a suspicious package or object. Do not use radios or mobile phones near the object.

☐ Immediately evacuate anyone in the immediate area surrounding the potential threat (affected room, rooms on either side, room above), saying: “We have an emergency in the building and must evacuate this area immediately according to our plan. This is not a drill.”

☐ Instruct staff to calmly and safely evacuate residents to a safe area.

☐ Activate facility’s EOP and appoint a Facility Incident Commander (IC).

☐ Announce the facility code to warn staff of situation (Code Yellow).

☐ Notify your supervisor or facility administrator as specified in the EOP.

☐ If a bomb threat is called in, be calm and courteous. If possible, refer to Bomb Threat Checklist and attempt to collect information from the caller that will help to identify the location of the potential bomb, e.g.,
  • Where is the bomb?
  • What does it look like?
  • When will it explode?

  • What kind of bomb is it?
  • What is your name?

  Record this and any other information you collect, such as whether the caller is male or female, characteristics of the caller’s voice and any background sounds you notice. It is best to write this information down.

☐ Communicate relevant information with law enforcement.

☐ In most cases, unless a suspicious device is located, facility evacuation is not warranted. If facility evacuation is required, see RAPID RESPONSE GUIDE - EVACUATION.

☐ Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
1.4 EARTHQUAKE

**Initial Actions**

- **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.

- **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.

- **If a resident is confined to a bed** –
  - Tell the resident to HOLD ON and PROTECT their head with a pillow.

- Activate facility’s EOP and appoint a Facility Incident Commander (IC).
- Assign staff to assess residents for any injuries that require immediate attention.
- Assign staff to assess the facility for damage that requires immediate attention (e.g., gas leaks, fires, sparking wires, broken glass, hazardous spills, etc.)
  - If a gas leak is suspected (e.g., you smell gas or hear a blowing or hissing noise), shut off gas and contact the proper utility company for restoration.
  - Do not allow any flame source until you are certain the gas lines have not been affected.
  - Inspect the facility for small fires (a common hazard after an earthquake); extinguish as necessary and/or call 9-1-1.
  - Look for electrical system damage. If you see sparks or broken or frayed wires, or if you smell hot insulation, turn off the electricity at the main fuse box or circuit breaker. If you have to step in water to get to the fuse box or circuit breaker, call an electrician first for advice.
  - Check for sewage and water line damage. If you suspect sewage lines are damaged, avoid using the toilets and call a plumber. If water pipes are damaged, contact the water company and avoid using water from the tap.
  - Heed public health notices/orders regarding water contamination (including the following notices: **Boil Water**, **Do Not Drink Water**, and **Do Not Use Water**). Consider all flood water contaminated. Avoid walking through flood waters and wash hands thoroughly after contact. Do not use pre-packaged food and drink.
### Initial Actions

- Products that came into contact with flood water. When in doubt, throw it out!
- Report utility problems to appropriate utility company/agency.
- Activate your emergency water plan. See Appendix M – Disaster Water Supplies for further information.

- If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the need for evacuation vs. shelter in place.

- Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.

- If facility evacuation is required, see RAPID RESPONSE - EVACUATION. If the decision is to shelter in place, see RAPID RESPONSE GUIDE – SHELTER IN PLACE.
1.5 EVACUATION

**Initial Actions**

- **☐** Activate facility’s EOP and appoint a Facility Incident Commander (IC).
- **☐** Announce the facility code to warn staff of situation (Code Green).
- **☐** Activate the Emergency Transportation procedure of the EOP. (See Appendix M – Facility Evacuation and Maps).
- **☐** Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report activation of the facility’s EOP and need to evacuate.
- **☐** Assess which residents might be able to go to families and contact in advance.

**Assess:**
- Number and types of beds needed
- Available staff to support transferred residents (call in additional staff if needed)
- Potential transportation requirements based on the number of residents, medical needs and mobility status

- **☐** If residents need to be transferred to another facility, identify available beds by the following procedures:
  - Coordinate with other facilities in the healthcare system or neighbor/buddy facilities with whom you have a pre-existing relationship
  - If the above resources are unavailable or inadequate, request assistance from the NYSDOH Healthcare Evacuation Coordination Center (HEC) if activated, and/or utilize HCS.

- **☐** Obtain transportation resources by contacting the contracted transportation providers.
  - If the necessary resources are unavailable or inadequate, request assistance from the NYSDOH (HEC) if activated, and/or utilize HCS.
### Initial Actions

**Prepare for evacuation:**
- Collect and package residents’ equipment and medications
- Collect and package residents’ belongings for transport, including glasses, dentures, hearing aids, etc.
- Prepare water and snacks to accompany residents during transport period
- Prepare copy of medical chart to accompany resident

**If surrounding roads may be damaged, verify planned evacuation routes with the appropriate public safety or emergency management agency.**

**Track residents to destinations and notify family members of evacuation and planned destination. If needed, additional tools and information on Evacuation are included in the Evacuation Annex:**
- Appendix M – Facility Evacuation and Maps,
- Appendix M – Resident Evacuation Tracking Form (NHICS 260),
- Appendix M – Resident Evacuation Checklist,
- Appendix M – Sample Face Sheet
### Initial Actions

- **Activate facility’s EOP and appoint a Facility Incident Commander (IC) if warranted.**
- **Assess residents for signs of distress and/or discomfort.**
- **Initiate actions to safely increase resident comfort, offer warm liquids (keeping in mind relevant dietary modifications/restrictions).**
- **Do not leave residents unattended near a heat source.**
- **If the internal temperature of the facility remains low and potentially jeopardizes the safety and health of residents, consider re-location to a warmer part of the facility (on sunny side; downwind) or evacuation to another facility. Consider establishing “warming centers” in the warmest locations where residents can be congregated with limited heating, blankets, warm beverages, and similar measures.**
- **If the decision is made to evacuate the facility, see RAPID RESPONSE GUIDE – EVACUATION.**
- **Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.**

---

2 The determination of what constitutes *excessive cold* should be tailored to the impact of the temperature and its duration on the health and well-being of the facility’s residents. An informed decision should be made by responsible facility administrators. A suggested guideline to consider is a facility temperature of 65 degrees Fahrenheit or lower for a period of four hours.
### 1.7 EXTREME WEATHER – HEAT

#### Initial Actions

- **Activate facility’s EOP and appoint a Facility Incident Commander (IC) if warranted.**
- **Assess residents for signs of distress and/or discomfort.**
- **Call 9-1-1 if any resident appears to be suffering from heat-related illness such as heat cramps, heat exhaustion, or heat stroke.**
- **If the outdoor temperature is cooler than the internal facility temperature, consider opening windows and using fans to bring cooler air into the building.** If the outdoor temperature is not cooler, keep the windows closed and shades drawn. (Note: it may be necessary to increase security to accommodate open windows, etc.)
- **If the internal temperature of the facility remains high and potentially jeopardizes the safety and health of residents, consider evacuation to another facility.**
- **Provide cool washcloths.**
- **Encourage residents to drink fluids to maintain hydration.**
- **If the decision is made to evacuate the facility, see RAPID RESPONSE GUIDE – EVACUATION.**
- **Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.**

---

8 The determination of what constitutes excessive heat should be tailored to the impact of the temperature and its duration on the health and well-being of the facility’s residents. An informed decision should be made by responsible facility administrators. A suggested guideline to consider is a facility temperature of 85 degrees Fahrenheit or higher for a period of four hours.
1.8 FIRE – EXTERNAL

Initial Actions

☐ Monitor local alert system and local news for evacuation reports and instructions.

☐ Monitor residents and staff for complications related to smoke exposure.

☐ Activate facility’s EOP and appoint a Facility Incident Commander (IC).

Preemptive methods to mitigate smoke and fire risk:
- Close all windows, doors, and vents
- If using HVAC, shut system down to close vents
- Prepare evacuation bags, records, and ID tags
- Contact transportation companies to alert them you may need to evacuate

In case of immediate threat:
- Move residents to a pre-designated staging area for rapid evacuation
- If you smell gas, and it is safe to do so, shut off the gas. Do not do so unless need is certain as only the gas company can turn it back on.
- Contact the transport companies and facilities you have agreements with.
- Notify resident families.
- Leave a message on the facility phone with a contact number and information regarding facility status.

☐ If the decision is made to evacuate the facility, see RAPID RESPONSE GUIDE – EVACUATION.

Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
1.9 FIRE – INTERNAL

### Initial Actions

- **Rescue anyone in immediate danger while protecting the safety of the rescuing staff member(s).** Follow the facility’s procedure for Alarm, Rescue, Confine, Extinguish/Evacuate (ARCE); Pull, Aim, Squeeze, Sweep (PASS); and other urgent response measures for a fire.

- **Alert residents and staff members; pull the fire alarm.**

- **Announce the facility code to warn staff of situation (Doctor Red)**

- **Call 9-1-1 immediately to report a fire.** Include the following information:
  - Name of facility
  - Address and nearest cross street
  - Location of fire (floor, room number, etc.)
  - What is burning (electrical, kitchen, trash, etc.)

- **Activate facility’s EOP and appoint a Facility Incident Commander (IC)**

- **Contain the fire if possible without undue risk to personal safety.** Shut off air flow, including gas lines, as much as possible, since air feeds fires and air movement distributes smoke. Close all fire doors and shut off fans, ventilation systems, and air conditioning/heating systems. Use available fire extinguishers if the fire is small and this can be done safely.

- **Oxygen may lead to combustion in the presence of sparks or fire,** quickly re-locate oxygen-dependent residents away from fire danger.

- **If the decision is made to evacuate the facility,** see RAPID RESPONSE GUIDE – EVACUATION.

- **Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.**
1.10 FLOOD

**Initial Actions**

- **☐** Rescue anyone in immediate danger while protecting the safety of rescuing staff member(s).

  If the flood poses danger to residents, staff or visitors, call 9-1-1 immediately and include the following information:
  - Name of facility
  - Address and nearest cross street
  - Describe flood situation (basement, room numbers, etc.)

- **☐** Activate facility’s EOP and appoint a Facility Incident Commander (IC).

- **☐** Alert residents, staff, and visitors.

- **☐** Unplug non-essential appliances, equipment, and computers.

  Check for gas leaks, water line ruptures, sewage contamination, etc. If you smell gas, and it is safe to do so, shut off the gas. Do not do so unless the need is certain as only the gas company can turn it back on. Report utility problems to appropriate utility company/agency.

- **☐** If water lines are disrupted, consider the water supply to be contaminated and follow the facility plan for emergency water. Heed public health notices regarding water contamination (including the following notices: **Boil Water**, **Do Not Drink Water**, and **Do Not Use Water**). Consider all flood water contaminated. Avoid walking through flood waters and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that come into contact with flood water. When in doubt, throw it out! Report utility problems to appropriate utility company/agency.

- **☐** If needed, activate your emergency water plan. See Appendix M – Disaster Water Supplies for further information.

- **☐** Gather critical supplies to take to higher ground/evacuation (e.g., medications, drinking water, health records, important personal items, communication devices, blankets)

- **☐** Do not allow electrical devices to come into contact with water.

- **☐** If the decision is made to evacuate facility, see RAPID RESPONSE GUIDE – EVACUATION.

- **☐** Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
1.11 HAZARDOUS MATERIAL/WASTE

**Initial Actions**

If a reportable hazardous material/waste spill or release occurs (or is threatened) on facility property, call 9-1-1 immediately to report the incident. The facility may also be required to notify local authorities (FDNY and NYCDEP). Include the following information:

- Name of caller and facility
- Exact location, date and time of spill, release or threatened release
- Substance, quantity involved and isotope (if known)
- Chemical name (if known)
- Description of what happened

Alternately, the facility may be notified by authorities of an external hazardous materials/waste spill or release that may affect the facility.

Announce the facility code to warn staff of situation (Code Orange)

Activate facility’s EOP and appoint a Facility Incident Commander (IC).

Assess residents for signs of distress; keep residents, staff, and visitors away from the site of the spill.

Access the Safety Data Sheet (SDS, formerly the Material Safety Data Sheet) for the material spilled or released on the facility’s property. Determine if material/waste poses a safety or health risk to residents, staff, or visitors. All SDS’s should be available on site, but if SDS cannot be located on site, consider checking the internet.

Utilize appropriate Personal Protective Equipment (PPE) if warranted.

Close windows, doors, and ventilation systems as needed to protect air quality by preventing the spread of dangerous fumes or smoke.

Coordinate with public safety agencies (fire and law) and emergency management to determine if evacuation is necessary.

If the decision is made to evacuate, see RAPID RESPONSE GUIDE – EVACUATION.

Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.

Follow public health advice regarding water or air contamination (including the following notices: Boil Water, Do Not Drink Water, and Do Not Use Water).
1.12 INFECTION DISEASE OUTBREAK

Initial Actions

- If either the volume or severity of an infectious disease significantly threatens or impacts day-to-day operations, activate facility’s EOP and appoint a Facility Incident Commander (IC).
- Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
- Obtain guidance from NYCDOHMH and the U.S. Centers for Disease Control and Prevention (CDC).
- Implement appropriate infection control policies and procedures.
- Clearly post signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas. Consider providing hand sanitizer and face/nose masks if practical.
- Consider advising visitors to delay visits if needed to reduce exposure risk to residents.
- Advise staff to check for signs and symptoms of illness and to not work if sick. Activate emergency staffing strategies as needed.
- Limit exposure between infected and non-infected persons; consider isolation of ill persons.
- Conduct recommended cleaning/decontamination in response to the infectious disease.
- If needed the procedure for Handling Remains is included in Appendix M.
## 1.13 MISSING RESIDENT / ELOPEMENT

### Initial Actions

- Record the time that the resident was discovered missing and when and where he/she was last seen.
- Verify that the resident has not signed out or been discharged.
- Perform census verification and resident roll call to determine if there are any other missing residents.
- Activate facility’s EOP and appoint a Facility Incident Commander (IC) if warranted.
- Announce the facility code to warn staff of situation.

**Search the facility’s grounds for the resident**, working in an organized and concentric pattern from the last known location. Check closed circuit camera recordings of the last known area. If necessary, distribute copies of the resident’s photograph to the staff searching the grounds. Keep a record of the areas searched. Be sure to check:

- Closets
- Storage rooms
- Under beds and behind furniture
- Stairwells and roof/basement
- Walk-In refrigerators/freezers

**If the missing resident is not found following an expedient search, call 9-1-1** and provide:

- Name and description of missing resident
- Description of clothing, ambulation method, cognitive status
- Photo if available

**Notify:**

- Responsible party / next of kin that resident is missing and search is underway
- Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.

- Coordinate with public safety agencies in searching for the missing resident.
- Once the resident is found, notify the responsible party/next of kin, facility staff and public safety agency representative.
1.14 SHELTER IN PLACE

Initial Actions

☐ Activate facility’s EOP and appoint a Facility Incident Commander (IC).

☐ Identify safe and unsafe areas of the facility relative to the specific threat.

☐ Move residents from unsafe areas to safe areas. Be sure to include medications, important personal items, etc.

☐ Increase the safety of “safe areas” by reducing hazards, e.g., close, lock, and move away from windows (during extreme winds) into interior hallways; secure exterior doors, and other openings that may create hazards.

☐ Plan for the availability of food, water and other essential disaster supplies for residents and staff during the time period anticipated for sheltering in place. In addition to non-perishable food and water and critical medications, consider battery-powered radios, first aid supplies, extra blankets, flashlights, batteries, duct tape, plastic sheeting, plastic garbage bags, and eating utensils.

☐ Comfort and assess residents for signs of distress.

☐ Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.

☐ Continually reassess the safety of sheltering in place and prepare to activate the facility evacuation plan if at any time the risk of sheltering in place is greater than the risk to evacuate (see Appendix M – Facility Evacuation and Maps). Keep the NYSDOH notified of any change in status.

☐ If needed, extended shelter in place guidance is contained in Appendix J.
### 1.15 POWER OUTAGE

#### Initial Actions

- Call 9-1-1 if the power outage causes or threatens a medical emergency (e.g., power is lost to a ventilator).
- If the power outage poses a risk to the safety of residents, staff, or visitors, take actions to reduce/eliminate the threat without jeopardizing the safety of staff.
- Report the outage to the appropriate utility company or repair vendor.
- Activate facility’s EOP and appoint a Facility Incident Commander (IC).
- Back-up power starts automatically if necessary. Distribute flashlights to all staff.
- Comfort and assess residents for signs of distress.
- Account for all residents.
- Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
- Take all reasonable steps to protect food and water supplies and maintain a safe environment of care for residents and staff.
- If the decision is made to evacuate the facility, see RAPID RESPONSE GUIDE – EVACUATION. If the decision is made to shelter in place, see RAPID RESPONSE GUIDE – SHELTER IN PLACE. Consult other RAPID RESPONSE Guides as appropriate to the situation causing the power outage, e.g., flood.
1.16 WORKPLACE VIOLENCE, EXTREME

**Initial Actions**

- **☐** Dial 9-1-1 if there is any threat of workplace violence.
- **☐** If applicable, announce the facility code to warn staff of extreme violence (Active Shooter).
- **☐** Activate facility’s EOP and appoint a Facility Incident Commander (IC).
- **☐** Move residents to the closest safe area.

- **☐** Follow the RUN, HIDE, FIGHT mnemonic
  - If a dangerous or armed assailant is in the facility, flee the dangerous area if possible.
  - Assist residents and visitors to take cover behind doors, heavy furniture, or on floor.
  - Take refuge behind locked doors. If possible, cover windows by drawing blinds or taping paper in the window.
  - Maintain contact with 9-1-1 to provide and receive information.
  - Silence the ringer on cell phones.
  - If there is an argument without physical contact –
    - De-escalate the situation:
      - Avoid threatening body language (e.g., don’t stand with arms crossed)
      - Maintain a calm voice
      - Avoid arguing
    - Ask the individual to leave the premises.
    - If the individual does not immediately leave, dial 9-1-1 and request assistance.
- **☐** Initiate Lockdown procedures

- **☐** Notify the NYSDOH MARO Regional Office (Nursing Homes Program Director, 212.417.6197) during normal business hours (8:00 a.m. to 5:00 p.m.); on nights, weekends, or holidays contact the NYSDOH Duty Officer at 1-866-881-2809 to report an unusual occurrence and activation of facility’s EOP.
RECORD OF CHANGES

The contents of this manual are subject to change without prior notice. Should revisions become necessary, written updates will be distributed to each department and department head for inclusion in the manual. Department heads are responsible for updating the Emergency Operations Plan manuals within their areas of responsibility, keeping them current, and being familiar with their content. Department heads and supervisory personnel shall ensure that all staff members are updated and current on the Emergency Operations Plan.

When inserting revisions to this manual, the person revising the document shall complete and initial the table below.

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2 EXECUTIVE SUMMARY

The Rebekah Rehab & Extended Care Center Comprehensive Emergency Management Plan (CEMP) is a compilation of “all-hazards” general principles, policies, and procedures for administration and staff to follow in effectively responding to an emergency incident or unusual situation either within the facility or within the community. This CEMP was established to promote a system to save lives; protect the health and ensure the safety of facility residents and staff; alleviate damage and hardship; and reduce future vulnerability to hazards that may disrupt normal activities within the facility. Furthermore, this document indicates the commitment to annual planning, training, and exercise activities in order to ensure the facility has the necessary capabilities to respond to internal or external emergencies or incidents that affect the facility.

Our strategy in developing these plans is to enable frequent activation at no cost or impact to the facility when encountering the multitude of near-routine events that stress our organization. This provides us with frequent exposure to the use of our emergency procedures, for small, low impact events. In turn, frequent exposure to emergency procedures results in increased familiarity and readiness, enhancing our ability to respond swiftly and effectively when a true “disaster” strikes.

The foundation of the plan is the Nursing Home Incident Command System (NHICS), which is an incident management tool that provides for efficient and effective utilization of facility resources in response to any type of unusual event. This tool is based on the national standard Incident Command System (ICS) used by public safety agencies and other participants in a regional emergency response, which enhances our interoperability and streamlines communication and coordination during a crisis. Use of the NHICS program ensures that the facility meets the requirements of the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and the United States Department of Homeland Security (DHS) National Incident Management System (NIMS) for best managing crisis incidents.

Rebekah Rehab & Extended Care Center (RRECC) has adopted NHICS as a system that has proven effective in reducing the confusion and chaos commonly experienced by healthcare facilities at the onset of an incident. The NHICS Plan is a logical management structure with defined responsibilities, clear reporting channels, and common nomenclature to help unify facility staff with other internal and external responders. The NHICS organization groups all activities within five management functions: Command, Operations, Planning, Logistics, and Finance-Administration. Each function has a leader assigned to it, with the leader of the command function – the Incident Commander – being in overall charge of everything.

The plan further identifies a series of objectives likely to be needed during any type of emergency, and pre-organizes these objectives into subordinate functions, assigned to other supervisors to carry out. Each of these leadership positions prioritized job

4 An all-hazards approach can be further defined as the planning, development, and implementation of all emergency functions necessary to prepare for, respond to, and recover from emergencies and disasters caused by all threats, whether natural, technological, or manmade.
description, called a Job Action Sheet, written to describe the important duties of each particular role. This manual contains a NHICS Table of Organization, which was developed using this system, as well as the various Job Action Sheets for each of the positions. A variety of NHICS forms are also included in this manual, which are used with NHICS Plan job assignments to facilitate documentation.

This plan is intended to be flexible in every respect. Since it is not possible to predict exactly what the nature or scope of an emergency will be, the plan is intended as a guide, to be modified as needed at the direction of competent authority. The plan does not prescribe every step for every person in every possible situation. Rather, it creates a framework adaptable to various situations. The plan is specific in assigning responsibility, authority, and areas to be covered. It is flexible in allowing individuals in command to call upon further reserves of personnel, supplies, equipment, and space, as required, but in an organized, documented, and logical manner.

The Facility Administrator is the designated Senior Facility Leader for the Emergency Management Program. This senior leader establishes organizational accountability at the executive level for program implementation, compliance, effectiveness, and performance improvement.

This plan supersedes all previous emergency management plans. Any recommendations or questions regarding the content or format of this plan should be referred to the Emergency Management Coordinator (Extension 1117) or any member of the Facility Emergency Management Team.
3  INTRODUCTION

3.1 Mission Statement
The mission of the Rebekah Rehab & Extended Care Center emergency management program is to:

- Utilize the four phases of emergency management – mitigation, preparedness, response, and recovery – to frame our approach to crisis events
- Assess the vulnerability of the facility to real or perceived threats that may adversely affect the environment of care or our ability to deliver resident care services
- Establish policy and procedures for effective, efficient response to those threats
- Utilize an all-hazards approach to emergency management that is applicable to any type of situation or event, whether pre-identified or not
- Utilize the national standard Nursing Home Incident Command System (NHICS) as the management model for our response to crisis
- Orient and educate our leadership and staff to their roles in emergency management
- Incorporate our emergency management activities into the facility’s routine operations and overall quality management process, including an ongoing annual exercise, evaluation, review, and revision cycle
- Facilitate community emergency management, integrating the facility’s activities with emergency management programs across the region, thereby fostering the coordination of medical planning, preparedness, response, information sharing, and recovery throughout the region.

3.2 Purpose
The purpose of the CEMP is to improve the facility’s capability to detect, respond to, recover from, and mitigate the negative outcomes of threats and emergencies of all kinds. This all-hazards plan is established to provide a timely, integrated, and coordinated response to the wide range of natural, technological, and human-caused incidents which can occur outside of the facility or facility campus (“external incident”) or within the facility campus (“internal incident”) which cause, or have the potential to cause an unusual impact on normal facility operations or services and require a pre-planned response.

The objectives of the Rebekah Rehab & Extended Care Center Emergency Management Plan, both before and during a crisis, are to set forth procedures for:

- Advance assessment of the facility’s vulnerability to potential unusual events
Orientation, training, and exercising facility personnel for their roles during an emergency

Use of NHICS for clear and direct command, control, and organization of the facility during a crisis

Mobilization and response of the facility and its departments to any type of situation or event that adversely impacts its ability to provide services or provides an overload of residents

 Maximizing safety and protection from injury to residents, visitors, and staff

Attending promptly and efficiently to all individuals requiring medical attention in an emergency situation

Integration of the facility with the regional health care community, local government, and emergency response agencies

Establishment and maintenance of a suitable environment of care

Providing and maintaining necessary logistical support for the physical plant, facility systems, and materiel and nutritional supplies

Enabling a crisis planning process that tracks current situations, anticipates future developments, and develops timely strategies to mitigate their impact

Maintaining continuity of the clinical, business, social, and other organizational functions to the extent possible

Recovery from an unusual event and resumption of normal activities

Management of critical incident stress for our staff and residents

Quality management oversight of the emergency management process

Compliance with all applicable regulatory requirements

Meeting these objectives will enable the facility to fulfill its primary functions in a crisis, which are to:

 Protect our residents, staff, and physical plant, to ensure safety and continuity of operations

 Provide for the largest possible number of people requiring our services promptly and effectively to reduce the number of deaths and disabilities and to aid recovery

 Provide proper and ongoing care to our residents and victims of a disaster and restore normal services as quickly as possible following an emergency

 Maintain resident care in the event of partial or total evacuation of the facility
3.3 Scope
Within the context of this plan, an incident is any unusual, crisis, or emergency situation or event which overwhelms or has the potential to cause adverse impact on the routine capabilities of the facility. The CEMP applies to all employees, individuals providing service under arrangement (contractors), and volunteers.

3.4 Plan Organization
The Rebekah Rehab & Extended Care Center Emergency Preparedness Program is organized into three principal sections. Pages with colored borders are used to facilitate quick user-friendly navigation of the document. These sections include:

- **Quick Start and Rapid Response Guides** *(red-border pages)*, which provide immediate direction for initial actions to be taken in an urgent situation. The Quick Start guides direct immediate plan activation and notifications for the highest vulnerability events identified in our HVA.
- **Emergency Management Program** *(white pages, no border)*, which describes the facility’s emergency management program and core narrative elements of the all-hazards planning framework, as well as a description of the incident command system that will be used to manage any unusual event or situation.
- **Emergency Operations Plan** *(pink-border pages)*, which includes the guidelines, procedures, and tools used to respond to an incident or event.
- **Plan Annexes and Appendices**, including NHICS job action sheets *(green-border pages)*, forms *(blue-border pages)*, a glossary, Department Emergency Operations Plans (DEOP) for each facility department, and Critical Event Annexes (CEA), which are event-specific annexes for a series of incidents that have been planned for based on the organization’s hazard assessment and perceived vulnerability.
4 EMERGENCY MANAGEMENT PROGRAM

4.1 Leadership Participation

RRECC leaders, including those of the medical staff, are active participants in the emergency management program. The signatories of this plan have been involved in the Hazard Vulnerability Analysis (HVA) revision, plan development, training, and implementation and routinely provide management oversight and input for program improvement.

4.2 Emergency Management Program Executive Oversight

In order to establish clear responsibility at the executive level for oversight of emergency management, the Facility Administrator has been designated as the Senior Facility Leader for the Emergency Management Program. This senior leader establishes organizational accountability at the executive level for program implementation, compliance, effectiveness, and performance improvement. These activities encompass programmatic functions that are not within the purview of the facility incident commander during EOP activation.

The responsibilities encompassed under this designation include, but are not limited to:

- Staff implementation of program activities addressing the four phases of emergency management
- Staff implementation of program activities across the six critical areas of healthcare emergency management
- Collaboration across clinical and operational areas to implement emergency management facility-wide
- Identification of and collaboration with community response partners.

4.3 Emergency Management Coordinator

The Director of Safety and Security is the Emergency Management Coordinator. Responsibilities of the Emergency Management Coordinator include, but are not limited to:

Responsibilities include the following:

- Schedule all regular and ad hoc EMT meetings, tracking attendance, and ensuring participation
4. Emergency Management Program

- Schedule and maintaining a CEMP review program, identifying which sections of the Plan are up for review and informing EMT members to review those sections in advance of the next meeting
- Schedule and maintain the calendar of Trainings, Drills, and Exercises
- Develop training objectives, protocols and evaluation tools
- Arrange for training Instructors and/or conduct trainings and drills as needed
- Collect and analyze training evaluations and recommending improvements for subsequent trainings
- Schedule After-Action Reviews and Improvement Planning following all exercises and/or real-world incidents
- Collect and analyzing incident and event documentation
- Preparation of AAR/IP documentation and updates to the relevant EMP documents, both hard copy and electronic versions
- Conduct the annual Hazard Vulnerability Assessment review
- Recommend or implement new or to-be-implemented mitigation planning efforts
- Ensure that all Communications Plan information and contact lists are current and up to date
- Incorporation of new or updated memoranda of understanding (MOU) to the EMP
- Maintain documentation of the status of the Community Partners Outreach initiative.
- Take a primary or backup Incident Management Team (IMT) role as assigned; serve as the FCC manager if not assigned a role

4.4 Emergency Management Team

The role of the facility’s Emergency Management Team (EMT) is to coordinate the development and maintenance of the Emergency Management Plan, ensure the emergency preparedness program meets relevant standards and requirements, and provide and/or coordinate training, drills, and exercises. The Emergency Management Team meets on a quarterly basis.

The team includes representation from Administration, Facilities Management, Information Technology, Nursing Administration and Housekeeping. The team will also seek information from other staff in relevant areas such as Recreation, Finance, Rehab,
Social Work, or Dietary on an as need basis. The team is chaired by the Administrator or the Emergency Management Coordinator. Appendix A lists the current team members.

### 4.5 Annual Effectiveness, Program Goals, and Objectives

1. Rebekah Rehab & Extended Care Center will test its Emergency Operations Plan once a year, either in response to an actual emergency or a planned exercise.

2. EOP activations are documented and critiqued. Findings are used to identify opportunities to improve the planning process, the emergency operations plan or a plan scenario, staff training, or the resources available to staff during emergency situations.

3. Training is provided for all staff required to respond to emergency situations. Training is specific to staff roles and responsibilities. Training includes use of personal protective equipment or other specialized equipment required to be used or operated.

4. Key problems, failures, and user errors requiring attention and action are identified.

5. Performance improvement standards, collection, and analysis of data are identified and reported to the Facility QA Committee.

6. Opportunities to improve emergency management performance, planning, response, and staff training are sought after and identified.

7. An annual evaluation of the objectives, scope, performance, and effectiveness of the Emergency Management program is conducted, and the results are reported to the Facility Administrator.

### 4.6 Measuring Effectiveness

1. The Facility Administrator, as the Senior Facility Leader for the Emergency Management Program, has overall responsibility for evaluating the effectiveness of the emergency management planning activities and the EOP. The Emergency Management Team is responsible for coordinating the program performance improvement standard process, to objectively measure the effectiveness of the Emergency Management program. The Facility QA Committee determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Human, equipment and management performance is evaluated by the Facility QA Committee to identify opportunities to improve the Emergency Management program.
The Facility QA Committee report summarizes performance compared to the performance improvement standard. If deficiencies are identified, a plan of action is developed to address the deficiency. The Facility QA Committee is responsible for evaluating the relevance of performance improvement standards. When no findings occur for a period of a year, the Facility QA Committee recommends to the Emergency Management Team that new measures are to be developed.

The performance improvement measurement process is one part of the evaluation of the effectiveness of the Emergency Management program. A performance improvement standard has been established to measure one important aspect of the Emergency Management program. Compliance with this standard is considered essential to meeting the overall objective of providing quality support of resident care. The current performance improvement standard for the Emergency Management program is:

All elements of the Emergency Operations Plan activated during a drill or actual emergency are implemented and carried out correctly.

4.7 Performance Improvement

(1) The Facility Administrator, as the Designated Senior Facility Leader for the Emergency Management Program, is responsible for establishing the facility’s priorities for performance improvement within the emergency management program.

(2) Implementation of selected facility-wide performance improvements shall be based on the following:
   a. Review of the annual emergency management planning reviews
   b. Review of the evaluations of all emergency response exercises and all responses to actual emergencies
   c. Determination as to which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term.
5 SITUATION OVERVIEW AND PLANNING ASSUMPTIONS

5.1 Situation Overview

Rebekah Rehab & Extended Care Center (RRECC) is a 215 bed Nursing Facility which provides 24-hour care for individuals in need of skilled nursing and short term rehabilitation care, offering comprehensive skilled nursing care to a population which includes people in need of short term rehabilitation and geriatric long term care.

As a healthcare provider in New York City, in addition to general preparedness for emergencies in a densely populated urban setting, the facility maintains a heightened level of readiness for terrorism and weapons of mass destruction events due to current national circumstances. Serving the population of the tri-state area, RRECC is also challenged with maintaining clinical operations and service delivery during times of crisis and emergency.

The worst-case scenario for the organization would be a major impact incident (e.g., natural disaster or mission-critical system failure) occurring during the overnight shift of a weekend or holiday, requiring surge expansion of facilities, or resulting in loss of the facility’s ability to maintain the environment of care. Such an event could further escalate into additional concurrent or sequential emergencies that adversely impact resident safety and the organization’s ability to provide care, treatment, and services for at least 96 hours before external support arrives.

Initially, we will use staffing and resources that are available internally for sufficient care. In the worst-case scenario, the incident will be managed by maximization of existing resources until external support is available to the facility. The Facility Command Center (FCC) should be operational virtually within thirty (30) minutes from the initial notification of the incident, and additional staff from call-back telephone lists will be in the facility within three hours from the time they have been notified.

It may be the case that staffing cannot be maximized due to circumstances such as a severe weather emergency, or other conditions may supervene that do not allow maximum utilization of resources to handle the incident. In these cases, the incident management team will develop a process utilizing NHICS guidelines and other resources as outlined in this plan to optimize available assets to manage the incident.
6 HAZARD VULNERABILITY ANALYSIS

A Hazard Vulnerability Analysis (HVA) is a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach to develop a common understanding about the hazard risks that the facility faces. The HVA helps to prioritize issues for the CEMP to address, by creating an orderly process for identifying the facility's highest vulnerabilities.

The HVA is developed in consultation with those community organizations that assess external threats, probabilities, and impacts (i.e., New York City Emergency Management [NYCEM]; New York City DOHMH), and a completed HVA is submitted annually for their review and validation. The facility corresponds at least annually with these agencies and maintains an ongoing dialogue to communicate its needs and vulnerabilities and to identify community capabilities needed during a response. Mitigation, preparedness, response, and recovery strategies and actions for the identified high-vulnerability hazards can be found in the Critical Event Annexes.

Emergency incidents that may occur and require a response have been analyzed, prioritized, and are presented in the following hazard vulnerability matrix. The risk definitions, scenarios, and ratings may be found following the matrix (Appendix B).

The seven highest vulnerability events for this facility are listed below:

<table>
<thead>
<tr>
<th>Potential Hazard/Event</th>
<th>Probability</th>
<th>Risk / Vulnerability Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>3</td>
<td>37%</td>
</tr>
<tr>
<td>Flood</td>
<td>3</td>
<td>35%</td>
</tr>
<tr>
<td>Hazmat Incident</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td>Temperature Extremes</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Epidemic</td>
<td>2</td>
<td>30%</td>
</tr>
<tr>
<td>Internal Fire</td>
<td>3</td>
<td>29%</td>
</tr>
<tr>
<td>Infectious Disease Outbreak</td>
<td>3</td>
<td>27%</td>
</tr>
</tbody>
</table>

Table 2. Highest Vulnerabilities
7 PLANNING CONSIDERATIONS

7.1 Phases of Emergency Management
RRECC utilizes the four phases of emergency management – mitigation, preparedness, response, and recovery – to frame our approach to crisis events. Each of these phases plays a specific role in our emergency management program, and together, they comprise a cycle that ensures ongoing readiness for any crisis.

7.2 Mitigation
Mitigation measures are steps taken by the facility in advance to minimize the impact that a crisis event would have, should it occur. Such measures are targeted based on the risks identified in the hazard vulnerability analysis, which is reviewed and revised annually. Mitigation activities undertaken include:

7.2.1 Natural Events
- Trees around the facility are regularly pruned, to reduce the possibility that fallen branches during a storm may cause damage or injuries. Con Edison prunes trees that may impinge upon overhead electrical wiring pathways.
- Roof drains are checked and cleaned regularly to reduce the possibility of flooding and roof overloading.
- Storm drains are checked and cleaned monthly to reduce ground flooding.
- RRECC maintains its own vehicles and plow for heavy snow clearance.

7.2.2 Technological Events
- Facility design is fire-safe; compliant with NFPA fire and life safety standards. No smoking or open flame is permitted in the facility. Staff are conscious of fire safety issues.
- A multidisciplinary team conducts hazard surveillance rounds. Team members include representatives from Facilities Management, Nursing, Infection Control, Pharmacy, and Safety and Security. All resident care areas are checked twice yearly, and non-resident care areas are checked at least annually.
- Building maintenance is ongoing to prevent failure of life safety systems, utility systems, mission-critical systems, fuel systems, heating, ventilation, and air conditioning, and other facility components. Preventive maintenance procedures are carried out to minimize or eliminate hardware downtime. Where possible, equipment and service redundancies have been implemented to provide redundant utility pathways. Machinery and utility rounds are conducted regularly.
- Regular preventive maintenance rounds are conducted on emergency electrical power generators weekly. Generators undergo regular monthly full-load testing, with records maintained.
• All areas of the facility have fire detection equipment and all have fire sprinklers. A visual inspection of the fire alarm control panels is conducted daily. Fire protection systems are tested in accordance with regulatory agency requirements.
• Elevator preventive maintenance contracts are in effect. Logs are maintained.
• Video monitors are located in strategic areas. Switchboard staff receive training in how to respond to phoned-in bomb threats. Security personnel receive training in how to respond to bomb threats and on how to conduct area searches for explosive devices. Staff are conscious of security issues and alert to unfamiliar items in their work areas.
• Systems are in place to assure that employees are treated fairly. Human Resources’ exiting process allows terminated employees to air their grievances.
• The facilities have been evaluated to ensure adequate engineering controls to minimize resident, visitor, and employee exposure.
• Information Services (IS) and the Data Center have instituted measures to minimize the likelihood of system outages. Where possible, preventive maintenance procedures are carried out to minimize or eliminate hardware downtime. Sophisticated virus protection technology and policies governing software and data management are in place to protect against deliberate attacks, with users responsible for compliance to ensure system security and integrity.
• Information Technology has instituted measures to minimize the likelihood of system outages. The telephone system is backed-up by batteries and the facility emergency generator in case of electrical outage. Where possible, preventive maintenance procedures are carried out to minimize or eliminate hardware downtime. Hardware and service redundancies have been implemented to provide redundant telecommunications pathways.

7.3 Preparedness
Preparedness measures are actions taken prior to an event that prepare the facility and staff for response. Such measures include planning, policy development, equipment stockpiling, training, and exercises. Preparedness measures undertaken include:
• All staff members, individuals providing services under arrangement, and volunteers are trained initially upon on-boarding and receive an annual refresher. Education is consistent with their expected emergency roles, and is reinforced with tabletop and full-scale exercises.
• The Facility Emergency Operations Plan is accessible on the facility intranet. All areas of the facility have access to a copy of the Plan.
• Every department in the facility has a written Department Emergency Operations Plan (DEOP) posted specific to their department, and is responsible for educating its staff on the details of that plan.
Each nursing station maintains a cabinet with flashlights, call tap bells, electrical extension cords, and walkie-talkies to be distributed as needed in the event of a loss of power. These are checked quarterly and during drills. All batteries are changed regularly.

Copies of all manuals and plans are maintained in the FCC, Facilities Management Department, each unit and Administration.

Fire drills are held regularly. Staff is updated monthly in fire safety procedures and the use of extinguishers through drills and in-service education. Firefighting and extinguishing equipment is deployed and maintained in operational condition. The Fire Response Team (FRT) provides rapid initial response to all alarms. All available staff are part of the facility fire response team. There is representation from current shift on the team. The fire alarm system is connected to the New York City Fire Department through a central station system, and the Fire Department response is automatic. Logs are maintained.

Backup communication systems include portable radios, and mobile phones. Some equipment redundancies exist, as do recovery plans. Switchboard staff is trained in, and exercise, downtime procedures.

Some IT equipment redundancies exist, as do recovery plans. IT staff are trained in, and exercise, downtime procedures. Backup files are stored securely both on and off-site.

Nursing staff are trained in mass casualty triage. Emergency medical triage tags and resident tracking kits are in place in the 24 Hour Office. Surge Capacity plans exist for rapid expansion of resident care areas.

Engineering controls enable rapid shutdown of ventilation systems. Security measures enable rapid lock-down of facility (to control influx of contaminated people). Selected staff members in the Safety and Security and Facilities Management Departments are trained in hazardous materials awareness.

Dependent care programs enable staff to bring dependents to work in the event of travel or utility disruptions, as needed. While all employees should have an individual family plan, the Dependent Care program will provide a temporary location for sheltering of dependent family members by using volunteers and personnel from the facility labor pool to provide limited dependent care. The primary focus of the Dependent Care program is to ensure that there is enough staff available to adequately care for the resident population in-house at the time of the incident, and any casualties resulting from the emergency event itself.

RRECC maintains its own vehicles and plow for heavy snow clearance.

Staff personal, family, and household pet preparedness is emphasized regularly, and supportive materials are distributed and posted on the internet, including social media. Staff is aware of weather issues and is encouraged to plan accordingly.
7.4 Response
Response activities are those functions carried out in response to an actual event. These measures are described in detail in the Emergency Operations Plan (pink-border pages), as well as on the various Job Action Sheets.

7.5 Recovery
Recovery activities are those actions taken following an event that are intended to return the organization to its pre-event state. Recovery actions taken range from the concluding steps taken by each member of the NHICS staff (described on their Job Action Sheets) to compiling documentation, conducting a critique, preparing an after-action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the emergency management plan, and training or re-training personnel, as necessary.

7.6 Critical Areas of Healthcare Emergency Management
Through an ongoing planning and training process, specific focus has been given to six critical areas of emergency management that are frequently challenged in crisis: communications, resources and assets, safety and security, staff roles and responsibilities, utilities management, and resident clinical and support activities. This plan describes strategies and tactics for managing each of these critical areas. In addition, the 96-Hour Self-Sustainment Annex addresses the mission-critical capabilities, technologies, and processes that are essential to the facility’s operation, and describes the application of the four phases of emergency management to each critical area.

This responsibility shall include, but is not limited to, maintaining records and information on city, state, and federal preparedness grants that have been received, and progress on work performed toward grant deliverables.

All RRECC Emergency Operations Plans, policies, and procedures, training materials, response and exercise procedures, equipment changes or purchases, evaluation and corrective action processes shall incorporate and support NIMS components, principles, and policies. All required elements of NIMS compliance are incorporated into this document.
8 DEPARTMENTAL PLANS / PREPAREDNESS

Each department shall have a plan to implement during an emergency incident. The plan, called a Department Emergency Operations Plan (DEOP), shall be prepared by the department head, and updated annually. The DEOP is a one-page form that describes the department’s overall responsibilities and immediate short-term actions at the time of emergency plan activation. The department head shall post copies conspicuously for ready reference and review by departmental staff. At a minimum, each DEOP should include the following:

- Departmental mission during emergency activation
- Leadership roles for Department personnel according to the Nursing Home Incident Command System Organizational Chart
- Process for reporting status to the Facility Command Center (FCC)
- Notification process for Departmental staff, including staff augmentation process
- Process for terminating and reactivating non-essential functions

Department heads shall ensure that all personnel within their departments are current on emergency procedures and equipment, and familiar with their personal roles, as well as the facility’s plan for managing emergencies. The department head of each department is responsible for providing a copy of their DEOP to the Emergency Management Coordinator. Each department is responsible for maintaining the accuracy of its internal plan and shall inform the Emergency Management Coordinator in writing of all changes, deletions, and/or additions to their plan.

8.1 Department-specific Contingency Procedures

Certain departments maintain extensive contingency procedures for department-specific activity. For example, the Facilities Management Department maintains detailed procedures for failure and restoration of various utilities; and the Dietary Department maintains five days of menus for meal service when cooking is not possible. These department-level procedures shall be considered attachments to a given department’s DEOP, and shall be maintained by the department for immediate reference as needed. The department head shall ensure that such DEOP attachments are current and reviewed annually.

8.2 All Departments

In preparation for Emergency Operations Plan activation, department heads shall:

(1) Ensure that all staff are formally oriented to the Emergency Operations Plan on assignment to the department, and at least annually thereafter.
(2) Maintain a current department call-in plan listed by title so that any personnel can be reached in the event of an emergency (Departmental Off-Duty Mobilization Plan). This should be included in each departmental Emergency Operations Plan Manual and should be updated regularly. Distinguish ahead of time those employees who live nearest the facility, or who are most willing to come in on short notice, and identify them accordingly in the call-in plan.

(3) Determine, for individual departments, plans for relieving personnel in event of a large scale or prolonged event.
9  COMPETENCIES, TRAINING, AND TESTING

9.1  Emergency Preparedness and Response Competencies

9.1.1  Staff Competencies

The ability of a facility to respond to an emergency depends upon having staff that know what to do, and have the needed skills. RRECC employees should be able to:

1. **Describe** how to initiate activation of the EOP when encountering a potential emergency situation.

2. **Locate** and **use** their departmental emergency operations plan (DEOP), and implement the actions described that apply to their position.

3. **Describe** the mission of their department during response to emergencies of all kinds, including their departmental chain of command and role within the NHICS System.

4. **Locate** and **use** the section of the EOP that applies to their position.

5. **Describe** their emergency response role and be able to **demonstrate** it during drills or actual emergencies.

6. **Demonstrate** use of any equipment (such as personal protective, safety, or special communications equipment) required by their emergency response role.

7. **Describe** their responsibilities for communicating with or referring requests for information from other employees, residents and families, media, general public or their own family, and **demonstrate** these responsibilities during drills or actual emergencies.

8. **Demonstrate** the ability to seek assistance through the chain of command during emergency situations or drills.

9. **Demonstrate** the ability to solve problems that arise carrying out their role during emergency situations or drills.

9.1.2  Leadership Competencies

The following core emergency competencies are those needed as a facility leader, facility-wide manager, department head, or senior manager in a large department. These may be demonstrated in a variety of ways, depending upon the leader’s exact role and the specific emergency or drill. These competencies provide a template for continued leadership development, and can be used flexibly with other emergency preparedness activities within the facility. RRECC leadership should be able to:
(1) **Describe** how to activate the EOP when a member of their staff encounters a potential emergency situation.

(2) **Describe** the mission of the facility during response to emergencies of all kinds, including the emergency response chain of command and the NHICS System.

(3) **Demonstrate** the ability to review, write, and revise as needed those portions of the EOP applicable to assigned management responsibilities and **participate** in the facility’s hazard vulnerability analysis process on a regular basis.

(4) **Manage** and **implement** the EOP during drills or actual emergencies within an assigned functional role and chain of command.

(5) **Describe** the collaborative relationship of the facility to other facilities or agencies in the local emergency response system and **follow** the planned system during drills and emergencies.

(6) **Describe** the key elements of the facility’s emergency preparedness and response roles and policies to other agencies and community partners.

(7) **Initiate** and **maintain** communication with other emergency response agencies as appropriate to assigned management responsibilities.

(8) **Describe** responsibilities for communicating with other employees, residents and families, media, the general public or their own family, and **demonstrate** them during drills or actual emergencies.

(9) **Demonstrate** use of any equipment (such as personal protective equipment or special communication equipment) required by their emergency response role.

(10) **Demonstrate** flexible thinking and use of resources in responding to problems that arise carrying out their functional role during emergency situations or drills.

(11) **Evaluate** the effectiveness of the response within their area of management responsibility in drills or actual emergencies, and **identify** improvements needed.

### 9.2 Education and Training

Education and in-service training is done through the new employee orientation program, the annual in-service education process, and through an ongoing series of tabletop, functional, and full-scale exercises. Management and leadership personnel receive more extensive train-the-trainer NHICS training. They are expected to provide periodic training reinforcement to subordinate supervisors and staff.

In addition to covering the NHICS program and general emergency procedures, training addresses specific roles and responsibilities during emergencies, and the information and
skills required to perform duties, communicate using backup systems, and obtain logistical support during emergencies. Competencies are demonstrated and evaluated during exercises and at in-service education sessions.

### 9.3 Drills and Exercises

As a sub-group of the facility’s Emergency Management Team, an exercise planning team has been trained in exercise design and development. The team is responsible for maintaining an ongoing program of training and exercises to ensure a constant state of readiness.

RRECC shall conduct a full-scale activation of this plan at least once each calendar year, either in response to an actual emergency or in a planned full-scale exercise. If possible, the facility will participate in a community-based exercise; if one is not available, the exercise will be conducted as an individual full-scale facility-based exercise.

The annual exercises may include an influx of actual or simulated residents, and may include a community-wide component. The exercise scenario will be realistic, and be developed based on a high-vulnerability event identified in our HVA. When possible, the community-based exercise should be an external NIMS-based “all-hazards” exercise that involves responders from multiple disciplines, different agencies, or organizations.

For planned exercises, scenarios will include elements that challenge the “six critical areas” of emergency management. These areas will be specifically monitored and assessed by the person(s) conducting the evaluation process.

- Communication, including the effectiveness of communication both within the facility as well as with response entities outside of the facility, such as local governmental leadership, police, fire, public health, and other health care organizations within the community;
- Resource mobilization and allocation, including responders, equipment, supplies, personal protective equipment, and transportation;
- Safety and security;
- Staff roles and responsibilities;
- Utility systems;
- Resident clinical and support care activities; and
- Effectiveness of improvements made in response to critiques of the previous exercises.

Consistent with the NIMS/ICS compliance requirements, RRECC will use NIMS/ICS/CIMS in all internal and external, local and regional emergency management drills and exercises. To the extent possible, NIMS/ICS/CIMS principles will be used in planning such exercises, as well, as a tool to reinforce the concepts.
A non-participating member of the Emergency Management Team, who will document performance and identify opportunities for improvement in a corrective action plan, will evaluate each exercise. The corrective actions so noted shall be reviewed through a multi-disciplinary process including administrative, clinical (including physicians), and support staff, and incorporated into modifications to the Emergency Operations Plan. Planned exercises should also evaluate the effectiveness of improvements that were made in response to critiques of the previous exercises.

9.4 Homeland Security Exercise and Evaluation Program (HSEEP)
The Department of Homeland Security (DHS) Homeland Security Exercise and Evaluation Program (HSEEP) is a capabilities- and performance-based exercise program designed to provide common exercise policy and program guidance capable of constituting a national standard for all exercises. HSEEP incorporates consistent terminology that can be used by all exercise planners, regardless of the nature and composition of their sponsoring agency or organization.

Exercise programs funded entirely or in part by the ASPR Hospital Preparedness Program (HPP) cooperative agreement funds shall meet the intent of the HSEEP practices for exercise program management, design, development, conduct, evaluation, and improvement. Therefore, exercises sponsored by another agency in which RRECC participates must be HSEEP compliant. Exercises sponsored by RRECC shall demonstrate the following four performance requirements:

- RRECC may conduct an annual Training and Exercise Plan Workshop (T&EPW) and maintain a Multi-Year Training and Exercise Plan.
- RRECC will plan and conduct exercises that are:
  - Consistent with the Multi-Year Training and Exercise Plan
  - Based on capabilities and associated critical tasks
  - Tailored toward validating the capabilities and based on the facility’s HVA, and
  - Reflective of NIMS principles, and include the required documents as needed to support exercise planning, conduct, evaluation, and improvement planning (e.g., Exercise Plan, Player Handout, Master Scenario Events List [MSEL], Controller/Evaluator Handbook).
- RRECC will develop and submit a properly formatted After-Action Report/Improvement Plan (AAR/IP).
  - An after-action conference shall be conducted following every exercise
  - Key personnel and the exercise planning team are presented with findings and recommendations

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- The final AAR/IP with recommendations and corrective actions will be completed for each exercise
- RRECC will track and implement corrective actions identified in the AAR/IP.
  - Corrective actions shall be specific, measurable, designate a projected completion date, and be assigned to a department and individual leader within that department for resolution
  - Corrective actions shall be continually monitored and reviewed by the Emergency Management Team.
10 QUALITY MANAGEMENT AND EVALUATION

10.1 Critique and After-Action Review

An important component of this plan is to review and critique the response to each incident by means of feedback from facility staff and appropriate outside agencies, and analysis of the response documentation. All emergency response exercises and all responses to actual incidents shall be evaluated. Monitoring activities and observations shall include relevant input from all levels of staff affected, including licensed independent practitioners. This information is summarized and disseminated as part of the ongoing quality improvement process of the facility, and incorporated into the plan as indicated.

The Emergency Management Team, together with the Facility Administrator, as the Senior Facility Leader for the Emergency Management Program, are responsible for the evaluation and objective documentation of the facility’s performance. The HSEEP After-Action Report, or other similar standardized document, will be used as a documentation tool.

Following any Level 3 activation, each NHICS command and general staff member will prepare a written review of the event, documenting both their departments and the facility’s overall response. The focus of this documentation shall be the identification of both excellent performance as well as opportunities for improvement, and/or changes recommended in the facility’s response plans and procedures. This documentation shall be forwarded to the Emergency Management Team within 72 hours following incident termination.

The leader of the Emergency Management Team shall schedule a meeting of department heads/chiefs of service and Committee members within three days following incident termination, as conditions warrant, in order to conduct a formal critique of the event. A critique is conducted to evaluate adequacy of the facility’s response to an incident, with the intention of identifying best practices and opportunities for improvement, or revising policies or procedures. Active participants from all areas of the facility should be included. The objective is to get as complete a picture of what happened and the facility response to the event as possible. The purpose of the session is to talk; discuss who did what, when, where, how, and why. It is important to get clear recall in order to clarify where policy worked and where it might be improved.

The results of the written reviews and critique proceedings shall be compiled into an after-action report (AAR) and improvement plan, which will serve to document the event, the facility’s response, and any follow-up actions needed to improve future performance. The AAR shall be forwarded to the Facility Administrator, as the Senior Facility Leader for the Emergency Management Program, for review and endorsement within two weeks following incident termination.
Following review and endorsement, the deficiencies and opportunities for improvement identified during the post-exercise/post-incident evaluation process shall be communicated to the Facility QA Committee and to senior facility leadership.

10.2 Plan Development and Maintenance

This plan was developed in response to the regulatory requirements and standards promulgated by the CMS Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, Part 483, as effective November 16, 2016; as well as The Joint Commission Nursing Care Center Accreditation Program, Leadership Chapter and Emergency Management Management Chapter, as effective January 1, 2016. Compliance is additionally established with the 11 National Incident Management System (NIMS) Implementation Objectives for Healthcare Organizations, as well as the National Fire Protection Association (NFPA) Standard 99-12 Health Care Emergency Management and Standard 1600, Standard on Disaster/Emergency Management and Business Continuity Programs.

Important input for plan revisions arise from opportunities for improvement that were identified during incident drills and critiques of actual emergency situations. An Emergency Management Team, consisting of members representing clinical departments, resident care services, administration, security, engineering, quality management, and other areas of the facility, prepared the plan. Incident Management Solutions, Inc, a New York-based certified emergency management consultancy, created the plan template under contract for the New York City Department of Health and Mental Hygiene, and facilitated the emergency planning and training process.

The plan is presented to the RRECC Quality Council and Board for approval. Education and in-service is done through the new employee orientation program, the annual in-service education process, self-learning packets and questionnaires, and through an ongoing series of tabletop, functional, and full-scale exercises. Administration, resident care services leadership, and key departmental individuals are invited to meetings of the facility Emergency Management Team for more intensive discussion of the plan.

Plan review and evaluation is performed through facility Emergency Management Team meetings, quality management/performance improvement reviews, periodic emergency operations drills, exercises, and through responses to actual occurrences.

Department-specific plans shall be revised at least annually. Copies shall be forwarded to the leader of the Emergency Management Team by each department head no later than June 30 each year. These plans shall include, at a minimum, an updated Department Emergency Operations Plan (DEOP) form, and a current telephone notification list for all personnel assigned to the department.
Every year, during the first quarter, the Emergency Management Team conducts a full review of the plan. At a minimum, this review shall include:

- Assessment of the Emergency Operations Plan’s objectives, scope, performance, and effectiveness
- Reassessment of the Hazard Vulnerability Analysis based on experience over the preceding year
- Development or formalization of any incident-specific plans necessitated by the revised Hazard Vulnerability Analysis
- Revision of existing procedures based on actual experiences and new information, standards, or best practices in the emergency management community
- Establishment of an emergency management training and exercise calendar and objectives for the coming year

The leader of the Emergency Management Team is responsible for carrying out this review, and reporting the Team’s findings and recommendations to the Facility QA Committee for approval. The revised Emergency Operations Plan and upcoming year’s training program shall be approved and published no later than August 1.

Revisions of the facility-wide plan will be distributed to all department heads, for education of their staff and updating of the Emergency Operations Plan manuals.

The leader of the Emergency Management Team is responsible for plan distribution, and shall conduct periodic inspections of each unit to ensure that plans are in place and current, and that staff are familiar with plan contents and their responsibilities.
11 NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS)

11.1 National Incident Management System Background

While most emergencies are handled locally, when a major incident occurs, help may be needed from other jurisdictions, the state and the federal government. On February 28, 2003, President Bush issued Homeland Security Presidential Directive-5. HSPD-5 directed the Secretary of Homeland Security to develop and administer a National Incident Management System (NIMS). NIMS provides a consistent nationwide template to enable all government, private-sector, and nongovernmental organizations to work together during domestic incidents. NIMS was developed so responders from different jurisdictions and disciplines can work together better to respond to natural disasters and emergencies, including acts of terrorism. NIMS benefits include a consistent, unified approach to incident management; standard command and management structures; and emphasis on preparedness, mutual aid, and resource management.

NIMS is a comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. The intent of NIMS is to:

- Be applicable across a full spectrum of potential incidents and hazard scenarios, regardless of size or complexity
- Improve coordination and cooperation between public and private entities in a variety of domestic incident management activities

11.2 NIMS Compliance

The 11 NIMS compliance objectives for healthcare facilities are organized into five activity groupings, listed below. The facility’s NIMS compliance activities are reflected within the groupings.

11.2.1 Adoption

- Adoption of NIMS: HSPD-5 requires Federal departments and agencies to make the adoption of NIMS by State and local organizations a condition for Federal preparedness assistance (grants, contracts, and other activities). There are 26 compliance elements for organizations to establish “NIMS compliance,” of which 11 apply to healthcare facilities. This Emergency Operations Plan ensures that RRECC meets current NIMS compliance requirements.

- Federal Preparedness Awards: Administration ensures that federal preparedness grants and cooperative agreements support NIMS implementation (in accordance with the eligibility and allowable uses of the awards). RRECC participates in trade associations and other appropriate emergency management entities, as well as any available regional healthcare planning coalitions in order to ensure regional interoperability and leveraging of federal grant programs. The Emergency
Management Coordinator is responsible for maintaining documentation as required by the funding agency.

11.2.2 Preparedness Planning

- **Revise and Update Plans:** RRECC has revised and updated the Emergency Operations Plan (EOP), reviewed and updated as necessary standard operating procedures (SOPs) and standard operating guidelines (SOGs) to incorporate NIMS and National Response Framework (NRF) components, principles and policies, including planning, training, response, exercises, equipment, evaluation, and corrective actions. The date of the most recent update is found in the Table of Revisions at the beginning of this document and on all applicable supporting documentation.

- **Mutual-Aid Agreements:** RRECC participates in interagency mutual aid and/or assistance agreements, including agreements with public and private sector and nongovernmental organizations. (See Section 21.1 for additional information on mutual aid agreements.)

11.2.3 Preparedness Training and Exercises

- **IS 700, ICS 100 and 200:** All members of the Emergency Management Team and personnel who are likely to assume an incident command position described in this Emergency Operations Plan are required to take IS-100.HCb Introduction to the Incident Command System for Healthcare/Healthcare facilities, IS-200.HCa Applying ICS to Healthcare Organizations, and IS-700.a National Incident Management System: An Introduction. Records are maintained by the Emergency Management Coordinator.

- **IS 800B NRF (National Response Framework):** Members of the Emergency Management Team are required to complete IS-800 or an equivalent course. Other leadership staff are encouraged but not required to take this course.

- **Training and Exercises:** All training and exercises are conducted using ICS management methods and NIMS concepts. Post-event documentation includes evaluation of NIMS concepts and use of ICS.

11.2.4 Communication and Information Management

- **Interoperability Incorporated into Acquisition Programs:** RRECC participates in regional and state initiatives to ensure that capital purchases of emergency preparedness equipment, communication, and data systems are compatible (interoperable) with that of other responder agencies and organizations. The Director of Purchasing is responsible for ensuring compliance with this requirement.

- **Standard and Consistent Terminology:** It is facility policy that common and consistent terminology is used when responding to an incident, including the establishment of
plain language communications standards (see Section 18.8 for additional information).

11.2.5 Command and Management
- **Incident Command System (ICS):** RRECC manages all emergency incidents, exercises, and preplanned (recurring/special) events using ICS organizational structures, doctrine, processes, and procedures (i.e., NHICS), as defined in NIMS (see Section 14 and the EOP portion of this document for additional information).

- **Adopt Public Information Principles:** RRECC has policies for public information activities including designation of those individuals authorized to act as spokespersons and handle media inquiries. Authorized Public Information Officers are trained in this type of communication and are also responsible for participating in Joint Information Systems (JIS) and Joint Information Centers (JIC) during an incident or event (see Sections 22.3 and 22.4 for additional information).

11.3 Citywide Incident Management System (CIMS)
Mandated by mayoral executive order in 2005, the Citywide Incident Management System (CIMS) was established as the City’s program for responding to and recovering from emergencies, and for managing planned events. The CIMS protocol is the City’s implementation of NIMS. CIMS establishes roles and responsibilities and designates authority for city, state, and other government entities, and non-profit and private sector organizations performing and supporting emergency response.

While CIMS has been developed to address New York City’s unique incident management requirements, its full compliance with NIMS ensures compatibility with incident command systems in use in other states and federal agencies. CIMS is also designed to be scalable, facilitating the integration of additional organizations, such as private sector and non-profit entities.

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CONCLUSION

The RRECC Comprehensive Emergency Management Plan is a wide-ranging, yet flexible all-hazards set of crisis action procedures that have been tried and validated under a host of actual and simulated emergency conditions. These procedures, when properly implemented and led, will ensure that any crisis response will maximize safety, effectiveness, and efficiency; enable provision of the best possible care for residents and the community; and maximize continuity of operations for the organization.
12 ADVANCE PREPARATIONS

Although many incidents occur with little or no warning, there are others where advance notice is provided to the facility hours, days, or longer ahead of an occurrence. Examples may include weather events (e.g., storm watches and warnings), public safety threats (e.g., changes in the National Terrorism Advisory System), and routine events (e.g., a planned shutdown of the facility electrical system for testing or service; the annual Employee Appreciation ceremony).

For such situations, there are actions that may need to be implemented by the facility in advance of the event to prepare the organization to respond when and if the threat materializes or an adverse impact occurs. The actions are grouped based on the six critical areas of healthcare emergency management. Depending on the circumstances, these guidelines may be implemented hours to days before impact is anticipated. Variation from prescribed activities may occur at the discretion of the Incident Commander, and activities may be adjusted to meet specific situations. Event-specific preparations are further detailed in the Critical Event Annexes.

12.1 General Preparedness Measures

As an event approaches, general readiness measures may include, but are not limited to, the following:

- Activate the Emergency Operations Plan (EOP) and place potential Facility Command Center (FCC) staff on alert status
- Establish a Planning Section to prepare specific contingency plans for the impending situation
- Activate a watch desk to monitor evolving conditions
- Activate or place in alert status external support agreements (e.g., security augmentation, staff transportation, staff lodging, dependent/pet care)
- Maintain monitoring of local and/or relevant news media and weather forecasting for updates and status changes
- Review emergency plans and procedures with staff and other stakeholders
- Review and update appropriate mitigation measures
12.2 Communications

- Communicate information with staff regarding the impending event, facility and community activities being undertaken, and staff and staff family personal preparedness measures
- Test radio, paging, mass notification, and broadband global area network (BGAN) links and alternate communications plans and equipment
- Ensure all portable device batteries and workstations on wheels (WOW), including spares, are fully charged
- Update regional critical resource inventories and online data management systems
- Establish contact with local broadcast news media to review procedures for public announcements and staff alert broadcasts
- Establish contact with the Greater New York Healthcare Facility Association, the New York City Department of Health and Mental Hygiene (NYCDOHMH), and New York City Emergency Management (NYCEM). Provide liaisons to Emergency Operations Centers (EOCs), as needed.
- Maintain effective communications with all involved parties and stakeholders: staff, residents, resident families, vendors, assisting and cooperating agencies, and the community.

12.3 Resources and Assets

- Review inventory of critical supplies to mitigate against loss of community support lasting more than 96 hours
- Inventory and replenish (as necessary) resource stockpiles, including food, potable water, linen, pharmaceuticals, medical supplies, spare batteries, generator fuel, and damage control materials
- Update resource and asset inventories
- Place advance or accelerated orders to reinforce stockpiles as needed/anticipated
- Activate or mobilize emergency stores and/or vendor-managed inventories
- Review and update vendor emergency contact information
- Review status of emergency purchase orders and standing order deliveries
- Service and fuel facility vehicles and generators
- Stock food and bedding or make preliminary arrangements for staff lodging and hygiene
- Secure or consolidate supplies of scarce resources (e.g., antibiotics, fuel)
- Consider fiscal needs, including availability of cash reserves to support post-event purchases and staff cash advances
- Pre-position supplies and equipment to areas of anticipated need
- Relocate critical assets to safer/more secure areas
12.4 Security and Safety

- Remove/secure outdoor items that could become airborne, lost, or damaged (e.g., patio furniture, trash receptacles, fuel tanks, medical gas cylinders, maintenance equipment)
- Apply ice/snow melting agents
- Secure materials (e.g., pharmaceuticals, narcotics) requiring special handling or security measures
- Deploy enhanced security measures, ranging from 100 percent identification checks to facility or campus lockdown (refer to Section 23—Security and Safety for detailed measures to implement as conditions dictate)
- Evaluate parking areas for restriction or traffic flow adjustment
- Establish staging areas for incoming resources
- Conduct an event-specific threat and vulnerability assessment of the facility
- Review policies and accommodations for community influx for shelter or resources
- Review procedures for security reinforcement (including external vendor and law enforcement contacts)
- Review use-of-force policy
- Consider plans for restriction of facility access/egress and traffic flow

12.5 Staff Management

- Prepare staff scheduling enhancements to cover the period, including shift alterations, extended shifts, and additional contracted coverage
- Place off-duty/on-call staff in alert status
- Review human resource policies covering staff absenteeism during emergencies
- Implement denial of leave requests, cancellation of prescheduled leaves and days off, and medical clearance for use of sick leave
- Ensure continuity of executive leadership coverage in the staffing plan
- Update lists of employees who live or will stay within close proximity of the facility. Ensure that complete address information, including apartment numbers, and contact information, including cell phone, e-mail, and text messaging addresses are updated.
- Facilitate and encourage establishment of employee self-help transportation pools. Restrict use of facility vehicles to provide staff transportation for extreme circumstances.
- Create sleeping arrangements or reserve hotel accommodations for key staff
- Assist staff in preparing their homes and families for the potential event impact (e.g., stocking food; fueling vehicles; reviewing dependent care; family communications plan; personal finance; and pet care arrangements)
### 12. Advance Preparations

- Identify potential need for staff dependent care (including pets) and activate plans as needed
- Direct incoming personnel to bring extra clothing, and personal necessities (including medications) in preparation for an extended stay
- Review facility emergency procedures with staff, including shelter-in-place and evacuation plans and policies for absenteeism
- Brief the Critical Incident Stress Debriefing (CISD) team, if needed

### 12.6 Utility Management

- Review and practice event-specific utility management, shutdown, restoration, and recovery procedures
- Establish contact with service and support vendors and public utilities
- Review and update emergency service contact information

### 12.7 Resident Management

- Prepare modifications of clinical scheduling, including cancellation of elective procedures, census reduction, and discontinuation of outside resident activities. Pre-assign available staff to meet projected facility staffing needs.
- Notify residents and clinicians regarding the potential cancellation/suspension/delay in planned services (e.g., admission, treatment, procedure)
- Implement alternate care plans for residents requiring life-dependent procedures and services (e.g., renal dialysis)
- Prepare to activate surge-capacity spaces for intake of evacuated special needs populations, overflow, or evacuees from other impacted long term care facilities
13 CONCEPT OF OPERATIONS – PLAN ACTIVATION

13.1 Incident Recognition -- Notification of an Incident

The person receiving the first notification that an emergency incident has taken place will quickly obtain as much information as possible on the situation. The person receiving notification shall immediately contact the Switchboard Operator (Dial 0), stating “This is an Emergency Plan alert.” The Switchboard Operator shall initiate an Emergency Plan Alert form, and immediately notify the Facility Administrator during business hours and the Nursing Supervisor at all times. This notification must be accomplished by direct voice contact. The Facility Administrator (in his/her absence, the Nursing Supervisor) will
ascertain the facts, assess the situation, and make the decision to assume command and activate the Emergency Operations Plan.

In making the activation assessment, the Facility Administrator/Nursing Supervisor will be guided by two clear policy directions. First, an early but unnecessary plan activation is better than a needed but delayed activation; i.e., if an incident appears to present an actual or potential impact on the facility, activate the plan. Second, the best training tool for familiarizing staff and leadership with emergency procedures is through experiencing an actual plan activation, even if at a low level. Therefore, the organization benefits from low-level emergency plan activation as a training experience for more significant events. **When in doubt, the plan should be activated and command established.**

### 13.2 Activation/Response

The Emergency Operations Plan will be activated at one of the following activation levels. Note that activation can occur at any level and does not require a stepwise sequence of activation. For example, the plan can be activated at Level Four for a situation having a major impact on the facility, and all activities and notifications consistent with Levels One and Two shall be implemented concurrently. Refer to the Emergency Operations Plan Activation Matrix for parameters that describe conditions that may lead to activation at the various levels.

#### 13.2.1 Level One Activation (Alert)

Activated when advance notice has been received for an incident or event that may have an actual or potential unusual impact on facility operations, but no impact is noted in the facility yet (e.g., a hurricane warning).

Concurrent with initial notification of a fire in the facility, the Emergency Operations Plan shall automatically be activated at Level One. If the fire incident requires outside assistance or in any other way has an unusual impact on facility operations and services, the Emergency Operations Plan is to be activated at whatever other Level is appropriate.

#### 13.2.2 Level Two Activation (Minor Impact)

Activated for an incident with a minor impact on facility operations. This type of activation typically occurs when an incident impacts one or two departments or a small part of facility operations, is limited in nature, and is of short duration. The majority of the facility will maintain normal operations.

#### 13.2.3 Level Three Activation (Moderate Impact)

Activated for an incident with a moderate impact on facility operations. This type of activation typically occurs when an incident impacts about half of facility operations and requires substantial support. Normal operations are maintained in the unaffected areas of the facility.
### 13.2.4 Level Four Activation (Major Impact)

Activated for an incident with **significant** impact on facility operations, including the potential for long duration. During a Level Four activation, the majority of facility resources and operations will be focused on managing the incident.

The **EOP Activation Matrix** may be found in **Appendix B**.
14 ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

14.1 Nursing Home Incident Command System (NHICS)

In 2004, Homeland Security Presidential Directive-5 directed the development and implementation of the National Incident Management System (NIMS). The overarching goal within NIMS is the development of a consistent national template for preparedness and response, allowing government and nongovernment agencies to work together. This was a major development in emergency management, as there is now a federal mechanism for ongoing collaboration based on best practices and lessons learned. Use of an ICS is a component of NIMS, paving the road for collaboration among a variety of agencies, disciplines, and providers within the critical healthcare and public safety infrastructure.

The use of an Incident Command System (ICS) in emergency response has been well established in military, public, and private sector entities for decades. In 2006, the Hospital Emergency Incident Command System was revised to ensure consistency with established ICS concepts, allowing greater connectivity of hospitals with public safety and emergency management partners. The 2006 revision project yielded new tools for hospitals to use in the development and enhancement of emergency management programs.

These tools, including incident planning and response guides and the development of healthcare based ICS forms; provide planners with additional resources to augment their current plans. A key element of the overall healthcare emergency management program is the planning with community partners, including other nursing home and long-term care facilities. These critical resources play an integral role in a successful response through enhancement of the community medical surge capacity and capabilities.

Through the leadership of the California Association of Healthcare Facilities (CAHF), this guidebook and its toolkit were developed to provide nursing home and other long-term care facilities with the planning and response guidance to refine their emergency management programs through the use of a nursing home incident command system. This guidebook utilizes materials developed in the 2006 HICS revision project along with the nursing home ICS guidance developed by the State of Florida Health Care Association. In addition, the best practices identified by the Center for HICS Education and Training were used in the research and development of these materials. In the year following the release of NHICS in California, the American Health Care Association Disaster Preparedness Committee accepted the task of integrating the Florida Health Care Association NHICS Job Action sheets and Incident management team chart into CAHF’s NHICS materials in an effort to improve the national applicability of the materials. The result of their hard work is reflected in this 2011 edition of the NHICS Guidebook.
Every significant incident or event, whether large or small, and whether it is defined as an emergency, requires certain management functions to be performed. This guidebook is intended to explain in a clear and concise manner the critical components of the Nursing Home Incident Command System (NHICS) as well as the suggested manner for using the accompanying materials.

NHICS is intended to be used by nursing homes and other long-term care facilities regardless of size or resident care capabilities, and to assist with their emergency planning and response efforts for all hazards. By embracing the concepts of incident command design outlined in NHICS, a nursing home is positioned to be consistent with NIMS and to participate in a system that promotes national standardization in terminology, response concepts, and procedures.

The primary beneficiaries of NHICS will be facility administrators, department heads, physicians, nurses, and other personnel in long-term care facilities in the United States and internationally who will assume command roles during an incident. Students preparing for a career in medicine, nursing, and hospital administration, whose education should include understanding emergency preparedness principles and practices, will also find the material useful. Other community response partners need to understand the role of nursing homes and long-term care facilities, including the response activities and the needs that facilities will have during various types of incidents. Therefore, local/tribal, state, and federal public safety, emergency management, and public health officials will also benefit from reading this manual.

The guidebook has not been written to be the definitive text on emergency preparedness or to comprehensively teach the principles of incident command. Rather, the reader should find the short-paragraph and bulleted information format helpful in quickly understanding vitally important tenets of response planning, incident command, and effective response.

### 14.2 Assumption of Command

Once the plan is activated, the Facility Administrator (business hours) or the Nursing Supervisor (all other times) shall assume command, and be designated as the RRECC Incident Commander (IC) for that incident. The Incident Commander is the designee of the Chief Executive Officer, and is responsible for all facility resources and operations necessary to manage the incident. The Incident Commander is responsible for making policy decisions during emergency operations.

Upon assuming command, the Incident Commander shall immediately activate the Facility Command Center, either virtually (via radio) or by proceeding to the actual FCC location. The IC should generally remain at the FCC throughout the emergency, maintaining a visible command posture. If leaving the FCC, the IC shall identify an FCC
Manager who will be in direct contact at all times with the IC, preferably by clear radio channel, until his/her return.

For an isolated, localized Level 1 or Level 2 incident affecting only one department or area, the Facility Administrator/Nursing Supervisor may elect to designate the senior manager or supervisor in that department to be the incident commander. However, should conditions warrant or the incident escalate the Facility Administrator/Nursing Supervisor shall assume command. In any event, the Facility Administrator/Nursing Supervisor shall retain overall responsibility and accountability for the facility’s response to the incident until relieved by competent authority.

14.3 NHICS Incident Management Team and Order of Succession

Consistent with NHICS principles, the only position that must be activated is that of the Incident Commander. Should the IC determine that s/he can manage all necessary functions for the incident without additional assistance, no further positions need be activated. Additional positions are activated after the IC has assessed the situation, developed a plan to manage it, and can assign individual leaders to manage elements of the plan.

For each position in the NHICS organization, the Order of Succession Table identifies a primary person (Tier 1, business hours) and a secondary person (Tier 2, non-business hours). The Tier 2 coverage identifies those positions that cannot be filled with on-duty staff during non-business hours, signifying that an on-call person would likely be needed for those specific roles to be activated. It is anticipated that the organization can effectively staff through a Level 2 incident during non-business hours with existing staff on duty, but will need staff augmentation for any Level 3 or greater incident. The incident commander always retains the option of assigning staff based on assessment of the needs and objectives to be met and availability of personnel (managerial, supervisory, or senior trained staff) as needed.

The NHICS Incident Management Team Chart may be found in Appendix C. The NHICS Order of Succession Matrix may be found in Appendix D.

14.4 Department-level Leadership

In every department, the senior person present shall take charge and make all necessary decisions until relieved by a superior or otherwise directed by the FCC. Department heads are responsible for succession and continuity planning for leadership within their departments.
14.5 Identification of Key Personnel
A key element of effective incident management is the ready identification of leadership personnel and their assignments. Each leader in the NHICS organization will be issued a NHICS vest, and shall wear the vest for the duration of their assignment. The vests are color-coded by NHICS section, and have the position title prominently displayed on the front and rear for high visibility.

In addition, all staff members will display their facility photo-identification cards prominently on their outermost garments during a NHICS activation. Security officers will stop and deny access to incident facilities to any staff member not properly identified.

14.6 Transfer of Command
As conditions evolve or higher-level leadership arrives at the facility, command may be transferred between leaders. The decision to do so is generally at the discretion of the higher-ranking leader. However, at an incident of Level 3 or greater magnitude, the most senior leadership (as noted in the Order of Succession, tier 1) is expected to assume command functions.

The transfer of command is accomplished following a face-to-face briefing, during which the incident commander informs the person relieving her/him of conditions at the facility, impacts, problems, progress, the strategy for managing the incident, and any other pertinent information. The oncoming incident commander should consider retaining the off-going commander for a period of time in the FCC to maintain continuity in leadership and knowledge transfer.

As an incident de-escalates, consideration may be given to having lower-level leadership assume command roles, both for relief purposes, and for ongoing leadership development.

14.7 Development of the NHICS Organization
The IC will build the NHICS organization to effectively implement the incident objectives. Using the organizational chart template, the various positions and functions will be activated as needed. It is understood that not all positions necessarily need be activated to achieve the incident objectives, and that one individual may be assigned to more than one position.

A primary function of the Incident Commander is to ensure that expansion or escalation of the incident is sufficient to meet the incident objectives, while simultaneously minimizing the impact of the event on non-involved areas of the organization. As much as possible, normal routine activities and operations shall be maintained throughout the organization during a NHICS activation.
14.8 Delegation of Responsibility

Delegation of responsibility will occur based upon the requirements of the incident, the facility resources, and the available personnel. This may be an ongoing and dynamic process.

As with any management system, all responsibilities belong to a higher organizational level, until delegated by establishing a lower level. The incident commander is responsible for all incident functions, until she or he delegates some functions to section chiefs and unit leaders to carry out. Both clinical and operational functions will be managed administratively in the same manner.
15 DIRECTION, CONTROL, AND COORDINATION

15.1 Further Plan Implementation
Once notification of the incident has occurred, the plan has been activated, and command assumed, further plan implementation will occur. The sequence for this implementation is noted below. Note that these steps need not be sequential; several processes may occur simultaneously.

15.2 Identification of Incident Objectives
Based upon assessment of the incident and the status of facility resources, the Incident Commander will decide upon the initial response to the incident. Based on this process, the IC will develop an overall plan, and then divide the work into manageable objectives in accordance with generally accepted ICS principles. Where possible, these objectives should be framed to correspond to functions within the NHICS organizational chart, and those functions will then be activated and assigned to available staff members.

15.3 Development of an Incident Action Plan
With the NHICS organization in place based on a hasty initial plan, an incident action plan (IAP) will be developed to enable incident command staff to receive and disseminate information, perform an ongoing assessment of the incident, and monitor, coordinate and document plan response. Depending on the scope, complexity, and anticipated duration of the incident, the plan may be disseminated verbally, or may be written down and communicated more formally using the NHICS Incident Action Plan forms. When an incident extends beyond a single operational period (e.g., a single work shift), a written incident action plan shall be created and maintained by the Planning Section (Documentation Unit).

15.4 Escalation of Response
An incident may be appropriately handled with the initial response activities according to the above process, but it may also require escalation because of a need for additional resources, personnel, or because of incident scope or duration. In this case, other procedures, such as a staff augmentation plan (e.g., 12-hour emergency tours), or transfer of supplies from other facilities, may need to be implemented.

Escalation of plan activation is at the discretion of the Incident Commander, based on the impact that an event actually or potentially has on the organization. The rationale for escalating plan activation is that at each level of activation, additional pre-planned sets of nonessential functions may be set aside in each department, making staff and other resources available for higher-priority assignments. Each department’s DEOP identifies its nonessential functions by NHICS activation level, as well as the number of staff by title that will be made available as a result.
15.5 Planned Degradation of Services

In the event that demand exceeds capabilities and external support and solutions (including resident transfer or evacuation) are not available, a plan for degradation of services shall be developed and initiated by the Incident Commander. Such degradation of services may include (but is not limited to):

- Conserving, consolidating, and/or rationing scarce resources
- Reducing or curtailing services, capacity, and capabilities
- Closing the facility to new residents
- Altering standards of care
- Staged or partial evacuation
- Full facility evacuation and relocation

Specific strategies are found in the 96 Hour Self-sufficiency Annex. Comprehensive evacuation strategies and tactics are found in Nursing Facility Evacuation Annex.

15.6 Integration and Liaison with Local Government and External Emergency Response Agencies

15.6.1 Mutual Aid Agreements

RRECC recognizes the need and value of mutual aid agreements, and will participate in and promote NIMS-compliant interagency and inter-organizational mutual aid programs with public, private, and non-governmental organizations that are supportive in meeting mutual goals during an emergency.

15.6.2 Medical Facility Mutual Aid

15.6.2.1 Mutual Aid Agreement Partners

(1) The following facilities participate in the NYHH Emergency Preparedness Coalition (EPC) (agreements pending):

(2) EPC facilities will activate communications response to notify partners of each facility’s status, using a dedicated telephone, or through HERDS.

(3) The incident commander will determine if additional resources are needed.

A component of RRECC mutual aid planning ensures timely interaction with other local and regional health care organizations that also provide services in the geographic area. For each of the partnering health care organizations, the mutual aid agreements or attachments identifies:

- Essential elements of their command structures and control centers;
- Names and roles of individuals in their command structures;
- Command center contact information (e.g., phone, facsimile, e-mail);
- Resources and assets that potentially could be shared in an emergency response (coordinated with the Logistics Section during plan activation); and
15.6.2.2 Regional Cooperative Healthcare Planning

[For future use]

15.6.3 Public Safety

Public safety agencies in New York City have specific responsibilities in emergencies, as set forth in the city’s Citywide Incident Management System (CIMS) protocol. These responsibilities include:

- **Fire Department**: Fire prevention and suppression; pre-facility emergency medical care; search and rescue of injured and trapped persons; structural evacuation, management of CBRN/hazardous materials life safety and mass decontamination, and arson investigation
- **Police Department**: Law enforcement and investigation; intelligence collection and analysis; crime scene processing and evidence reservation; perimeter security; traffic control; crowd control; site security and force protection; population evacuation or in-place sheltering; safeguarding of property; and criminal investigation.

Under most circumstances, the ranking officer of the agency with primary responsibility for the situation (the “lead agency”) will be in command of the overall response, and will utilize the National Incident Management System/Incident Command System. Under some circumstances, where multiple governmental jurisdictions are involved and/or multiple agency responsibilities must be carried out simultaneously, the ranking agency commanders are expected to operate within a unified command system. In a unified command system, all participating jurisdictions and agencies contribute to the establishment and prioritization of incident goals and objectives and may provide resources to support them.

The facility maintains an ongoing relationship with various municipal agencies in the borough of Bronx, as well as throughout New York City. The New York City Police Department and New York City Fire Department are available to assist us in any incident.

Should an incident warrant active participation of public safety agencies in the facility’s emergency management process, each appropriate agency may be requested to assign a liaison to the RRECC Facility Command Center. In an internal incident involving the facility (e.g., a facility fire), the facility incident commander should participate in a unified command structure with the responding fire and police commanders, where possible.

15.6.4 Multi-Agency Coordination System (MACS)

When the scope of an incident requires, the City may establish a multi-agency coordination system (MACS). During a large-scale or widespread event, such as a

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natural disaster, disease outbreak, or terrorist attack, a MACS serves to support incident management policies and priorities across the entire City, a large area, or several individual events; facilitates logistics support and resource tracking; makes resource allocation decisions based on incident management priorities; coordinates incident-related information; and coordinates interagency and inter-governmental issues. The MACS would be established and coordinated by NYCEM, and would serve to integrate the varied activities of other agency and organization emergency operations centers across the region. RRECC may be asked to participate or assign a liaison. As needed, the facility will communicate its ability to share resources and assets (e.g., personnel, beds, transportation, linens, fuel, personal protective equipment, medical equipment and supplies) with other health care organizations outside the community in the event of a regional or prolonged incident.

15.6.5 Oversight
The facility has liaisons and communication lines established with other health care facilities, networks, and organizations in the region, as well as the Greater New York Healthcare Facility Association, and the city and state departments of health.

15.6.6 Governmental
The facility Emergency Management Team works in conjunction with New York City Emergency Management (NYCEM). Should an incident warrant close integration of local government in the facility’s emergency management process, NYCEM may assign a liaison to the RRECC Facility Command Center, and the facility may assign a representative to the city’s Emergency Operations Center.
16 INTEGRATED HEALTHCARE SYSTEM INTEGRATION

Incidents may occur which require the utilization of resources or services of other institutions within the Gotham Network. Notification shall be made to the Network Chief Executive anytime this plan is activated at any level. The Network Chief Executive should be contacted at the Gotham Executive Suite:

- Business hours: [phone]
- All other times: through the Switchboard Operator, [number]

For further information, see the *Gotham Network Comprehensive Emergency Management Plan*. 
17 INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

17.1 Assessment of Event and Available Facility Resources
The IC, command staff, and section chiefs will assess ("size-up") the situation and the facility resources in three categories: event, logistics, and operations. The initial response to the incident will be based on that primary review as related to personnel, equipment, supplies, structural components, and utilities available at the time of activation.

17.1.1 Criteria for Size-Up
Size-up refers to a mental process of appraising and evaluating all of the influencing factors relating to an emergency incident before committing personnel and resources to a course of action. This usually includes an estimation of hazards, life safety, extent or impact of the problem, and an initial strategy for response.

The following key elements should be considered when sizing up a facility incident:

- Type of incident
- Internal or external
- Threat environment and security assessment
- Size of incident or area affected
- Number of residents injured, expected at the facility, or affected by the situation
- Potential for change: will events remain stable, worsen, or improve?
- Anticipated duration of event impact
- Projected impact on normal facility operations
- Facility resident occupancy and bed availability
- Status of resident care and ancillary services
- Current and projected staffing levels (clinical, support, and supervisory/managerial)
- Status of facility physical plant, utilities, and environment of care
- Need for shelter-in-place, evacuation, or resident relocation
- Need for additional resources

17.1.2 Identification and Prioritization of Incident Objectives
Based on assessment of the incident and the status of facility resources, the IC will decide upon the initial response to the incident. For example, in the event of a hurricane, based on the effects of the hurricane on the physical plant and operation of utilities, the IC may decide to shut down operations in some areas, augment operations in other areas, evacuate the facility, or accept residents from other facilities.

Incident objectives should always be developed in the NIMS-standard sequence of events: life safety issues and objectives are always considered and addressed first, followed by incident stabilization and management issues, then considerations of preserving property and conserving resources. For example, in a fire, RACE is applied:
Rebekah Rehab & Extended Care Center | Emergency Operations Plan

<table>
<thead>
<tr>
<th>Policy Name:</th>
<th>17. Information Collection, Analysis, and Dissemination</th>
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<td>12.24.18</td>
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<tr>
<td>Revision Date:</td>
<td></td>
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<td>Reference:</td>
<td>CPG 101</td>
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</table>

Rescue people in harm’s way (life safety), Alarm and Confine (incident stabilization), and finally Extinguish the fire (property conservation). As in this example, certain objectives meet more than one priority; for example, confining the fire is at once a life safety, incident stabilization, and property conservation measure. The key is to ensure that objectives are selected and assigned in the proper priority.

The second consideration for assigning objectives is that they should always be SMART objectives:

- **Specific**: Clearly state the task
- **Measurable**: A point of completion (and progress along the way) can be definitively assessed
- **Attainable**: Resources being assigned can accomplish the mission
- ** Relevant**: Show a relationship to the situation at hand
- **Timely**: Establish a clear target for completion or prioritization

### 17.2 Departmental Status Reporting

A critical component in development of an effective emergency response is timely, accurate information. Within 15 minutes of EOP activation, each on-duty department head, or best available alternate in their absence, shall contact the Facility Command Center and advise the Planning Section Chief of the status of their areas. Each department shall immediately prepare a Status Report (STATREP), which must be transmitted by telephone, facsimile, email, or delivered by runner to the Facility Command Center within 15 minutes of the initial incident occurring (and periodically – at least once per shift -- thereafter).

The STATREP, which provides concise information on Staffing, Tracking (resident count), Available beds, Technology status, Resources available/needed, Event impact on department, and Problems or progress toward resolution, is the basis for the decision-making and prioritization that follows. Status reports should be communicated to the Facility Command Center periodically through the incident. Problems encountered shall be communicated immediately to the next level in the NHICS organization, or to the Facility Command Center.

The STATREP is delivered to an FCC staff member, who in turn will brief the Department on the nature and scope of the incident, and provide any other available information. In this way, the STATREP process serves as an information exchange “handshake,” assuring that the most accurate, timely information is passed along.
17.3 Information Needed

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Source</th>
<th>Used By</th>
<th>Shared With</th>
<th>Format</th>
<th>When Needed</th>
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<td></td>
</tr>
<tr>
<td>Current Census</td>
<td>Admissions</td>
<td>Nursing, Administration, Housekeeping</td>
<td>Sigmacare Morning Meeting</td>
<td>Paper &amp; Digital</td>
<td>Start of Event, Start of each Shift, End of Event</td>
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<tr>
<td>Resident Roster, with family contact information</td>
<td>Social Services</td>
<td>Social Services, Nursing</td>
<td>Sigmacare</td>
<td>Paper &amp; Digital</td>
<td>Start of Event, Start of each Shift, End of Event</td>
</tr>
<tr>
<td>Staff Call-down List</td>
<td>Staffing Coordinator</td>
<td>Department Heads</td>
<td>Staff Meeting</td>
<td>Paper</td>
<td>Start of Event, Start of each Shift, End of Event</td>
</tr>
<tr>
<td>Generator repair and refueling</td>
<td>Director of Facilities Management</td>
<td>Administrator, DNS, Director of Facilities Management</td>
<td>Meeting</td>
<td>Paper, Verbal</td>
<td>Start of Event, Start of each Shift, End of Event</td>
</tr>
<tr>
<td>Available Beds (grouped by gender)</td>
<td>Admissions</td>
<td>Nursing, Social Services</td>
<td>Sigmacare, Meeting</td>
<td>Digital, Paper, Verbal</td>
<td>Start of Event, Start of each Shift, End of Event</td>
</tr>
</tbody>
</table>

Table 3. Information Matrix

17.4 Management of Resident Information

The incident common communications plan will also address the timely collection, transfer, storage, and retrieval of resident (e.g., clinical; medication-related) and operational information generated at primary or alternate care locations—whether the alternate care location is located within a designated health care facility (e.g., conversion of a waiting room or other typically nonclinical area within the primary facility) or in another building on or off the facility campus. The Resident Care Branch will identify information-sharing requirements and work with the Logistics Section to provide communications equipment and support to alternate care sites.

Resident information will be provided to third parties (e.g., other health care organizations, State or City health departments, law enforcement entities) when such information is required to stop the spread of disease, protect the lives and safety of the general population, and/or preserve evidence. Requests for resident information will be processed through the Resident Care Branch of the Operations Section in the Facility Command Center.
17.5 Health Emergency Response Data System (HERDS)

The facility is a participant in the Health Emergency Response Data System (HERDS), as a web-based communication system for the collection of information that will be used by the New York State Department of Health to administer available resources during an emergency situation. During an emergency, FCC staff will log onto HERDS and report situation status and resources at periodic intervals.

The Nursing Supervisors have 24-hour access to the HERDS system. The Director, Information Technology is the System Administrator.

17.6 HIPAA Privacy Rule and Disclosures during Emergency Operations

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), has established ways in which patient/resident information may be shared under the HIPAA Privacy Rule in an emergency situation, even though the protections of the Privacy Rule are not set aside during an emergency. The HIPAA Privacy Rule protects the privacy of residents’ health information (protected health information, or PHI) but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a resident, to protect the nation’s public health, and for other critical purposes.

The following key points apply to the long-term care facility as a covered entity:

- **Treatment:** Under the Privacy Rule, the facility may disclose, without a resident’s authorization, PHI about the resident as necessary to treat the resident or to treat a different resident. Treatment includes the coordination or management of health care and related services by one or more health care providers and others, consultation between providers, and the referral of residents for treatment.

- **Public Health Activities:** The Privacy Rule permits the facility to disclose needed PHI without individual authorization to a public health authority, such as CDC, NYSDOH, or NYCDOHMH for the purpose of preventing or controlling disease, injury, or disability.

- **Disclosures to Family, Friends, and Others Involved in an Individual’s Care and for Notification:** Permissible as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the resident’s care, of the resident’s location, general condition, or death. This may include, where necessary to notify family members and others, the police, the press, or the public at large. If the individual is incapacitated or not available, the facility may share information for these purposes if, in their professional judgment, doing so is in the

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7 For additional information: [https://www.hhs.gov/sites/default/files/emergencysituations.pdf](https://www.hhs.gov/sites/default/files/emergencysituations.pdf) (viewed September 15, 2016)
resident’s best interest. PHI may also be shared with disaster relief organizations like the American Red Cross.

- **Imminent danger:** PHI may be shared with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public – consistent with applicable law (such as state statutes, regulations, or case law) and the facility’s standards of ethical conduct.

- **Disclosures to the Media or Others Not Involved in the Care of the Resident/Notification:** Upon request for information about a particular resident by name, a facility may release limited directory information to acknowledge an individual is a resident at the facility and provide basic information about the resident’s condition in general terms (e.g., critical, stable, or deceased) if the resident has not objected to or restricted the release of the information; or, if the resident is incapacitated, if the disclosure is believed to be in the best interest of the resident and is consistent with any prior expressed preferences of the resident.

- **Minimum Necessary:** For most disclosures, the facility must make reasonable efforts to limit the information disclosed to that which is the “minimum necessary” to accomplish the purpose.

- **Safeguarding Resident Information:** In an emergency situation, the facility must continue to implement reasonable safeguards to protect resident information against intentional or unintentional impermissible uses and disclosures, including applying the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information.

- **Limited Waiver:** The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, the Secretary of HHS may waive certain provisions of the Privacy Rule under the Project Bioshield Act of 2004 (PL 108-276) and section 1135(b)(7) of the Social Security Act. If the President declares an emergency or disaster and the Secretary declares a public health emergency, the Secretary may waive sanctions and penalties against a facility that does not comply with the following provisions of the HIPAA Privacy Rule:
  - The requirements to obtain a resident's agreement to speak with family members or friends involved in the resident’s care
  - The requirement to honor a request to opt out of the facility directory
  - The requirement to distribute a notice of privacy practices
  - The resident's right to request privacy restrictions
  - The resident's right to request confidential communications
  - If the Secretary issues such a waiver, it only applies: (1) in the emergency area and for the emergency period identified in the public health emergency declaration; (2) to facilities that have instituted a disaster protocol; and (3) for up to 72 hours from the time the facility implements its disaster protocol
  - When the Presidential or Secretarial declaration terminates, a facility must then comply with all the requirements of the Privacy Rule for any resident
17. Information Collection, Analysis, and Dissemination

still under its care, even if 72 hours has not elapsed since implementation of its disaster protocol.
18 INCIDENT FACILITIES / DESIGNATED AREAS

The facility has pre-established specific locations on the campus where predetermined incident management activities will occur. The table in Appendix E depicts those locations, known as incident facilities, which may be activated for use during Emergency Operations Plan activation. Should a particular facility or location be unsuitable for any reason, the responsible unit leader or section chief shall ensure that a suitable alternate site is selected, and its location is provided to the FCC and all concerned parties.

The NHICS Incident Facilities/Designated Areas Matrix may be found in Appendix E.
19 FACILITY COMMAND CENTER

19.1 Facility Command Center Mission
The Facility Command Center (FCC, formerly known as the Emergency Operations Center, or EOC) is the command and control point from where the IC, command staff, and section chiefs will direct the organization’s response to an incident. At a minimum, a virtual FCC shall be established for every Level 1 or greater incident. The virtual FCC shall be operational via radio link within five minutes of plan activation. For every Level 2 or greater incident, an actual FCC shall be established, and shall be operational within 15 minutes of plan activation.

19.2 Facility Command Center Staffing
The FCC is staffed with (as the positions are activated) the Incident Commander, section chiefs (i.e., Operations, Planning, Logistics, and Finance Chiefs), command staff (i.e., Safety, Liaison, and Public Information Officers and Medical/Technical Specialists), the Resource and Situation Unit Leaders, and several staff members as assigned to answer the telephone and radio, operate FCC equipment, compile information, and maintain records. All other NHICS position staff should be deployed to appropriate work locations to carry out their duties. A security post should be assigned outside the door of the FCC as the gatekeeper, ensuring that only those individuals with business inside are allowed to enter, then depart quickly. The gatekeeper shall maintain a log of all FCC participants and visitors.

19.3 Virtual vs. Actual Activation

19.3.1 Virtual FCC
A virtual FCC is a structured communications arrangement between incident leaders who are not physically located together. In a virtual FCC arrangement, the IC and any activated command staff and section chiefs establish and maintain communication via a designated conference network (e.g., telephone conference bridge, radio network, intranet chat), rather than mobilizing in a physical FCC location. This may be effective under the following conditions:

1. A Level 1 incident, where a potential event or actual event with minimal impact is being monitored but no immediate leadership actions (beyond planning or resource mobilization) are required.
2. An effective communications network can be established and reliably maintained
3. A schedule of contacts is established and maintained
4. Leadership visibility or physical centrality is not beneficial or significant to incident management
(5) Command and control can be effectively maintained

When a virtual FCC is established, the Public Information Officer carries out all notifications and communication activities remotely.

At the discretion of the IC, a virtual FCC shall be transitioned to an actual FCC when any of the above conditions cannot be met or maintained.

19.3.2 Actual FCC

An actual FCC is established for any event of Level 2 or greater, or when the conditions permitting a virtual FCC cannot be met or maintained. The actual FCC provides the distinct advantages of shortening lines of communication, avoiding reliance on technology for command and control actions, improving access to information, and hastening the decision-making process. When activated, an actual FCC shall be operational within 15 minutes of the activation decision.

The IC will direct the organizational transition from a virtual FCC to an actual FCC. The virtual FCC environment will be maintained while the actual FCC participants are assembling. In the event that conditions require the loss of virtual contact between FCC participants during the assembly process (e.g., leaders must travel off-site and may be unavailable for contact), alternates shall be identified to maintain command and control until such contact can be reliably re-established. At no time shall the loss of communication be permitted to disrupt the command and control process of the organization.

The IC should generally remain at the FCC throughout the emergency, maintaining a visible command posture. If leaving the FCC, the IC shall identify an FCC Manager who will be in direct contact at all times with the IC, preferably by clear radio channel, until his/her return.

19.4 Facility Command Center Operations

The Facility Command Center (FCC) will be located in Administration. The Facility Command Center will serve as the command and control point from where the IC, command staff, and section chiefs will direct the facility response to the incident. The FCC shall be operational within 30 minutes of plan activation.

The Facility Command Center shall initiate the following functions as soon as possible:

1) Assign appropriate staff to NHICS functions, provide briefing and direction, and issue NHICS vests and clipboards.

2) Activate the FCC telephone lines, and assign incoming numbers to activated NHICS section chiefs and FCC staff as necessary. (Telephone equipment is maintained and delivered by the Facilities Management Department).

3) Log in and track status reports from all departments reporting.
(4) Communicate with Admitting Office regarding bed availability and current census.

(5) Call in additional help as necessary, using the NHICS organizational structure to provide specific assignments, prevent freelancing, and ensure control, coordination, and integration of effort.

(6) Initiate the Situation tracking function, maintaining as complete a log of events and decisions as possible. (Log sheets are maintained in the FCC Emergency Equipment Cabinet.)

(7) Establish a process to collate forms, reports, and logs described in this plan to facilitate decision-making, documentation, and business continuity.

(8) Secure the FCC and restrict entry only to authorized personnel whose presence is required. An FCC sign-in log should be maintained documenting those people present in the FCC.

19.5 Facility Command Center Communications Area

(1) One area of the FCC (which may be an adjacent external space, such as exterior offices, based on conditions) shall be designated as the FCC Communications Area. The mission of the FCC Communications Area is to ensure constant monitoring and an uninterrupted line of communication between NHICS leadership and key areas of the facility, without the communication process or technology disrupting the FCC activities or distracting the leadership from their primary responsibilities.

(2) Activities occurring there shall include monitoring the telephones, radios, email, and text messaging. Qualified staff shall be assigned to the Communications Area, under the direction of the Public Information Officer.

(3) All significant message traffic into and out of the FCC shall be documented using NHICS 213 Message Forms and/or logged in the Communications Area.

19.6 Facility Command Center Evacuation / Relocation

If Administration is inaccessible, or becomes unusable during the incident, the alternate FCC location is the 202 Community Room. Evacuation or relocation of the FCC shall only be at the direction of the Incident Commander.
### 20. NOTIFICATIONS AND COMMUNICATIONS/COMMUNICATIONS PLAN

#### 20.1 Healthcare Emergency Codes

<table>
<thead>
<tr>
<th>Emergency Code</th>
<th>Meaning</th>
<th>Immediate Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Plan</strong></td>
<td>Emergency Operations Plan activated</td>
<td>IC activates FCC; Command and General Staff as directed</td>
</tr>
<tr>
<td><strong>Doctor Red</strong></td>
<td>Fire</td>
<td>Fire Department Response Required; Fire Response Team responds to location of alarm</td>
</tr>
<tr>
<td><strong>Code Green</strong></td>
<td>Evacuation</td>
<td>Affected areas evacuate as directed</td>
</tr>
<tr>
<td><strong>Code Blue/STAT</strong></td>
<td>Medical Emergency</td>
<td>Medical Code Team responds to location</td>
</tr>
<tr>
<td><strong>Code Amber</strong></td>
<td>Infant / Child Abduction</td>
<td>Lockdown of exterior gates; Security monitors CCTV</td>
</tr>
<tr>
<td><strong>Code Yellow</strong></td>
<td>Explosive Device or Bomb Threat</td>
<td>Police Department Response Required; Security response to location</td>
</tr>
<tr>
<td><strong>Doctor Hunt</strong></td>
<td>Security Emergency / Resident Elopement / Missing Resident</td>
<td>Lockdown of exterior gates, Security monitors CCTV, staff members respond to location</td>
</tr>
<tr>
<td><strong>Active Shooter</strong></td>
<td>Person with Weapon; Hostage Situation Workplace Violence</td>
<td>Police Department Response Required; Security response to establish perimeter; all others stay away</td>
</tr>
<tr>
<td><strong>Code Orange</strong></td>
<td>Hazardous Materials Incident</td>
<td>Environmental Services response to location</td>
</tr>
<tr>
<td><strong>Code Triage</strong></td>
<td>Multiple Casualty Incident</td>
<td>FDNY EMS Response Required; Casualty Care Group activation</td>
</tr>
<tr>
<td><strong>Code Black</strong></td>
<td>Severe Weather / Tornado Warning</td>
<td>All residents and staff relocated to interior corridors away from windows</td>
</tr>
</tbody>
</table>
RRECC utilizes a standard set of emergency codes for announcing critical events while minimizing the alarm to non-staff present in the facility. If a situation corresponds to one of the above-listed Healthcare Emergency Codes, the IC shall direct the appropriate code announcement immediately preceding the Emergency Plan announcement:

**20.2 Emergency Alert Radio (EAR) Network**

RRECC maintains a dedicated internal radio network for immediate leadership notification and response. This system, called the Emergency Alert Radio (EAR) Network, consists of radios with a dedicated EAR channel at the following locations:

- Carried during an activation by the Incident Commander-designee (Facility Administrator on duty or Nursing Supervisor)
- Front Desk/Switchboard
- Facility Operations
- Nursing Stations
- Nursing Office
- Fire Response Team leader

This radio channel is to be used for immediate notification and virtual FCC activation when an unusual situation or emergency arises. During non-emergency periods, it may be used only for brief messages, and should generally be kept clear.

**20.3 General Announcement of Plan Activation**

Upon implementation of the Emergency Operations Plan, the Incident Commander shall:

1. Direct Switchboard Operator to activate the overhead page and phone paging systems and announce: “**Attention, Attention, Code ____ (location).**” and repeat the message three (3) times at approximately 30 second intervals. This will be the signal to all personnel in the facility to carry out the specific duties specified in this EOP manual and their department’s DEOP.
   
   a. If the event is a drill/exercise, the operator shall add: “**This is a drill.**”
   
   b. In the event of failure of the overhead paging and phone paging systems, the Emergency Alert Radio Network will be used for then activation of the Emergency Plan.
(2) Assign the Switchboard Operator or Logistics Section Chief to set up Emergency Message instructions.

(3) If directed, establish communications with the New York City Fire Department Communications (718.430.0264) and Police Department (43rd Precinct, 900 Fetley Ave, Bronx NY 10473, 718-542-0888) as conditions warrant.

(4) As conditions warrant, make notifications as listed on the Activation Matrix and Switchboard Notification List. These notifications will be made by Switchboard.

### 20.4 Intra-departmental Notifications

In every department, the senior person present shall take charge and make all necessary department-level decisions until relieved by a superior or otherwise directed by the FCC. Each on-duty department head or designee, on being notified of the incident, is responsible for notifying their own key personnel. Department heads shall keep an up-to-date call list incorporating phone and pager numbers within their immediate access at all times, with copies on file at Switchboard and Administration for this purpose.

When notified of Emergency Operations Plan activation, department heads or designees shall:

1. Receive information concerning the emergency via the mass notification alert or other notification system.
2. Remain available for contact if needed. If in the facility, report to their departments to assume command of department operations. If not in the facility, contact their departments by telephone for information and direction, report individual availability, but do not respond unless specifically instructed otherwise.
3. Activate the Off-Duty Mobilization Plan **only** if directed by the Facility Command Center.
4. Instruct staff to remain in designated work locations unless otherwise directed.
5. Reassign personnel per Facility Command Center direction.

### 20.5 On-Duty Personnel Notified of an Emergency

When notified of Emergency Operations Plan activation, all personnel shall:

1. Cooperate and comply with directions of person assuming command of the department.
2. End all non-emergency telephone conversations.
3. Avoid elevators during fire.
(4) Continue working in usual areas unless otherwise instructed. If working in an area remote from their assigned supervisor (e.g., a social worker working with a resident in the resident’s room), an employee shall:
   a. Make immediate contact with the facility supervisor responsible for their current location (e.g., head nurse in the resident’s unit) to establish accountability and ensure that help is not needed in that unit
   b. Make phone contact with the employee’s immediate supervisor for accountability and instructions

(5) Wear Facility ID badge conspicuously for clear identification.

(6) Remain on duty until released by immediate supervisor, and be subject to disciplinary action if found leaving premises without authorization during emergency plan activation.

(7) If reassigned by immediate supervisor, follow instructions of supervisor in new area.

The Logistics Section Chief shall ensure that ongoing communication of information and instructions is accomplished by the most appropriate, available communication mechanism (e.g., public address announcement, text message, e-mail). For longer-term incidents, the Public Information Officer is responsible for updating and communicating with employees, residents, residents’ families, and other stakeholders to ensure a flow of accurate, consistent information through the course of the incident.

20.6 Off-Duty Personnel Notified of an Emergency

Off-duty personnel notified of an emergency at the facility or in the community shall:

(1) Keep home or cellular phone lines open for updates and await call from FCC or department head.

(2) Make arrangements for child/dependent/household pet care in event employees are called to report to work.

(3) Not respond to the scene of an emergency or disaster as a medical care provider unless properly trained, equipped, and part of the community’s organized emergency response plan.

20.7 Off-Duty Mobilization Plan

Should the response of off-duty personnel become necessary, the Incident Commander will notify the Public Information Officer and direct the activation of the Off-Duty Mobilization Plan. This plan enables each department’s personnel to be mobilized as needed, quickly and efficiently.
The plan consists of notification of affected department heads/chiefs of service and, if they cannot be reached, an alternate. It then becomes the responsibility of the department heads/chiefs of service or designees to mobilize their departments’ off-duty personnel as necessary. The plan minimizes impact on any one person for contacting personnel.

Each department, professional and administrative, will maintain an off-duty mobilization plan, including a list of all personnel in the department, as well as a list, with current office, cellular, and home telephone numbers; text messaging and email addresses, of those people the department manager plans to call. Department managers shall ensure that a copy of this list is available to them outside the facility at all times while off-duty. In addition, department managers shall provide copies of the entire departmental staffing contact list, with all current numbers, to both Switchboard and the Safety and Security Department whenever updated. Every manager, employee, and member of the medical staff is responsible for ensuring that their contact information is kept current at the department level. Department heads are responsible for maintaining and testing current departmental plans and contact numbers for personnel mobilization and/or recall. Such testing shall be conducted at least twice each year, with at least one test each year done on weekends and another during nighttime hours. The results of the tests shall be forwarded to the Emergency Management Team for documentation.

Upon activation of the Emergency Operations Plan, the senior person on duty will notify his/her department manager or designee as established in the departmental plan. The senior person in command in the department will then be responsible for authorizing the notification of those people as specified in the departmental plan.

Human Resources will maintain an up-to-date list of department heads, chiefs of service, and alternates/designees, including current office, cellular, and home telephone numbers. A copy of the list will be kept in Administration, 24 Hour Office and at Switchboard.

In the event that additional physician or nursing staff are required, the affected department heads/chiefs of service will activate the physician and/or nursing call lists as needed. Clerical or other designated staff will be assigned to make the appropriate notifications.

It should be noted that no notification should be considered complete until two-way contact has been established, i.e., pager notification does not constitute a definitive notification of an emergency situation; voice contact must be established. The best assurance of message receipt is through a read-back, or repeating back of the message as received to the person who transmitted it. In this way, message receipt is assured and comprehension is supported.

20.8 Notification to New York State Department of Health

The correct point of contact and access number to report facility involvement in disasters on nights, weekends or holidays is the NYSDOH Duty Officer at 1-866-881-2809. During
normal business hours (8:00 a.m. to 5:00 p.m.), contact the NYSDOH Regional Office in the customary manner.

The NYSDOH Duty Officer number will forward the call to a NYSDOH staff person. The bullets listed below outline the process that will follow your call to the Duty Officer:

- You will be prompted to leave a message and a number where you can be reached.
- The Duty Officer will call back promptly, so remain at that number.
- There is one Duty Officer on call for all of New York State. When your call is returned, he/she will ask for the type of emergency, and the type of facility (e.g. hospital, nursing home, adult home) involved.
- You will be routed to the Administrator on Duty for that program in the region where the facility is located.
- The Administrator on Duty will assist with facility response to the situation.

### 20.9 Development of a Common Communications Plan

- When establishing the NHICS, the Incident Commander shall ensure that a common communications plan is utilized. The common communications plan must ensure that all operating elements of the NHICS are able to maintain a common operating picture and consistent situational awareness, and are able to share information effectively across the organization, as well as with any external partners or agencies who may be participating in the response. All communications with external entities shall be in plain English, without the use of codes or ambiguous language.
21 SAFETY AND SECURITY

RRECC is committed to maintaining the safety and security of the facility and its occupants as an essential function during every activation of the EOP. The Incident Commander (IC) maintains overall responsibility for safety and security of the facility. Conducting a safety assessment and authority for planning and carrying out safety-related objectives may be delegated to the Safety Officer (NHICS Command Staff member). Conducting a security assessment and authority for planning and carrying out security-related objectives may be delegated to the Physical Plant/Security Unit Leader (NHICS Operations Section). The IC shall ensure that safety and security needs are addressed as a primary and critical function of EOP activities.

21.1 Safety

The Safety Officer is assigned to ensure the safety of staff, residents, and visitors, and to monitor and correct hazardous conditions related to the incident. The Safety Officer has the authority to halt any incident-related activity that poses an immediate threat to life and health.

The Safety Officer shall carry out the activities described on the Job Action Sheet (JAS) as applicable to the incident. In general, these activities include assessing and understanding the situation and the facility’s response, conducting a focused safety threat/risk assessment, determining and directing implementation of necessary risk reduction and protective measures (including use of personal protective equipment), and maintaining situational awareness of self and others regarding safety risks and evolving hazards or their mitigation.

21.2 Security

The Physical Plant/Security Unit Leader is assigned to manage all incident-related activities related to personnel and facility security such as access control, crowd and traffic control, and law enforcement interface. The Physical Plant/Security Unit Leader has the authority to carry out any incident-related activity deemed necessary to maintain order and protect the facility and its occupants from criminal threat or activity during an emergency event. Such activities include but are not limited to:

- Controlling vehicular and pedestrian traffic flow on the campus and in the immediate vicinity
- Controlling vehicular and personnel access to the campus and on facility property
- Controlling access and egress to and from facility buildings, including access and egress management within buildings and critical areas
- Controlling visitation, including shortening visit length, limiting numbers of visitors, ending visitation, and escorting visitors off the premises
- Identifying and verifying the identity of all persons on facility property
21. Safety and Security

Policy Name: 21. Safety and Security
Issue Date: 12.24.18

Reference: CMS §483.73 (a)(2) | NYSDOH DAL 05-11 | TJC EM.02.02.05 EP1,3,4,6,9

- Maintaining order, including management of crowds and control of disturbances/restoration of order
- Preventing crime or threat of criminal activity
- Protection of critical infrastructure
- Searching facility property for people (including unauthorized occupants, perpetrators, escapees, eloped residents, abducted infants or children) and threats (including investigation of threats of explosives or suspicious substances, and reports of weapons or other contraband)
- Safeguarding of damaged areas, evidence, and crime scenes until properly relieved by a law enforcement agency
- Assigning non-security staff members to assist in carrying out risk-limited security objectives such as traffic and visitor control when needed
- Coordinating activities on and off the campus with external law enforcement and investigative agencies

21.3 Coordination of Security Activities with Community Security Agencies

The RRECC HR Department maintains an ongoing relationship with the public safety agencies in New York City. Should an incident warrant active participation of community security agencies in the facility’s emergency management process, each appropriate agency may be requested to assign a liaison to the RRECC Facility Command Center. For an incident with a primary security focus (e.g., a search for a perpetrator), the Physical Plant/Security Unit Leader shall establish a Security Command Post (SCP) at the Security Communications Center (see Incident Facilities Matrix). Each community security agency participating in on-site security activities shall assign a radio-equipped senior officer to the SCP as a liaison with the RRECC Security Department, to ensure optimal coordination and maximize effectiveness. As needed, the SCP may issue facility security radios to ensure interoperability and coordination with community security agency liaisons. The RRECC Physical Plant/Security Unit Leader shall participate in a unified command structure with the responding community security agency commanders, where possible.

21.4 Control of Facility Access, Egress, and Individual Movement

21.4.1 Access Restriction
All staff members will display their facility photo-identification cards prominently on their outermost garments during EOP activation. Security officers will stop and deny access to incident facilities to any staff not properly identified.

When the EOP is activated at Level Three or greater, or at the discretion of the Incident Commander, RRECC will close and secure all entrances with the following exceptions:

- **Main Entrance**: employees and authorized personnel
21.4.2 Signage
Signs shall be posted at all secured entrances, noting that the entrance has been locked down by order of the Security Department, and showing the direction and name of the nearest accessible entrance. Security officers and assigned staff members will be assigned to all entrances to control visitors. Social Work personnel and facility volunteers will be assigned to assist visitors as needed.

21.4.3 Facility Visitor Control
As directed, Security Officers prepare to institute 100 percent identification check of every person entering facility buildings. Only people carrying facility identification cards or accompanied by such a person will be allowed in the facility. Relatives of incident victims will be directed to the Resident Information Area. Direct deliveries (e.g., food, flowers) will not be permitted; items will be left at the Lobby Information Desk for staff delivery within the building.

21.4.4 Media Access
Security Officers should be alert to the potential for news media presence, be prepared to escort credentialed members of the press to the Media Briefing Area (see Incident Facilities Matrix) where press briefings will be given, and keep news media away from family members. At no time will members of the press be permitted access to the facility without authorized escort.

21.4.5 Security Deployment
Security personnel will be assigned to the Main Lobby and, where needed, for purpose of crowd/traffic control (see Security Control Post map, confidential/restricted distribution). Security Officers shall be deployed to the point of entry to monitor access and restrict it to assigned employees or those from an ancillary department or have a NHICS JAS and have been assigned to the area during a Level Two, 3, or 4 activation. Security officers shall be assigned to provide crowd control at incident-related/affected areas. Officers should establish contact with on-scene police department representatives immediately upon their arrival. Police should be asked to assist with traffic and crowd control, if available.

21.4.6 Visitors Already Present
Any or all visitors on resident floors may be asked to leave facility grounds upon EOP activation. In general, visitors will be permitted to remain in the facility unless their presence creates or increases the risk. If visitors are asked to leave, families should be told that they will be notified by the facility if they are needed. Where human compassion dictates, families/visitors will be permitted to remain with residents if it is at all possible.

21.5 Control of Facility Vehicular Access, Traffic, and Parking

21.5.1 Vehicular Restriction
As directed, Security Officers shall establish barriers at all vehicular entrances to facility grounds and parking facilities. Officers shall attempt to expedite removal of vehicles from
key areas to facilitate access for emergency equipment. Only the following vehicles shall be permitted onto facility grounds:

- Police Department
- Fire Department
- Emergency Medical Service
- New York City Emergency Management (NYCEM)
- Authorized Emergency Vehicles (including properly-identified private ambulances)
- Office of Medical Examiner
- Funeral hearses (with proper identification)
- RRECC Facility Staff (with proper identification badge/card)

21.5.2 Campus Visitor Control
As directed, officers shall institute 100 percent identification check of every person entering the campus. Only people carrying facility identification badges/cards or accompanied by such a person will be allowed onto the grounds. Relatives of incident victims will be directed to park in the visitor lot, or as designated by the Security Department, and be directed to the Resident Information Area.

Unattended vehicles will not be permitted in restricted areas. Such vehicles shall be towed promptly.

21.5.3 Security Staffing Augmentation
Depending on the situation and time of day, additional staff may be assigned to assist with security-related tasks. RRECC will select staff in from all departments/job titles to perform security measures, and they should be deployed as needed at the discretion of the Incident Commander as per the Job Action Sheet (JAS).
21.6 Law Enforcement Coordination

At the discretion of the police department, if requested, a New York City police officer will be assigned to the Security Command Post to help coordinate traffic in and around the facility.
21.7 Hazardous Materials and Waste Management during EOP Activation

In the absence of functioning processes for management of sewage, biohazardous waste, and/or other hazardous materials during an emergency, the Environmental Unit Leader shall assume responsibility for waste management. Strategies may include (but are not limited to):

- Waste stream reduction strategies
- Use of alternate waste collection and disposal methods
- Use of improvised on-site storage facilities for securing toxic or hazardous materials until proper disposal methods can be re-established

Additional information is contained in Support Annex, Hazardous Materials Response as well as in the 96 Hour Self-sufficiency Annex.
22 MEDIA INTERACTION AND PUBLIC INFORMATION

22.1 Media Relations

RRECC remains committed to the principles of a public right to know, balanced against the rights of facility residents, staff, and visitors to privacy, and RRECC’s obligation to preserve and protect those rights. When an incident involving EOP activation generates media interest, the Incident Commander shall assign a Public Information Officer (PIO). The mission of the PIO, a Command Staff member, is to serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media. The PIO shall gather the necessary information to provide to the appropriate stakeholder groups, develop appropriate messaging (including content, format, and medium, covering traditional and social media, as appropriate), and, with the approval of the IC, release the information.

22.2 Media Access

When members of the press present themselves (or are expected) at the facility in connection with EOP activation, the Public Information Officer shall establish a Media Staging Area. The PIO will be in charge of this area, and will release information to the media as directed by the Incident Commander, CEO, or designee.

Consideration shall be given to assigning media relations staff or a deputy PIO to the Media Staging Area exterior to the facility, to address immediate media and public inquiries in the absence of an on-site PIO, or until a Media Briefing Area is established.

The following general policies apply to any situations involving the media during EOP activation:

(1) Members of the press will not be allowed elsewhere inside the facility without prior approval from the Incident Commander.

(2) In the event that a member of the press is granted access to any part of the facility, they shall be accompanied and escorted at all times by the PIO or an assigned assistant.

(3) Still or video photography is only permitted with escort from and authorization by the facility Office of Media Relations.

(4) Written consents will be required prior to any photographs or video taken of people (including residents, staff, and visitors) on the facility campus.

22.3 Social Media

Social media refers to forms of electronic communication and networking applications through which users create online communities to share information, ideas, personal messages, and other content (such as photos and videos). Social media applications include, but are not limited to, Facebook, Twitter, YouTube, Instagram, and SnapChat.
During an emergency plan activation, although we can’t reach everyone with social media, it should be used together with other channels of communication to maximize reach within the community.

Even in the case of massive power outages, people still have access to their phones and use them to access social media for news and notifications during disasters. By using hashtags (“#”), posting in Facebook groups, or even using direct messages, the facility can let both employees and other stakeholders (e.g., resident families; community members) know what is going on, and how to best stay in touch while the disaster persists. Municipalities and news outlets use social media to distribute information when conventional means are not available or practical.

Social media can also be used as a two-way communication tool. During disaster, it can be used to listen in a number of ways. Staff can contact the facility to let us know what is happening in their area, and if or when they might make it to work. Citizens can let the media know where news is happening, which we can monitor to learn about conditions in our area or community. Families and friends can find out if their loved ones are safe, and determine if they can be of any help to them. Charitable organizations can determine where to allocate resources as people communicate their needs to them via social media channels.

When the switchboard is flooded and cell networks are overloaded, as they often are in disaster, we can respond to individual message and requests using social media messaging apps, informing stakeholders and the public regarding conditions at the facility and in our community, what help is needed (or not needed), and the general status of our facility, residents, and staff. Social media can also be used to respond to general inquiries in a more public way, thereby answering common questions without having to send several individual messages.

The key caveat for our facility is that under no circumstances should protected health information (PHI) be released over publicly-accessible social media outlets. When in doubt, the Public Information Officer shall be contacted for message approval.

22.4 Public Information System

During an incident involving multiple agencies or organizations, it is vital that public information be communicated using “one voice,” that is, a consistent message delivered across all participating community response entities. A Public Information System (PIS) provides accurate, timely, and coordinated information to incident leadership and the public. When a PIS is established—as directed by NYCEM, DOHMH, or other authority—RRECC will ensure that any information released is only done in coordination with the PIS guidelines as established at the time of the incident.
22.5 Joint Information Center

At the discretion of the City NYCEM or DOHMH, a PIS may be supported through the establishment of a Joint Information Center (JIC). In a JIC, the public information officers of all health care partners and jurisdictional authorities, including RRECC (if the facility is a participating agency), co-locate and develop a joint public information message for dissemination. Under those circumstances, all media releases would be coordinated through the JIC.
23 OPERATIONS

23.1 Clinical Operations
The Resident Care Branch Director is responsible for oversight of all clinical activities to include:

- Services provided for vulnerable populations, such as geriatric, pediatric, disabled, serious chronic conditions, substance abusers;
- Identification and protection of residents who are susceptible to wandering or at risk for elopement or abduction;
- Resident personal hygiene and sanitation needs;
- Mental health service needs;
- Chaplain services;
- Mortuary services; and
- Documentation and tracking of resident clinical information

In coordination with the Operations Chief, Medical Director, and Nursing Unit Leader, the Resident Care Director will determine the need for modification, discontinuation, and restoration of clinical services, and make appropriate recommendations to the Incident Commander.

(1) When directed, members of Medical Staff will report to the Labor Pool and will be assigned by the Staff Unit Leader or Resident Care Director.

(2) No member of the medical staff is authorized to respond off the campus to an emergency or incident scene without the express authorization of the Incident Commander.

23.2 Bed Capacity Expansion
When the incident commander determines that normal bed vacancies cannot accommodate the admission requirements of casualties, the following steps shall be taken:

(1) As many residents as possible normally scheduled for discharge the following day will be discharged immediately. Available house staff physicians shall be prepared to discharge these residents upon notification.

(2) Additional beds can be made available by doubling and tripling bed capacity in existing resident rooms or using day rooms and dining rooms as resident rooms.

(3) Residents selected for evacuation, either discharged home or to another facility, will be sent to the Main Lobby. Nursing will supply staff to oversee these areas with the help of house staff and other physicians.
(4) For additional information, see Critical Event Annex Mass Casualty Incident/Resident Influx (Surge Capacity Matrix).

23.2.1 Surge Capacity
For additional information, see Critical Event Annex Mass Casualty Incident/Resident Influx (Surge Capacity Matrix).

23.2.2 Airborne Infectious Isolation Capacity (AIIR)
The facility has private rooms which can be designated as infection/isolation rooms, if indicated.

The matrix of AIIR rooms may be found in Appendix F.

The Medical Director and/or the Director of Nursing is authorized to direct any facility activities related to infectious or communicable diseases, and will serve as a technical specialist/advisor to the Incident Commander as conditions warrant.

23.3 Resident Discharge
Discharging Residents: The Social Services Department will participate in the process of transferring residents to other medically appropriate settings in order to make facility beds available for a resident influx as a result of hospital rapid patient discharges.

Resident Pick-Up: During emergency conditions, residents will be discharged through the Main Lobby entrance and/or the rear entrance depending on circumstances. Relatives and those coming to pick up residents will be instructed to enter the facility through the Main Campus Entrance and/or the rear entrance as circumstances dictate and they will be directed to the parking area as needed.

23.4 Alternate Care Site Operations
There are several circumstances under which establishment of an alternate care site may become necessary. These include the need to evacuate all or part of the facility due to an internal or external event threatening the facility or its occupants; an external incident producing a resident surge that exceeds the facility’s staffed capacity for care; an event where special circumstances, such as a communicable disease threat, require separation of some residents from the general facility population; or an event where the facility is tasked with establishing a screening facility or point of distribution for medication or vaccination during a community-wide crisis. Under such circumstances, the Incident Commander may elect to activate one or more pre-planned alternate care facilities (see Annex).

When activated, the following general procedures shall be implemented:
The Emergency Operations Plan will be activated at a minimum of NHICS Level 3. Notification will be made to local government and oversight agencies.

A suitable command structure will be established and staffed for each alternate care site. The site commander will be known as the Offsite Operations Chief, and will report at the general staff level to the Incident Commander. The level of command staff provided will be determined by the nature, scope, and anticipated duration of the alternate site activation.

Clinical and support staff for the alternate site will be determined by the Site Operations Chief, and resourced as available from the facility labor and medical staff pools.

The Logistics Section Chief will address logistical needs, including transportation and communications between the facility and the alternate site. At a minimum, telephone, facsimile, and two-way radio communications links should be established. Transportation will be required for movement of residents, staff, and equipment. In the event of anticipated operation in excess of 24 hours, efforts should be made to establish computer data links as well. The Logistics Section will also support medical and pharmaceutical supply needs.

The Planning Section will be responsible for planning and documentation needs, including management of resident tracking and records. NHICS standard forms will be used for tracking and incident documentation.

As the need for an alternate care facility decreases, the Site Operations Chief, in consultation with the Incident Commander, general staff, and DNS, will develop a written action plan for de-escalation of alternate care site operations; return of residents, staff, records, and resources to the facility; and discontinuation of alternate care site operations.

### 23.5 Psychological First Aid

Psychological First Aid (PFA) serves today as one of the basic tools used by Crisis Counselors responding to an emergency or disaster. This simple and straightforward supportive intervention is recognized at the local, state, and national levels as an effective way to help those impacted by disaster understand and cope with their reactions. PFA does not require previous training or education as a behavioral health practitioner. It can be used by every lay person as well.

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PFA procedures have been adapted to be suitable for nurses, certified nurse aides, social workers, and other direct care staff to use with elderly persons and persons with disabilities in nursing homes, other adults, families, adolescents, and children in the immediate aftermath of disasters and acts of terrorism. PFA is supported by disaster mental health experts as the "acute intervention of choice" when responding to the psychosocial needs of children, adults, and families affected by disaster and terrorism. It is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.

The Psychological First Aid for Nursing Homes Field Operations Guide (PFA NH FOG) contains specific strategies that have been tailored to address the specific emotional needs and concerns of older individuals who reside in long-term care facilities. Should conditions warrant, the Psychosocial Unit Leader or Resident Services Branch Director should consider the need for implementation of PFA support procedures as outlined in the PFA NH FOG.

### 23.6 Temporary Suspension or Modification of Statutes and Regulations in New York State during Emergencies

In New York State, healthcare providers are required to comply with many standards mandated through statute or regulation by local, state, and federal government. These requirements range from licensure of healthcare professionals, to care of patients, to maintenance of building grounds. During an emergency, the conditions under which healthcare providers typically operate may change rapidly. In this altered environment, adherence to some laws or regulations may interfere with a provider's ability to deliver care.

To allow healthcare providers to cope with disaster, statutes and regulations may be temporarily suspended or modified. These temporary suspensions and modifications are often referred to as waivers. In most cases, an emergency declaration by the state or federal government must be made and a formal request process is followed. In other cases, language in a statute or regulation allows for suspension or modification under certain specified conditions with or without an emergency declaration. If a healthcare provider encounters a statutory or regulatory barrier and there is no emergency declaration, the statute or regulation does not allow flexibility, or there is uncertainty, the provider should contact NYSDOH for guidance.

Certain statutes or regulations include language allowing temporary suspension or modification of requirements under specified conditions which may or may not necessitate an emergency declaration. Once those conditions are met, the alterations described in the language of the statute or regulation may be made. As an example of regulatory

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9 For additional information: [https://www.hanys.org/emergency/planning/docs/healthcare_emergency_guidebook.pdf](https://www.hanys.org/emergency/planning/docs/healthcare_emergency_guidebook.pdf) (viewed December 3, 2016)
flexibility during an emergency: during an emergency, a medical facility may temporarily exceed the bed capacity specified in the operating certificate. The regulation also allows for operation at an alternate or additional site approved by the Commissioner of Health on a temporary basis (10 NYCRR 401.2).

### 23.7 Section 1135 Waivers

When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to her regular authorities under Section 1135 of the Social Security Act. Certain Medicare, Medicaid, Children’s Health Insurance Program (CHIP) and HIPAA requirements may be waived as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

For purposes of waiver or modification, an emergency area and period is where and when there is: a) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Stafford Act, and b) a public health emergency declared by the Secretary.

The following requirements may be waived or modified:

- Certain conditions of participation, certification requirements, program participation or similar requirements for individual health care providers or types of health care providers;
- Pre-approval requirements;
- Requirements that physicians and other health care professionals hold licenses in the State in which they provide services if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area) for purposes of Medicare, Medicaid, and CHIP reimbursement only;
- Sanctions under the Emergency Medical Treatment and Active Labor Act (EMTALA) for redirection or reallocation of an individual to another location to receive a medical screening pursuant to an appropriate state emergency preparedness plan or a state preparedness plan for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency. A waiver of EMTALA sanctions

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10 For additional information: [http://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx](http://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx) (viewed October 10, 2016)
is effective only if actions under the waiver do not discriminate on the basis of a resident’s source of payment or ability to pay;

- Sanctions under section 1877(g) (Stark) relating to limitations on physician referral under such conditions and in such circumstances as the Centers for Medicare & Medicaid determines appropriate;
- Deadlines and time tables for performance of required activities to allow timing of such deadlines to be modified;
- Limitations on payments for healthcare items and services to permit Medicare Advantage Plan enrollees to use out-of-network providers in an emergency situation;
- Sanctions and penalties arising from noncompliance with HIPAA privacy regulations relating to: a) obtaining a resident’s agreement to speak with family members or friends or honoring a resident’s request to opt out of the facility directory, b) distributing a notice of privacy practices, or c) the resident’s right to request privacy restrictions or confidential communications. The waiver of HIPAA requirements is effective only if actions under the waiver do not discriminate on the basis of a resident’s source of payment or ability to pay.

### 23.8 Loss of Local Community Support

There may be incidents or times when the local community is unable to support the facility in six critical areas: communications; resources and assets; safety and security; staff responsibilities; utilities management; and resident clinical and support activities. Significant degradation or loss of local community support for any of the six critical areas may result in the suspension of specific services, alterations to the standards of care; temporary or partial facility closure, or facility-wide evacuation. See [96-Hour Self-Sufficiency Annex](#) for detailed information.

### 23.9 Staff Support Functions

#### 23.9.1 Housing

When conditions warrant the implementation of staffing augmentation plans and/or require boarding arrangements for staff members, the Staff Support Unit shall coordinate such arrangements. Temporary facilities will be set up in the Rehab Department. As needed, the Planning Section will develop staff schedules that establish appropriate downtime periods, and staff members will be rotated out of their work duties for planned downtime.

#### 23.9.2 Transportation

External conditions may create transportation difficulties for staff, inhibiting their ability to report for duty. Such conditions may include, but are not limited to, weather or environmental emergencies, disruptions of public transportation, rationing or shortages of fuel, or establishment of security perimeters. When needed, the Transportation Unit
shall coordinate transportation resources and arrangements, supported by the Security Department. If necessary, the City EOC should be contacted to assist in providing regional transportation arrangements or coordinating facility and outside agency transportation assets; or for arranging “essential personnel” identification for facility staff.

### 23.9.3 Dependent Care

Facility staff members who also provide care for personal dependents generally have their own arrangements for dependent care when they must report for duty. The facility recognizes that under some unusual circumstances, individual staff members may be called to duty without having arrangements for personal dependents. At the discretion of the Incident Commander, when conditions warrant, the facility may provide on-site child and elder dependent care for staff dependents, enabling the staff members to report for duty. Staff should call RRECC Administration at (718.863.6200) for incident-specific information.

Adult and pediatric dependent care area will be established as needed. These areas will be supervised by an assigned staff member, and staffed by facility volunteers. If the volunteers are not available, designated facility staff will be utilized. Arrangements will be provided for on-duty staff to visit with their dependents as schedules permit. While all employees should have an individual family plan, the dependent care process will provide a temporary location for sheltering of dependent family members by using volunteers and personnel from the facility labor pool to provide limited dependent care. The primary focus of the dependent care process is to ensure that sufficient staff is available to adequately care for the existing and incoming resident population during and following an incident.

### 23.9.4 Psychological First Aid for Staff

In the immediate aftermath of a disaster, almost everyone will find themselves unable to stop thinking about what happened. These are called intrusion or reexperiencing symptoms. They will also exhibit high levels of arousal. For most, fear, anxiety, re-experiencing, efforts to avoid reminders, and arousal symptoms, if present, will gradually decrease over time. The expected psychological outcome is recovery, not psychopathology. However, because stress reactions are so pervasive after a major disaster, it can be difficult to know when a stress reaction is more severe and may require clinical intervention.

The PFA program described in Section 23.5 is a key mechanism for enhancing workforce resilience, and is useful for staff and other non-residents, as well. The Psychological First Aid Field Operations Guide (PFA FOG) contains specific strategies that have been tailored to address the emotional needs and concerns of individuals including children, adolescents, parents/caretakers, families, and adults exposed to disaster or terrorism, as well as first responders and other disaster relief workers. Selected Social Work staff have been trained in PFA procedures. Should conditions warrant, the Psychosocial Unit Leader or Resident Services Branch Director should consider the need for
implementation of PFA support procedures as outlined in the PFA FOG. If necessary, the facility PFA team can be reinforced by mental health staff from other healthcare facilities or the DOHMH, contacted through the City EOC.

23.9.5 Pet Care

Facility staff members who also provide care for household pets are expected to have their own arrangements for pet care when they must report for duty. The facility recognizes that under some unusual circumstances, individual staff members may be called to duty without having arrangements for household pets. At the discretion of the Incident Commander, when conditions warrant, the facility may provide limited pet care facilities on the facility campus, enabling the staff members to report for duty. Staff should call the Employee Information Hotline (718.xxx.xxxx) for incident-specific information.

Should such provisions be enacted, the following procedures shall apply:

1. Only household pets will be allowed, including the following: dogs, cats, rabbits, birds, ferrets, and small mammals (e.g., guinea pigs, hamsters, gerbils, hedgehogs)

2. No reptile or insect pets are allowed, as many people have fears or phobias regarding these species

3. Pets should arrive in an appropriate pet carrier, cage, or airline kennel (provided by the owner) and shall remain confined in it throughout their time at the shelter. No pet should be allowed out of the cage without a leash and identification. Dogs that arrive without a carrier will only be housed in a separate confined area if one is available.

4. The owner shall provide proof of rabies vaccination for dogs, cats, and ferrets. Other vaccinations should also be up to date.

5. Animals are sheltered at the owner’s own risk

6. Pet supplies shall be provided by the owner as applicable to their pet(s)

If pet accommodations cannot be made at the facility, staff may be referred to the [insert pet facility name, address, and contact information] for emergency accommodations.
24 LOGISTICS

24.1 Logistics Section Activities
Logistics Section functions include all activities necessary to establish and support the environment of care, and provide the resources (including personnel) necessary for the facility to carry out its mission. Such activities include, but are not limited to, oversight of support activities such as resident transportation; critical supplies [e.g., pharmaceuticals; medical hardware and software; food and water; linen]; maintenance of essential building utility needs; physical plant management during evacuation and re-occupancy; backup internal and external communications systems; and hazardous materials support. Annexes to this plan provide department, system, or event-specific details of logistical functions. The City EOC may be called upon for additional support in the event that the facility requires external assistance in logistical support.

24.2 Staffing Augmentation Policy
By their very nature, unusual events tend to be staff-intensive, as additional resources are needed for a multitude of tasks. It is RRECC's policy to consider any employee on the premises during an Emergency Operations Plan activation to be on duty. An employee may be called upon to aid in other than job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. Any employee found leaving the premises without authorization during the period of Emergency Operations Plan activation will be subject to disciplinary action.

24.3 Labor Pool

24.3.1 Labor Pool and Credentialing Area
(1) The facility establishes a Labor Pool and Credentialing Area as an initial response strategy when conditions indicate that staffing augmentation will be needed to respond to a particular incident.

(2) The mission of the Labor Pool and Credentialing Area is to serve as a mobilization point for medical and non-medical personnel and volunteers, and a credentialing area for any situation where medical volunteer credentialing or identification is required (refer to Section 24.6, below). During most incidents, which are typically of a minor (lesser) impact, full use of the Labor Pool and Credentialing Area is not required.

(3) The Labor Pool consists of two separate components, which may be activated individually or collectively, as conditions warrant:
## 24. Logistics

### a. General Labor Pool and Credentialing Area

- Established initially as a gathering location for non-clinical staff that will be awaiting assignment.

### b. Nursing Staff Pool

- Co-located with the Labor Pool or established in a separate location, as a mobilization point for nursing staffing.

#### (4) The Staffing/Scheduling Unit Leader is responsible for the operation of the Labor Pool and Credentialing Unit, regardless of location. The Unit Leader is responsible to:

- Collect and inventory available staff and volunteers at the designated location (Labor Pool) for assignment as needed.

- Maintain adequate numbers of both clinical and non-clinical personnel, as directed by the Logistics Section Chief.

- Assist in the maintenance of staff morale.

#### (5) Each department’s DEOPs specifies, by title and shift (time of day), the specific number of clinicians and employees that may be sent to the Labor Pool when directed. **Staff shall only report to the Labor Pool when specifically directed to do so by the FCC.**

#### (6) When arriving at the Labor Pool, staff shall report directly to the Unit Leader, sign in, and remain in the designated area, available for assignment, until assigned or relieved.

#### (7) The Labor Pool and Credentialing Area shall be activated for NHICS Level 3 or greater incidents, or other situations as directed by the Incident Commander where its use would improve intra-organizational staffing. Once activated, it shall remain activated and staffed in accordance with each department’s DEOP **when directed** until the activation is de-escalated or until otherwise directed.

### 24.3.2 Staff Deployment from the Labor Pool

#### (1) When activated, the first manager or supervisory staff member to arrive at the Labor Pool location shall assume the role of the Staffing/Scheduling Unit Leader until relieved by the individual assigned by the FCC.

#### (2) The Unit Leader shall immediately develop a roster of staff members reporting.

#### (3) The Unit Leader shall establish and maintain a positive communications link with the FCC using telephone or radio.

#### (4) When a NHICS leader requires staff support, the request shall be made directly to the Staffing/Scheduling Unit Leader. Available resources shall be assigned from the Labor Pool. Every effort shall be made to assign staff to tasks consistent with their level of training or credentialing. If additional staffing is
needed, the Staffing/Scheduling Unit Leader shall request a specific additional staff assignment from the FCC.

(5) The Staffing/Scheduling Unit Leader shall provide periodic updates to the FCC on staffing levels available and assigned, by title.

(6) In addition to deploying clinical staff as needed for resident care activities, non-medical assignments from the Labor Pool may include (but are not limited to):
   a. Resident transport
   b. Security augmentation
   c. Evacuation teams
   d. Runners / messengers
   e. Switchboard support
   f. Clerical or ancillary support
   g. Resident information
   h. Proving information, escorts, assistance, or other services to family members and visitors
   i. Other tasks or assignments as needed

24.3.3 Virtual Labor Pool
   (1) For incidents of extended duration, or where it is desirable to have pre-designated staff available for deployment but not productive to maintain them in a personnel staging area for a prolonged time, the Support Branch Director or Logistics Section Chief shall consider establishing a virtual labor pool.

   (2) For a virtual labor pool, the Staffing/Scheduling Unit Leader develops a roster of staff available for deployment by establishing contact with each department. The roster is maintained, and updated for each operational period. The employees so registered remain at their current work assignments unless specifically needed. When needed, the immediate supervisor will be contacted by the Labor Pool and the employee will be directed when and where to report.

24.4 Emergency Shift Schedules
At the determination of the Incident Commander, all or some staff members may be changed to 14-hour emergency shifts in order to maximize staffing. These shifts may be scheduled as shown below, or as needed to meet facility emergency objectives.

Should the anticipated event make staff travel or access for shift changes difficult or unsafe (for example, in advance of a coastal storm or blizzard), the emergency shift
schedules should be divided into “Pre” and “Post” shifts. The Pre shift is given sufficient time off before the storm arrives to prepare their homes, families, and personal affairs, and is then expected to report while travel is still safe and permissible before the storm. They may be encouraged to bring immediate family members and pets, if conditions warrant, for safe shelter. The Pre shift will remain on duty (with sleep and rest periods assigned as needed) for the duration of the event. The Post shift will be sent home, if conditions permit, when the Pre shift reports, to weather the storm at home or appropriately sheltered. Once notified that conditions permit safe access to the facility after the storm, the Post shift reports for duty and relieves the Pre shift, until normal schedules can be resumed.

Regardless of regular schedules, staff should be given the opportunity to volunteer for the Pre and Post shifts of their choice.

<table>
<thead>
<tr>
<th>Emergency Shift</th>
<th>Work Hours</th>
<th>Normal Shift of Staff Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shift I</td>
<td>7AM -9PM</td>
<td>All Shift I (0600-1400, 0700-1500, 0900-1700, 1500-2300) staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shift II (2300-0700) staff</td>
</tr>
<tr>
<td>Emergency Shift II</td>
<td>7PM-9AM</td>
<td>Half of Shift II 2300-0700) staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Shift III (0600-1400, 0700-1500, 0900-1700, 1500-2300) staff</td>
</tr>
</tbody>
</table>

Table 6. Emergency Shift Schedule

24.5 Staffing Expansion Considerations

Some options for expansion of both professional and non-clinical staff include the following:

- Temporarily increase nurse-to-resident ratios on floors
- Hold current staff on overtime after shift
- Change from three 8-hour shifts to two 14-hour shifts
- Call back off-duty staff from earlier shift
- Call in next shift staff early
- Contract additional agency nurses
- Cancel staff days off (first one per week, then both)
- Cancel holidays and vacation leaves
- Coordinate through the City DOHMH and GNYHA for staffing support from outside the facility (consider credentialing needs) – including other
<table>
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<tr>
<th>Policy Name:</th>
<th>24. Logistics</th>
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<tbody>
<tr>
<td>Issue Date:</td>
<td>12.24.18</td>
</tr>
<tr>
<td>Reference:</td>
<td>CPG 101</td>
</tr>
</tbody>
</table>

healthcare facilities; home-based care staff; Medical Reserve Corps; and staff from an unaffected area of the City/region/state/country

### 24.6 Administrative and Temporary Clinical Privileges / “Disaster Privileges”

RRECC may activate its EOP for an incident where the facility is unable to meet immediate resident needs due to a shortage of clinical staffing. Under emergency conditions, granting of permission to provide care, treatment, and services shall be known as "disaster privileges."

#### 24.6.1 Licensed Independent Practitioners

During EOP activation, the Chief Executive Officer or Medical Director (or their designee) as needed may “permit volunteer licensed independent practitioners to provide care, treatment, and services.” Granting such privileges will be on a case-by-case basis at the discretion of the CEO or Medical Director. The privileges should be effective immediately and continue through the completion of the resident care needs or until the orderly transfer of resident care to an appropriately credentialed member of the medical staff can be accomplished.

Following approval for emergency credentialing privileges the practitioner shall be provided and maintain on his or her person written verification of said privileges for ready identification using the Licensed Independent Practitioner Job Action Sheet (JAS) or other written directive. This JAS identifies the practitioner’s role in the emergency response and identifies by name the person to whom they report.

The practitioner shall take direction from the Medical Director (or designee) regarding resident care services. The practitioner’s notations in the medical record shall reflect that the physician is working under “Disaster Privileges.” For quality review purposes, a list of all resident encounters should be kept, if practical. The practitioner’s performance will be monitored by the Medical Director, or designee, concurrently and retrospectively as conditions permit through a combination of direct observation, mentoring, and medical record review.

Practitioners who request “Disaster Privileges” must be currently licensed practitioners who maintain equivalent privileges at another facility. Privileges requested should be consistent with those currently in place in the appropriate department and specialty at the practitioner’s "home" facility.

Identification requirements for those practitioners requesting Disaster Privileges must be met before the practitioner shall be considered eligible to function as a volunteer licensed independent practitioner. Minimum identification credentials shall include a valid photo-identification issued by a state, federal, or government regulatory agency (e.g., driver's license, passport) and at least one of the following:
Rebekah Rehab & Extended Care Center | Emergency Operations Plan

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<thead>
<tr>
<th>Policy Name:</th>
<th>24. Logistics</th>
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</thead>
<tbody>
<tr>
<td>Issue Date: Revision Date:</td>
<td>12.24.18</td>
</tr>
<tr>
<td>Reference:</td>
<td>CPG 101</td>
</tr>
</tbody>
</table>

- A current facility photo-identification card clearly identifying professional designation
- A current license to practice
- Identification indicating that the individual is a member of a federal or state Disaster Medical Assistance Team (DMAT) or the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organizations or groups
- Identification indicating that the individual has been granted authority by a government entity to provide resident care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the facility or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during an emergency

As soon as the immediate emergency situation is under control (but not more than 72 hours from the time the volunteer practitioner presents to the facility, unless documented extraordinary circumstances intervene), primary source verification of the credentials and privileges of individuals who receive “Disaster Privileges” will be undertaken in accordance with RRECC Disaster Privileges Policy. This verification should include:

- Current New York State licensure verification
- DEA and state narcotics registration verification
- National Practitioner Data Bank (NPDB) discovery
- Federation of State Medical Boards (FSMB)
- New York State Office of Professional Medical Conduct (OPMC) or Office of Professions (OP)
- Health and Human Services/Office of Inspector General (HHS/OIG) List of Parties Excluded from Federal Programs; and
- Current active facility affiliation

If extraordinary circumstances intervene, the Logistics Section Chief shall document the following:

- Reason(s) verification could not be performed within 72 hours of the practitioner’s arrival
- Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services
Evidence of the facility’s attempt to perform primary source verification as soon as possible

24.6.2 Medical Volunteer Credentialing and Identification
The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. The Credentialing Department will be consulted as necessary in the credentialing process. Facility identification indicating “Volunteer Licensed Practitioner” and the individual’s name and title shall be provided and displayed conspicuously at all times while the practitioner is engaged in providing care and services.

24.6.3 Non-Licensed Independent Practitioners
During EOP activation, the need for assigning disaster responsibilities to volunteer non-licensed independent practitioners may arise. A volunteer non-licensed independent practitioner is defined as a person other than a licensed independent practitioner who is qualified to practice a healthcare profession; is required by law and regulation to have a license, certification, or registration; and is engaged in the provision of care and services (e.g., a registered nurse or respiratory therapist). RRECC may modify the usual process for determining qualifications and competencies of volunteer non-licensed independent practitioners only if necessary to meet immediate resident needs during an emergency. Assigning disaster responsibilities to volunteer practitioners shall be made on a case-by-case basis, taking into consideration the needs of the organization and the resident(s).

Identification requirements for those volunteer non-licensed independent practitioners assigned disaster responsibilities must be met before the practitioner shall be considered eligible to provide care and services. Minimum identification credentials shall include a valid photo-identification issued by a state, federal, or government regulatory agency (e.g., driver’s license, passport) and at least one of the following:

- A current, valid facility photo-identification card clearly identifying professional designation
- A current, valid license, certification, or registration as required by their professional discipline
- Primary source verification of license, certification, or registration (if required by law and regulation in order to practice)
- Identification indicating that the individual is a member of a federal or state DMAT or the Medical Reserve Corps, ESAR-VHP, or other recognized state or federal response organizations or groups
• Identification indicating that the individual has been granted authority by a
government entity to provide resident care, treatment, or services in disaster
circumstances

• Confirmation by a facility staff member with personal knowledge of the volunteer
practitioner’s ability to act as a qualified practitioner during an emergency

The Director of Human Resources shall maintain a list of all volunteer practitioners and
the responsibilities they have been assigned. Oversight of the professional performance
of volunteer practitioners, including direct observation, mentoring, and clinical record
review will be performed by the Director of Quality Management. Based on this oversight,
the Director of Quality Management shall recommend to the Logistics Section Chief
whether assigned disaster responsibilities should continue.

As soon as the immediate emergency situation is under control (but not more than 72
hours from the time the volunteer non-licensed independent practitioner presents to the
facility, unless documented extraordinary circumstances intervene), primary source
verification of the licensure, certification, or registration of individuals who were assigned
disaster responsibilities will be undertaken. Primary source verification is not required if
the individual has not provided care, treatment, or services under their assigned disaster
responsibilities.

• If extraordinary circumstances intervene, the facility shall document the following:
  • Reason(s) verification could not be performed within 72 hours of the practitioner’s
    arrival
  • Evidence of the volunteer non-licensed independent practitioner’s demonstrated
    ability to continue to provide adequate care, treatment, and services
  • Evidence of the facility’s attempt to perform primary source verification as soon as
    possible

24.6.4 Non-Medical Volunteer Management

The Logistics Section Chief will ensure that, as conditions warrant, appropriate identity
and credentialing verification processes are followed. The Credentialing Department will
be consulted as necessary in the credentialing process. Facility identification indicating
“Volunteer Non-Licensed Practitioner” and the individual’s name and title shall be
provided and displayed conspicuously at all times while the practitioner is engaged in
providing care and services.
24.7 Resource and Asset Management

24.7.1 Inventory Management
The Emergency Management Coordinator maintains a Critical Resource Inventory (see Resource Annex, Critical Resource Inventory) documenting all RRECC resources available to support the organization and facility residents during an emergency. Assets listed include PPE, food and water, medical/surgical supplies, pharmaceuticals, fuel for generators and vehicles, emergency lighting and communications equipment, evacuation chairs and medslseds, resident movement equipment, durable medical equipment, administrative supplies, and other items. The Resource Inventory is updated at least annually to ensure that adequate resource levels are maintained and supplier/vendor contact information is current.

24.7.2 Communication with Purveyors of Essential Supplies, Services, and Equipment
Contact information for around-the-clock (24x7x365) access to primary, secondary, and tertiary/alternate vendors for all critical supplies, services, and equipment (as noted in the Critical Resource Inventory) is maintained:

- By the department head of the facility department that routinely orders and maintains the stock of the particular good or service
- By the Purchasing Department, which assumes the role of the Procurement/Cost/Claims Unit during EOP activation
- In the FCC Resource Directory

At the outset of an incident during which critical resources may be needed, the Procurement/Cost/Claims Unit Leader shall be notified by the Planning Section Chief of a projected resource shortfall, and vendor contact shall be initiated. As conditions warrant, the Procurement/Cost/Claims Unit Leader shall contact one or more vendors, including others not listed in the Resource Annex, Critical Resource Inventory, until an acceptable source of supply is identified and arrangements are made to meet the need.

24.7.3 Resource Monitoring
During EOP activation, the Planning Section shall maintain current operational inventory status on all resources used for, or affected by, the incident. Such information shall be gathered and documented during the first eight hours of the incident, and every operational period thereafter, via departmental STATREP submissions and supply center resource updates. When pre-identified par level thresholds are met, the Planning Section shall follow up with Finance/Administration and Logistics Sections to ensure that necessary resource replenishment has been accomplished.
In the event that resource replenishment cannot be accomplished, the Planning Section shall develop alternative strategies for resource conservation and/or service reduction. This shall be done in coordination with the appropriate department heads. In the event that resource shortfalls are projected, the following actions may be implemented at the direction of the IC:

- Procurement from alternate or nontraditional vendors
- Procurement from communities outside the affected region
- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request for external stockpile support from the City DOHMH logistics cache
- Request for external stockpile support from the State Department of Health Medical Emergency Response Cache (MERC), or the Strategic National Stockpile (these requests go through the City Emergency Management) (see Support Annex, Strategic National Stockpile for additional information)

### 24.7.4 Resource Sharing

In the event of a large-scale emergency or regional crisis, there may be a need for sharing resources and assets with facility mutual aid partners, other healthcare organizations in the community or contiguous geographic area, or organizations across a larger region of the country. Resources and assets that may be shared include but are not limited to beds, transportation resources, linen, fuel, PPE, medical equipment, and supplies. Such resources may be needed by the facility or RRECC may be asked to provide support to other organizations.

Communication and coordination regarding the need for resources and assets shall be communicated initially through facility Liaison Officer or from the mutual aid partner or local entity requesting or providing support. If another entity requests resources, the call shall be routed to the Liaison Officer, who will document the information and refer the matter to the Logistics Section Chief. The Logistics Section Chief shall determine the feasibility of meeting the request, and shall make recommendations to the IC, who is responsible for directing the course of action and authorizing the external deployment of resources. If we seek resources from a mutual aid partner or local entity, the Logistics Section Chief shall direct the Liaison Officer to establish initial contact with the outside organization. Once contacts are established through the respective Command Centers, the Logistics Chiefs from participating agencies are free to coordinate their interactions directly to shorten the lines of communication.

If resources are needed beyond the scope of facility mutual aid partners or local entities, the Logistics Section Chief shall direct the Liaison Officer to establish contact with the City Emergency Management Emergency Support Function (ESF) 8—Public Health and Medical Services desk. City NYCEM will serve as the coordinating point for managing...
resources and asset deployment both within and outside the City during a large-scale incident.

24.7.5 Donation Management

Three donation scenarios may arise when RRECC is affected by a major emergency in the community. These donation scenarios include offers of miscellaneous goods and services from members of the public. These donations will be checked for appropriateness and expiration dates. Blood donations from individuals, would be directed to a proper blood collection center. Donations of medical supplies and/or equipment, including pharmaceuticals, from an identified supplier/vendor, all goods will be validated through the appropriate vendor. Note that management of unsolicited volunteer services should be carried out in accordance with the provisions of Section 28.3—Administrative and Temporary Clinical Privileges.

The following processes will be used to ensure the most efficient and effective utilization of donated goods received by the facility during an incident. It is likely the receipt of goods and services will not coincide with the needs of the facility or the healthcare needs of the community. Therefore, goods and services must be coordinated to realistically assess what is available versus what is needed.

24.7.5.1 Miscellaneous Goods and Services—General Policy

Except in extraordinary circumstances, unsolicited offers of donated goods or services should be referred to the City EOC. Depending on the scope of the incident, the City, or a designated Voluntary Organization Active in Disaster (VOAD), may establish a Donations Coordination Center (DCC) under the direction of a Donations Specialist. The DCC will be the responsible entity for receipt, cataloguing, warehousing, and integration/distribution of donated goods into and through the City’s overall disaster supply system.

Press releases and other forms of public information will be used to encourage and guide public donations. Donors will be discouraged from sending unsolicited goods directly to the facility. Donors should be encouraged to make cash donations to locally sponsored funds or to established local charitable organizations.

As needed, the Logistics Section Chief shall be responsible for assessing unmet needs and coordinating with the DCC regarding availability of donated goods and services to meet these needs from the available donations and volunteers responding. The Logistics Chief shall also arrange for the transport of goods and materials to or from the facility as conditions warrant.
24.7.5.2 Responsibility
The Logistics Section Chief shall be responsible for leading the donations management process. If necessary, a Donations Specialist shall be assigned to the Logistics Section. The Logistics Section shall:

- Establish a process for receiving and securing donated goods
- Establish a database and maintain tracking of all donated goods and services, including a record of the source and date received
- Warehouse and safeguard donated goods until they can be distributed
- Be alert for perishable items (e.g., food), hazardous or unidentified items (which may pose a threat), or items requiring special handling (e.g., medications requiring refrigeration)
- Maintain a listing of goods and services offered or available from any source
- Coordinate with recognized local support agencies to determine available resources and needs, and to arrange for distribution of donated goods to the community as available

24.7.5.3 Donations from an Identified Supplier/Vendor
In the event that an unsolicited apparent donation of supplies or equipment arrives at the facility, the shipment shall not be accepted without the express authorization of the Finance Section Chief. The identity of the purveyor shall be established, and the Supply Unit Leader, in consultation with the Director of Materials Management, shall determine whether the goods have been ordered or are needed. If no valid order can be verified, only the Finance Section Chief or designee is authorized to accept the delivery. This policy exists to protect the facility from taking delivery of unneeded “donations” that are subsequently billed to the facility after the crisis.

24.8 Utility Management
RRECC has identified alternative means or alternate sources of energy capable of providing critical utility services including but not limited to:

- Electricity
- Elevators
- Emergency lighting
- Fire detection, extinguishing, and alarm systems
- Fuel required for building operations, generators, and essential transport services
- Heating, ventilation, and air conditioning (HVAC) sufficient to maintain temperatures to protect resident health and safety, and for the safe and sanitary storage of provisions
- Sewage and waste disposal
- Water needed for consumption and essential care activities
### Policy Name: 24. Logistics

<table>
<thead>
<tr>
<th>Issue Date:</th>
<th>Revision Date:</th>
</tr>
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<tbody>
<tr>
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**Reference:**
- CPG 101 | CMS §483.73 (b) | NYSDOH DAL 05-11 | TJC EM.01.01.01 EP8; EM.02.02.03 EP1-3,6; EM.02.02.07 EP9; EM.02.02.09 EP2-7; EM.02.02.13 EP1,3,5-9; EM.02.02.15 EP1-5 6-8; EM.03.01.01 EP3

- **Water needed for equipment and sanitary purposes**

Provisions for advance preparation in anticipation of a possible utility loss/failure/shutdown are addressed in Section 12.6—Advance Preparations. Utility-specific alternate means, including detailed interruption/restoration procedures, are addressed in utility-specific annexes. Strategies for management of prolonged disruptions are addressed in *96 Hour Self-sufficiency Annex*. 
25 INCIDENT PLANNING

OP Step 1
IC/UC Develop and/or Update Objectives Meeting

OP Step 2
Command and General Staff Briefing

OP Step 3
Prepare for the Tactics Meeting

OP Step 4
Tactics Meeting

OP Step 5
Prepare for the Planning Meeting

OP Step 6
Planning Meeting

OP Step 7
IAP Preparation and Approval

OP Step 8
Operations Briefing

Initial Response

New Operational Period Begins

Execute Plan and Assess Progress

Step 1
Incident/Event Occurs

Step 2
Notification of Event/EOP Activation

Step 3
Initial Response and Assessment

Step 4
Briefing for Incident Management Team

Step 5
Initial UC Meeting

Step 6
Operations Briefing

Step 7
IAP Preparation and Approval

Step 8
Planning Meeting

Step 9
Prepare for the Tactics Meeting

Step 10
Tactics Meeting

Step 11
Prepare for the Planning Meeting

Step 12
Planning Meeting
25.1 General

RRECC is committed to using an organized planning process as an essential function of Emergency Operations Plan (EOP) activation. The planning process establishes a focused environment for effective incident-related data gathering and analysis regarding incident operations and assigned resources, development of alternatives for tactical operations, conduct of planning meetings, and preparation of the Incident Action Plan (IAP) for each operational period.

The Incident Commander (IC) maintains overall responsibility for planning functions. Incident planning activities involve developing strategies and outlining tasks and schedules to accomplish the incident goals as determined by the IC. Planning functions include resource and situation tracking and status-keeping, incident action planning, documentation and maintenance of records, medical staff assignments, and planning for demobilization. Authority for carrying out these activities may be delegated to the Planning Section Chief (NHICS General Staff member) or subordinate elements within the Planning Section. The IC shall ensure that incident planning needs are addressed as a primary and critical function of EOP activities.

25.2 Operational Periods

As soon as practical following the activation of the EOP, the IC shall organize the response objectives or operational activities into specified time periods. These time periods are called Operational Periods.

Operational periods will initially be of short duration, but for extended incidents they may be as long as 24 hours. For extended incidents (greater than a 24-hour period), a standard incident planning cycle with 12- or 24-hour operational periods should be established. The use of operational periods is an important function to enable effective resource management and tracking of task completion.

25.3 Incident Planning Cycle

For most incidents encountered at the facility, the NHICS activation level will be limited to Level Two (minor impact), total incident time will be of short duration (less than four hours), and the need for a full Planning Section operation will be limited. During such incidents, only one or two short-duration operational periods are typically needed beyond the initial action period, only limited Incident Management Team (IMT) leadership changes will occur, and not more than a single incident planning meeting will be necessary. Planning Section functions will typically focus on short-term forecasting, situation- and resource-status monitoring, and documentation. A written incident action plan, if needed, may be limited to a set of NHICS 201 (Incident Briefing), NHICS 202 (Incident Objectives), and NHICS 203 (Organization Assignment) forms.
For incidents of greater significance or longer duration, the use of an incident planning cycle is needed to ensure ongoing, coordinated, and efficient incident management. The operational period planning cycle, depicted in Figure 29-1, follows an eight-step operational period process once the incident is underway and the IC has conducted an initial briefing of the IMT (and, if applicable, the Unified Command team). During each of these eight steps, specific actions are taken by each of the major sections in support of the planning cycle. (See Incident Action Planning Annex for details of each step)

### 25.4 Incident Planning Process

The incident planning process is a core concept of ICS and takes place regardless of the incident size or complexity. This planning involves six essential steps:

- Understanding the facility’s policy and direction
- Assessing the situation
- Establishing incident objectives
- Determining appropriate strategies to achieve the objectives
- Giving tactical direction and ensuring that it is followed (e.g., correct resources assigned to complete a task and their performance monitored)
- Providing necessary backup (e.g., assigning more or fewer resources, changing tactics)

The ICS organization used for an incident reflects the principle of management by objectives. Incidents may be different but the ICS fundamentals remain unchanged. That is, the size and structure of the Incident Command organization for an incident reflects only what is needed to meet and support the identified incident objectives. As objectives are achieved, elements that are no longer needed are reassigned or demobilized.

When establishing incident objectives, the Incident Commander shall apply the following priorities:

1. Life Safety
2. Incident Stabilization
3. Property Preservation

### 25.5 Planning Section Responsibilities

During EOP activation, the Planning Section is focused primarily on the following activities.

#### 25.5.1 Situation Status Monitoring and the Situation Unit

There are two critical functions that the Situation Unit Leader is responsible for: monitoring current resident location (resident tracking) and monitoring resident and bed deployment
during the incident (bed tracking). This information may also be shared externally (e.g., with EMS agencies, other healthcare facilities, and the DOHMH) as needed.

25.5.2 Incident Documentation and the Documentation Unit

All documentation related to the incident is collected, compiled, and archived by the Documentation Unit Leader. Incident documentation is crucial for ongoing leadership activities as well as for the post-incident cost-recovery process. The Documentation Unit Leader is responsible for maintaining an ongoing record of the facility’s Incident Action Plans and other incident management forms so that IMT personnel can refer back to them if needed. At the termination of the incident, all the collated IAPs will be used to help document the facility’s response activities and decision-making processes.

25.5.2.1 Incident Documentation

Multiple methods of documentation will likely be used during an incident. Written documentation will be the primary method of information recording. Each IMT position is tasked with maintaining their own log of issues, actions, and outcomes. Actual recording of the information may be done on paper or on computers using standard word-processing, database, or spreadsheet programs. The continuous recording of phone lines or even the FCC operation itself can be helpful in reconstructing information received and actions taken during an incident.

Forms to support incident management activities are provided in the NHICS Forms Annex. Each form is intended to assist the facility in identifying the various types of information to record and archive during an incident. The forms may be found in Section 35, EOP Forms.

25.5.2.2 Contents of the Incident Action Plan

A formal written Incident Action Plan should contain the following documents, arranged in order. The actual IAP contents will depend on the specifics of the incident and are determined by the Planning Section Chief.

- IAP Cover page
- NHICS 202, Incident Objectives
- NHICS 203, Organization Assignment List
- NHICS 205, Incident Communication Log
- NHICS 206, Staff Medical Plan
- NHICS 207, Incident Organization Chart
- NHICS 251, Facility System Status Report
- NHICS 261, Incident Action Plan Safety Analysis

25.5.2.3 Sharing Information with Outside Agencies

Depending on the nature of the incident and its duration, the City EOC or Healthcare Evacuation Center (HEC) may request that healthcare facilities submit their IAPs at designated times for regional updates. This information will help community emergency
response officials better understand the issues the healthcare facilities are confronting and determine what future assistance may be required. Other information such as resident data, resource availability (e.g., personnel, equipment/supplies, medications) and response cost information may also be requested from the City and/or state EOC. Any requests for information from assisting or cooperating agencies, including external EOCs, shall be routed through the Liaison Officer. The release of any such facility information requires authorization of the IC or Planning Section Chief prior to dissemination.

25.5.3 Incident Demobilization and the Documentation Unit

Demobilization is the orderly, efficient disengagement and release of resources from the incident response and the facility’s return to normal operations. Planning for demobilization should actually begin from the outset of the response. While short-duration Level Two (minor impact) activations will typically be resolved and demobilized rapidly by simply releasing the few involved resources, a higher-level activation, or an incident with many resources participating, requires a structured demobilization process to ensure the orderly release of resources. The Demobilization Plan, which incorporates specific responsibilities and release priorities, becomes a component of the IAP. The ultimate decision as to when to move from response mode to demobilization will be made by the IC.

The criteria to begin demobilization will vary incident by incident, but fundamental considerations are based on a reduction of impact of the event on the facility. Impact assessment should include the following:

- The number of incoming residents is declining to a level manageable using normal staffing patterns and resources.
- There is no secondary rise in resident volume expected.
- Other responders are beginning their demobilization.
- Other critical community infrastructure returns to normal operations.

For large-scale and/or community-involved incidents, the IC shall consult not only with Command and General Staff but also with external decision makers, such as other healthcare facilities, public health/public safety agencies, and the local EOC, before making a final decision to begin demobilization. Depending on the situation, not all areas of the facility may be able to begin demobilization at the same time. Thus, planning will need to address not only when the demobilization process is to begin but also how it will be implemented.

An important component of demobilization is notification of the demobilization process, both within and outside the organization. The demobilization plan shall ensure that necessary notifications are carried out as required (see Section 22 for additional information).
26

26.1 Background
RRECC recognizes that monitoring and tracking costs and expenses associated with an emergency response is vital to expediting recovery by optimizing reimbursement and minimizing the financial impact on the facility. RRECC is committed to using an organized, incident-related financial monitoring and tracking process as an essential function of EOP activation. The finance/administration process establishes a focused environment for monitoring the utilization of financial assets and accounting for financial expenditures, as well as ensuring documentation of expenditures and cost reimbursement activities.

The Incident Commander (IC) maintains overall responsibility for tracking and managing incident-related costs and expenditures. Incident financial activities involve developing financial monitoring strategies and outlining costs, expenses, funding sources, and contracting arrangements to accomplish the incident goals as determined by the IC. Finance/administration functions include tracking of personnel time and related costs, ordering items and initiating contracts, arranging for personnel-related payments and Workers’ Compensation, tracking of response and recovery costs, and payment of invoices. Authority for carrying out these activities may be delegated to the Finance/Administration Section Chief (NHICS General Staff member) or subordinate elements within the Finance/Administration Section. The IC shall ensure that incident financial and administrative needs are addressed as a primary and critical function of EOP activities.

The costs associated with a facility response to any large-scale emergency can be enormous and can potentially become a crisis in itself. This is especially true if documentation is not collected properly and submitted within reimbursement deadlines set by the local, state, and federal government.

To optimize the tracking process, incident-related costs shall be accounted for from the outset of the response. The primary costs to be closely tracked should include any expense that may be considered either directly or indirectly incident-related. Costs that would be incurred on a routine basis (such as routine facility operations, or staff that would have been working their regular shifts anyway) are not generally reimbursable, so their tracking is not essential.

Costs to be monitored closely include:

- Personnel (especially overtime and fee-for-service staff)
- Event-related resident care and clinical support activities
- Incident-related resources
- Equipment repair and replacement
- Costs for event-related facility operations
The tracking of these costs should be done using RRECC’s existing cost accounting and documentation practices and NHICS financial tracking forms.

In some cases, normal reimbursement methods will be used and third-party insurance companies invoiced for all the resident care services rendered. However, in situations involving state or federally declared disasters, the facility may be eligible to recover additional response monies not otherwise being reimbursed. To be considered for reimbursement, RRECC will have to submit special applications that require detailed explanations and accurate records. Daily financial reporting requirements are likely to be modified and, in select situations, new requirements outlined by state and federal officials.

26.2 Finance/Administration and the Incident Planning Cycle

For most incidents encountered at the facility, the NHICS activation level will be limited to Level Two (Minor Impact), total incident time will be of short duration (less than four hours), and the need for a Finance/Administration operation will be limited. During such incidents, only one or two short-duration operational periods are typically needed beyond the initial action period, only limited Incident Management Team (IMT) leadership changes will occur, and not more than a single incident planning meeting will be necessary. Finance/Administration Section functions will typically focus on short-term cost projections and tracking, including incident-related overtime expenses and any associated emergency procurement items. The Section’s contribution to the written incident action plan, if needed, may be limited to a NHICS 256, Procurement Summary Report.

For incidents of greater significance or longer duration, the Finance/Administration Section will participate in the incident planning cycle to ensure ongoing, coordinated, and efficient incident management. The operational period planning cycle, depicted in Figure 29-1, follows an eight-step operational period process once the incident is underway and the IC has conducted an initial briefing of the IMT (and, if applicable, the Unified Command team). The Finance/Administration Section Chief will support the incident goals by ensuring that the necessary financial tracking, contracting, and documentation components are in place to support the activities of the other sections. Once a state or federal disaster declaration is made by government officials, the Finance/Administration Section Chief shall coordinate with the NYCEM to identify what state and federal financial aid documents must be completed for receiving reimbursement.

- Vendor expenses
- Mutual aid financial remuneration
- Personnel illness, injury, or property damage claims
- Loss of revenue-generating activities
- Cleanup, repair, replacement, and/or rebuild expenses
26.3 Finance/Administration Section

During EOP activation, the Finance/Administration Section is focused primarily on the following activities.

**26.3.1 Personnel Time Monitoring and the Time Unit**

The Time Unit Leader is responsible for identifying, tracking, and documenting all costs associated with incident-related staffing of the organization. This includes costs associated with staff overtime, addition of fee-for-service (per diem) personnel, and recall of off-duty staff.

**26.3.2 Procurement Status Monitoring and the Procurement/Cost/Claims Unit**

The Procurement/Cost/Claims Unit Leader manages incident-related contracting arrangements with external vendors. This may include but is not limited to activating or creating emergency purchase orders and triggering preplanned resource acquisition arrangements. The Procurement/Cost/Claims Unit Leader coordinates closely with the Materials Tracking Manager to document and track resources needed and/or projections for future needs, to ensure that the supply chain is maintained and needed resources are acquired.

**26.3.3 Incident-Related Claims and the Procurement/Cost/Claims Unit**

The Procurement/Cost/Claims Unit invests and documents any claims of accident, incident, illness, or injury caused or experienced by staff or others on the campus that are or may be related to the incident. Activities may range from generating routine Workers’ Compensation documents for post-incident follow-up to investigating allegations of primary or secondary incident-related damage or losses. Tracking and processing these claims becomes an important component of the post-incident cost-recovery process.

**26.3.4 Incident-Related Costs and the Procurement/Cost/Claims Unit**

The Procurement/Cost/Claims Unit Leader provides incident-related cost accounting and tracking, taking into consideration the activities of the other Finance/Administration Section units and the documentation generated. Tracking incident-related costs is a vital component of ensuring fiscal responsibility and the organization’s business viability both during the ongoing incident and to optimize reimbursement during the post-incident cost-recovery process.
27 DE-ESCALATION / DEMOBILIZATION

As the incident evolves, the Planning Section Chief shall begin to develop a strategy for demobilization of the response and associated resources, to facilitate an orderly return to normal operations. Depending on the scope of the incident, the demobilization process ranges from simple to complex. The Documentation Unit may be established to develop the assessment and plan for the demobilization and recovery. Demobilization and recovery plans should be carefully addressed as part of the Incident Action Plan (IAP) for the event.

The Incident Commander, the Section Chiefs, and other NHICS general staff members will analyze data and decide when to institute the de-escalation process. The Planning Section is responsible for creating a demobilization plan consistent with the needs of the incident.
28 INCIDENT TERMINATION

As information is received at the Facility Command Center regarding resolution of the incident, a decision is made by the Incident Commander to secure the facility from EOP activation status, terminate the plan response, and resume normal facility operations. This decision will be made based upon assessments of intra-facility conditions (as reported by each department and evaluated by the Facility Command Center), liaison with public safety agencies and, if appropriate, direct contact with involved external organizations.

The unusual location and distribution of residents, equipment, supplies, and staff will require proper guidance in order to accomplish a smooth transition to a more normal state. Only rarely will an all-clear signal be received from outside authorities; more often, management will note that the need for emergency procedures has passed. At this point, restoration and recovery measures should be thoughtfully initiated.

Termination of the response will include an orderly reduction (de-mobilization) of Emergency Operations Plan activation, making the proper notifications regarding plan termination, and collection of the documentation made during the plan response. The final position to be demobilized is that of the Incident Commander, who is demobilized when all incident operations have been terminated and facility operations have returned to normal.

To secure the Facility from Emergency Operations Plan activation status, the Incident Commander or designee will contact the Switchboard Operator, identify him/herself by name and title, and state: “the emergency incident is now over, announce Code Clear”. The Switchboard Operator will activate the voice page system and announce:

“Attention, Attention, Code Clear” and repeat this two (2) more times.

If the event is a drill, the operator will add: “This has been a drill” and repeat this (2) more times.
29 RECOVERY AND RESUMPTION OF NORMAL ACTIVITIES

Recovery activities are those actions taken following an event with the intent of returning the organization to its pre-event state. Recovery actions may range from the concluding steps taken by each member of the incident management team (described on their Job Action Sheets) to compiling documentation, conducting a critique, preparing an after-action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the emergency operations plan, and training or re-training personnel, as necessary.

As the incident evolves, the Planning Section Chief shall begin to develop a strategy for demobilization of the response and associated resources. Depending on the scope of the incident, the demobilization process ranges from simple to complex. The Documentation Unit may be established to develop the assessment and plan for the demobilization and recovery. Demobilization and recovery plans should be carefully addressed as part of the Incident Action Plan for the event.

The Incident Commander, in consultation with senior executive and clinical leadership, shall make the determination of when to transition from the response phase to the recovery phase and when to terminate the recovery phase. The Facility Command Center will remain active and staffed through the recovery process, or until the Incident Commander deems it appropriate to secure.

All NHICS officers will complete the recovery tasks itemized on their Job Action Sheets, and forward all incident-related documentation to the FCC for compilation. The FCC will assign staff as necessary to consolidate and process the paperwork and record keeping.

29.1 Facility Repair and Inspection

As the facility enters the recovery phase, there are several facility issues to consider. The first, general housekeeping and clean up, is likely to be indicated following almost any response. The combination of response-related activity, coupled with the possible suspension of non-essential routine housekeeping services to free up staffing for other assignments, suggests that early attention is needed in this area. The Environmental Unit shall take the lead in inspecting the facility, and planning, prioritizing, and organizing the cleanup personnel and assignments to accomplish the work expeditiously.

The second issue, damage assessment and mitigation, is indicated if the facility was involved in the problem (e.g.; fire, flood, earthquake) or has been unable to maintain an environment of care. In such cases, the Infrastructure Branch and the Safety Officer shall be activated. One or more damage assessment teams shall be sent out to mitigate immediate threats, assess general safety and habitability; and survey and document damage. The Infrastructure Branch Director shall develop a plan of action for facility restoration, and begin to carry out the plan as approved by the Incident Commander.
Longer-term recovery is the third issue. Depending on the extent of the damage, repairs and restoration may take days to months to carry out. To expedite the necessary activities, the facility may use outside vendors or contractors to perform some or all of the work. The Infrastructure Branch shall initiate the planning process, transitioning the information into the IAP process when possible.

29.2 Resumption of Clinical Services

Once an environment of care is restored, the restoration of on-campus clinical service can begin. The Resident Care Branch Director shall investigate and report on the status of clinical services; specifically, what can be resumed (and in what time frame), and what must continue to remain out of commission pending further activity or developments. If significant, the resumption and restoration process shall be prioritized, and incorporated into the IAP for each operational period until completed.

29.3 Repatriation of Residents and Staff

Repatriation is the process of returning residents and staff from relocation outside their normal service areas to their original facility placement. Key elements of any repatriation planning include establishing excellent communications between the facility and the returning individuals; and leadership consideration of the evacuees’ difficulties when returning to the facility.

The Logistics Section should consider assignment of “recovery ambassadors” – individuals who are exceptionally compassionate and can be deployed to assist returning individuals (residents and staff) with the myriad challenges that face them.

29.4 Resumption of Pre-Incident Staff Scheduling

As circumstances allow, personnel should be released from emergency duties to resume normal duties, attend to personal or family needs, be sent home, or to attend critical incident stress debriefing sessions, memorial services, or religious services. A staffing schedule should be quickly established, with early efforts targeted at releasing mutual aid personnel from other facilities, as well as volunteer licensed and non-licensed independent practitioners. Alternately, if the mutual aid and volunteer staffing will be used to provide relief for facility staff, then one-for-one relief scheduling should be arranged, and a relief schedule posted. Other staff members may be released based on personal necessity. Personnel from other departments that were temporarily reassigned should be returned to their own departments for assignment. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.

29.5 Resource Inventory and Accountability

Department managers shall initiate an inventory of all supplies and equipment, and should request repair, replacement, or replenishment as needed from the Logistics Section and/or from appropriate departments; this should be done by on-duty personnel.
immediately after the EOP is secured and should not be postponed until the next shift or ordering day. Department managers shall ensure that their areas are returned to a state of full operational readiness as quickly as possible.
30 APPENDIX A. EMERGENCY MANAGEMENT TEAM

The Emergency Management Team meets on quarterly basis as part of the Safety Meeting and additionally as needed, and is comprised of the following leadership staff members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Department</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenneth Gelb</td>
<td>CEO</td>
<td>Administration</td>
<td>347-996-7864</td>
<td><a href="mailto:kgelb@rebekahrehab.org">kgelb@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Jose Hernandez</td>
<td>Director of Facilities Management</td>
<td>Facilities Management</td>
<td>646-715-4359</td>
<td><a href="mailto:jhernandez@rebekahrehab.org">jhernandez@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Diana Ortiz</td>
<td>Director of Housekeeping</td>
<td>Housekeeping</td>
<td>347-728-3294</td>
<td><a href="mailto:dortiz@rebekahrehab.org">dortiz@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Dr. William Irish-O’Brien</td>
<td>Director of Nursing</td>
<td>Nursing</td>
<td>718-490-6028</td>
<td><a href="mailto:wirishobrien@rebekahrehab.org">wirishobrien@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Connie Capaldo</td>
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<td>Administration</td>
<td>347-514-1830</td>
<td><a href="mailto:ccapaldo@rebekahrehab.org">ccapaldo@rebekahrehab.org</a></td>
</tr>
<tr>
<td>Iddo Geva</td>
<td>Director of Information Technologies (IT)</td>
<td>Information Technologies</td>
<td>646-296-6565</td>
<td><a href="mailto:igeva@rebekahrehab.org">igeva@rebekahrehab.org</a></td>
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### APPENDIX B. HAZARD VULNERABILITY RATINGS

The following table represents the facility’s current vulnerability assessment, listed in order of highest to lowest vulnerability.

<table>
<thead>
<tr>
<th>Policy Name:</th>
<th>6. Hazard Vulnerability Ratings</th>
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<tr>
<td>Issue Date:</td>
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<td>Reference:</td>
<td>CPG 101</td>
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<td>Policy Name: 6. Hazard Vulnerability Ratings</td>
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<td>Issue Date: Revision Date: 12.24.18</td>
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<tr>
<td>Reference: CPG 101</td>
<td>CMS §483.73 (a)(1)</td>
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### APPENDIX C. EMERGENCY OPERATIONS PLAN ACTIVATION MATRIX

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>Definition/Parameters</th>
<th>Authority to Activate</th>
<th>Anticipated NHICS Activation</th>
<th>Notifications</th>
</tr>
</thead>
</table>
| 1 Alert/Notification | Information received indicating a situation or event that will have an actual or potential unusual impact on facility operations. Examples:  
- National Weather Service issuance of a blizzard/hurricane/tornado watch or warning  
- Awareness of a local/community/regional incident that may impact the facility (e.g., explosion nearby; disease outbreak; evacuation)  
- Activation of internal fire alarm (fire not confirmed)  
- Workplace violence threat involving a weapon  
- Cluster of DOH-reportable infectious diseases detected at the facility | Facility Administrator/Director of Nursing  
Nursing Supervisor (off-hours) (becomes Incident Commander)  
Note: Activation can occur at any level and does not require a stepwise sequence of activation. All activities and notifications consistent with lower levels shall be implemented concurrently. | Incident Commander  
Command and General Staff as needed  
Individual resources as needed | Facility Administrator  
Director of Nursing  
Chief Financial Officer  
Nursing Supervisor (non-business hours)  
Safety Officer  
Security  
Charge Nurses, other departments (e.g., housekeeping engineering, maintenance/other depts. and directors and supervisors as conditions warrant  
Local Fire/EMS Resources  
NYCEM (if services, support, or information needed) |
<table>
<thead>
<tr>
<th>Activation Level</th>
<th>Definition/Parameters</th>
<th>Authority to Activate</th>
<th>Anticipated NHICS Activation</th>
<th>Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2 Minor Impact</strong></td>
<td>An actual situation or event that is having a minor unusual impact on facility operations.</td>
<td>Facility Administrator/ Director of Nursing</td>
<td>• Incident Commander&lt;br&gt;• Operations Section Chief&lt;br&gt;• Command Staff as needed&lt;br&gt;• Liaison Officer&lt;br&gt;• Safety Officer&lt;br&gt;• Public Information Officer</td>
<td>• Facility Administrator&lt;br&gt;• Director of Nursing&lt;br&gt;• Chief Financial Officer&lt;br&gt;• Nursing Supervisor (non-business hours)&lt;br&gt;• Safety Officer&lt;br&gt;• Security&lt;br&gt;• Charge Nurses, other departments (e.g., housekeeping engineering, maintenance/&lt;br&gt;• Local Fire/EMS Resources&lt;br&gt;• NYCEM (if services, support, or information needed)</td>
</tr>
<tr>
<td><strong>Resident Factors</strong></td>
<td>Residents from single event (external or internal) 3 residents requiring EMS transportation and hospital emergency department services</td>
<td>Nursing Supervisor (off-hours) (becomes Incident Commander)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Logistical Factors</strong></td>
<td>Facilities  Facility or utility disruption that is limited, contained, and/or has a minor impact on operations (e.g., a partial system failure; failure of a non-mission-critical system, information technology (IT) system failure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff 5 percent reduction in staffing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplies/Materiel Actual or projected supply shortage of non-critical items, or 72 hours’ supply remaining of critical items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal occupancy Need for horizontal evacuation of residents/visitors/staff from an area of a building</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Activation Level

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>Definition/Parameters</th>
<th>Authority to Activate</th>
<th>Anticipated NHICS Activation</th>
<th>Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3 Moderate Impact</strong></td>
<td>An actual situation or event that is having a <strong>moderate</strong> unusual impact on facility operations.</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td>Facility Administrator, Director of Nursing, Chief Financial Officer, Nursing Supervisor (non-business hours), Safety Officer, Security, Charge Nurses other departments (e.g., housekeeping, engineering, maintenance/Local Fire/EMS Resources, NYCEM (if services, support, or information needed))</td>
</tr>
<tr>
<td></td>
<td>Residents from single event (external or internal)</td>
<td>Nursing Supervisor (off-hours) (becomes Incident Commander)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 residents requiring EMS transportation and hospital emergency department services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Resident Factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility or utility disruption affecting a major or mission-critical area or system, or affecting general operations</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Any change in staffing that requires the cancellation of 1 service and/or core support services (e.g. Meal Services, Nursing Services)</td>
<td>Nursing Supervisor (off-hours) (becomes Incident Commander)</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplies/Materiel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual or projected supply shortage of critical items, or 48 hours’ supply remaining of critical items</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal occupancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need for horizontal evacuation of residents/visitors/staff from area of building</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Event duration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 2 event lasting greater than 8 hours</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed</td>
<td></td>
</tr>
<tr>
<td>Activation Level</td>
<td>Definition/Parameters</td>
<td>Authority to Activate</td>
<td>Anticipated NHICS Activation</td>
<td>Notifications</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
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<td>-----------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Major Impact</td>
<td>An actual situation or event that is having a major unusual impact on facility operations.</td>
<td>Facility Administrator/Director of Nursing</td>
<td>Incident Commander, Operations Section Chief, Command Staff as needed, Liaison Officer, Safety Officer, Public Information Officer</td>
<td>Facility Administrator, Director of Nursing, Chief Financial Officer, Nursing Supervisor (non-business hours), Safety Officer, Security, Charge Nurses other departments (e.g., housekeeping engineering, maintenance/Local Fire/EMS Resources, NYCEM (if services, support, or information needed))</td>
</tr>
<tr>
<td></td>
<td>Residents from single event (external or internal) More than 7 residents requiring EMS transportation and hospital emergency department services</td>
<td>Incident Commander (off-hours) (becomes Incident Commander)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Logistical Factors</td>
<td>Staff</td>
<td>Facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilities</td>
<td>Staff</td>
<td>Internal occupancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplies/Materiael</td>
<td>Internal occupancy</td>
<td>Complete evacuation of a resident care unit or area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Event duration</td>
<td>Event duration</td>
<td>Level 3 event lasting greater than 24 hours</td>
<td></td>
</tr>
</tbody>
</table>
Within the Incident Management Team chart, positions are demonstrated for optimal staffing. When positions cannot be activated due to staffing, the roles and responsibilities are rolled into the highest position activated. For example, if the position of Liaison Officer cannot be activated, the tasks for that position become the responsibility of the Incident Commander.

33 **APPENDIX D. NHICS INCIDENT MANAGEMENT TEAM CHARTS**
## APPENDIX E. NHICS ORDER OF SUCCESSION MATRIX

<table>
<thead>
<tr>
<th>NHICS Position</th>
<th>Essential Mission</th>
<th>First Tier 14 Hour Shift</th>
<th>Second Tier 14 Hour Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCIDENT COMMANDER</td>
<td>Organize and direct the Facility Command Center (FCC). Give overall strategic direction for incident management and support activities, including emergency response and recovery. Authorize total facility evacuation if warranted.</td>
<td>Administrator</td>
<td>Director of Nursing/Nurse Supervisor</td>
</tr>
<tr>
<td>Safety Officer</td>
<td>Ensure safety of staff, residents, and visitors; monitor and correct hazardous conditions. Have authority to halt any operation that poses immediate threat to life and health.</td>
<td>Director of Facilities Management</td>
<td>Maintenance Supervisor</td>
</tr>
<tr>
<td>Liaison Officer</td>
<td>Function as the incident contact person in the facility for representatives from other agencies such as local emergency management, law enforcement, licensing agencies.</td>
<td>HR Director</td>
<td>Administrator</td>
</tr>
<tr>
<td>Public Information Officer</td>
<td>Serve as the conduit for information to residents, staff, visitors and families, and to the news media, as approved by the Incident Commander.</td>
<td>HR Director</td>
<td>POCR</td>
</tr>
<tr>
<td>Medical Director / Technical Specialist(s):</td>
<td>Consult with the Incident Commander and/or Operations Section Chief on the medical, biological/infectious, and/or hazmat implications related to the event. Oversee medical services and assist with diagnosis, treatment, and medical management of residents and injured staff as needed.</td>
<td>Medical Director</td>
<td>Doctor On Call</td>
</tr>
<tr>
<td>NHICS Position</td>
<td>Essential Mission</td>
<td>First Tier 14 Hour Shift</td>
<td>Second Tier 14 Hour Shift</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>LOGISTICS SECTION CHIEF</strong></td>
<td>Organize and direct those operations associated with maintenance of the physical environment and adequate levels of personnel, food, equipment, and supplies to support the incident activities. Oversee the deployment of supplementary resources. Participate in Incident Action Planning process.</td>
<td>Food &amp; Nutrition</td>
<td>Housekeeping</td>
</tr>
<tr>
<td><strong>Service Branch Director</strong></td>
<td>Organize and manage the services required to maintain the facility’s communication system and information technology/systems. Ensure critical business functions are maintained or restored as quickly as possible. Participate in developing facility’s Incident Action Plan.</td>
<td>IT Director</td>
<td>POCR</td>
</tr>
<tr>
<td><strong>Communication Hardware Unit Leader</strong></td>
<td>Organize and coordinate internal and external communications connectivity. Supervise communication personnel.</td>
<td>IT Staff</td>
<td>POCR</td>
</tr>
<tr>
<td><strong>Information Technology /Information Services Unit Leader</strong></td>
<td>Ensure that critical clinical and business data is maintained, restored, or augmented to meet response and recovery needs. Provide computer hardware, software, and infrastructure support to staff.</td>
<td>IT Staff</td>
<td>POCR</td>
</tr>
<tr>
<td><strong>Support Branch Director</strong></td>
<td>Organize and maintain the facility’s supplies, equipment, transportation, and labor pool in support of resident care and services. Ensure the provision of support services to staff and dependents in accordance with facility policy.</td>
<td>Nursing Administration Staff</td>
<td>POCR</td>
</tr>
</tbody>
</table>
### NHICS Order of Succession Matrix

<table>
<thead>
<tr>
<th>NHICS Position</th>
<th>Essential Mission</th>
<th>First Tier 14 Hour Shift</th>
<th>Second Tier 14 Hour Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply Unit Leader</td>
<td>Organize, manage, and support building systems, equipment, and supplies. Ensure proper cleaning and disinfection of nursing home environment. Acquire, inventory, and provide medical and non-medical care equipment and supplies.</td>
<td>Director of Housekeeping</td>
<td>POCR</td>
</tr>
<tr>
<td>Transportation Unit Leader</td>
<td>Organize and coordinate the transportation of all ambulatory and non-ambulatory residents within or outside the facility. Arrange for the transportation of residents, personnel, and material resources within or outside the facility.</td>
<td>Transportation Coordinator</td>
<td>POCR</td>
</tr>
<tr>
<td>Staffing/Scheduling Unit Leader</td>
<td>Maintain and coordinate adequate numbers of both medical and non-medical personnel and volunteers. Assist in the maintenance of staff sheltering and physical well-being. Assist with screening of volunteers as required.</td>
<td>Nursing Administration Staff</td>
<td>HR DIrector</td>
</tr>
<tr>
<td>PLANNING SECTION CHIEF</td>
<td>Oversee all incident- related data gathering and analysis regarding incident operations and assigned resources. Develop projections to inform long range planning, conduct planning meetings, and prepare the Incident Action Plan (IAP) for each operational period.</td>
<td>Director of Nursing</td>
<td>POCR</td>
</tr>
<tr>
<td>Situation Unit Leader</td>
<td>Collect, process, and organize ongoing situation information; prepare situation summaries; and develop projections and forecasts of future events related to the incident. Prepare maps and gather and disseminate information and intelligence for use in the Incident Action Plan (IAP).</td>
<td>Nursing Administration Staff</td>
<td>POCR</td>
</tr>
<tr>
<td>NHICS Position</td>
<td>Essential Mission</td>
<td>First Tier 14 Hour Shift</td>
<td>Second Tier 14 Hour Shift</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>-------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Documentation Unit Leader</td>
<td>Collect, process, and maintain accurate and complete incident files, including a record of the facility's response and recovery actions and decisions and key communications. File, maintain, and store incident files for legal, analytical, and historical purposes.</td>
<td>Nursing Administration Staff</td>
<td>POCR</td>
</tr>
<tr>
<td>FINANCE/ADMINISTRATION SECTION CHIEF</td>
<td>Monitor the utilization of financial assets and the accounting for financial expenditures. Supervise the documentation of expenditures and cost reimbursement activities. Ensure thorough investigation and documentation of incident-related claims, and the screening of volunteers. Contribute to the Incident Action Plan.</td>
<td>Director of Finance</td>
<td>Finance Department</td>
</tr>
<tr>
<td>Time Unit Leader</td>
<td>Document personnel time records, monitor, and report on regular and overtime hours worked/volunteered. Assist in the screening of volunteers and/or newly recruited staff.</td>
<td>Nursing Administration Staff / HR</td>
<td>POCR</td>
</tr>
<tr>
<td>Procurement/Claims Unit Leader</td>
<td>Provide cost analysis data for the declared emergency incident and maintain accurate records of incident cost. Responsible for administering accounts receivable and payable to contract and non-contract vendors. Responsible for receiving, investigating, and documenting all claims reported to have occurred on facility property during the emergency incident.</td>
<td>Assistant Director of Finance</td>
<td>POCR</td>
</tr>
<tr>
<td>OPERATIONS SECTION CHIEF</td>
<td>Develop and implement strategy and operations to carry out the objectives established by the Incident Commander. Oversee the direct implementation of resident care, and medical, dietary, and environmental services.</td>
<td>Director of Nursing</td>
<td>Nurse Supervisor</td>
</tr>
<tr>
<td>NHICS Position</td>
<td>Essential Mission</td>
<td>First Tier 14 Hour Shift</td>
<td>Second Tier 14 Hour Shift</td>
</tr>
<tr>
<td>-------------------------</td>
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<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Resident Services</td>
<td>Coordinate and supervise all aspects of resident care and services including nursing services, psychosocial care, dietary services, and movement into and out of the facility.</td>
<td>Medical Director</td>
<td>ADNS</td>
</tr>
<tr>
<td>Branch Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admit/Transfer &amp;</td>
<td>Organize and direct resident admissions, transfers, and discharges according to facility policies and procedures. Implement and monitor the facility’s resident identification and tracking system for both incoming residents or for facility residents evacuating to an onsite destination.</td>
<td>Director of Admissions / Social Services</td>
<td>Admissions</td>
</tr>
<tr>
<td>Discharge Unit Leader</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Unit Leader</td>
<td>Organize and direct nursing services, including management of incident-related trauma and special needs as well as routine nursing care. Organize and direct activities of daily living for residents. Evaluate personnel, medical supplies, and equipment to necessary to support resident care. Coordinate and supervise direct care staff.</td>
<td>Director of Nursing/Assistant Director of Nursing</td>
<td>POCR</td>
</tr>
<tr>
<td>Psychosocial Unit</td>
<td>Organize and direct, and supervise those services associated with the social and psychological needs of the residents, staff, and dependents. Supervise the provision and conservation of ancillary services (e.g. therapies).</td>
<td>Director of Social Services</td>
<td>POCR</td>
</tr>
<tr>
<td>Leader</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NHICS Position | Essential Mission | First Tier 14 Hour Shift | Second Tier 14 Hour Shift
--- | --- | --- | ---
**Infrastructure Branch Director** | Organize and manage the services required to sustain and repair the facility’s infrastructure operations including power/lighting, water/sewer, HVAC, buildings and grounds, medical gases, medical devices, structural integrity, environmental services, and food services. | Director of Facilities Management | POCR

**Dietary Unit Leader** | Organize, provide, and safeguard food and water stores to allow for the facility’s self-sufficiency for at least one week. Implement the facility’s emergency menu. Provide Incident Command with inventory levels and projected needs. Supervise dietary personnel. | Director of Food & Nutrition | POCR

**Environmental Unit Leader** | Ensure proper cleaning and disinfection of nursing home environment. Supervise housekeeping activities and laundry department. | Director of Housekeeping | POCR

**Physical Plant/Security Unit Leader** | Evaluate, organize, and manage the critical services required to sustain and repair the facility’s buildings and grounds including power, lighting, water, and waste disposal. Evaluate, organize, and manage the activities related to facility security such as access control, crowd and traffic control, and law enforcement interface. | Director of Facilities Management | POCR
### APPENDIX F. NHICS INCIDENT FACILITIES / DESIGNATED AREAS MATRIX

<table>
<thead>
<tr>
<th>Incident Facility</th>
<th>Mission</th>
<th>Responsible Officer</th>
<th>Pre-planned Location</th>
<th>Room Name/Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Command Center (FCC)</td>
<td>Command and control point for overall incident management. Location of incident commander, command staff, and section chiefs.</td>
<td>Incident Commander</td>
<td>Administration Office</td>
<td>1102</td>
</tr>
<tr>
<td>Media Briefing Area</td>
<td>Briefing area for media</td>
<td>Public Information Officer</td>
<td>Front Entrance</td>
<td></td>
</tr>
<tr>
<td>Security Command Post</td>
<td>Command and control point for on-site direction of security and law-enforcement related activities</td>
<td>Director of Facilities Management</td>
<td>Front Desk</td>
<td>0</td>
</tr>
<tr>
<td>Mass Dispensing Clinic or Point of Dispensing (POD)</td>
<td>A designated area to distribute medications and vaccinations and provide risk communication and public education information during a public health emergency</td>
<td>Director of Nursing/Assistant Director of Nursing/Nursing Manager/Nursing Supervisor POD Branch Director</td>
<td>In-Service Room</td>
<td>1156</td>
</tr>
<tr>
<td>Resident Information Area</td>
<td>Briefing area for visitors and families regarding status and location of residents</td>
<td>Director of Social Services</td>
<td>OT Suite</td>
<td></td>
</tr>
<tr>
<td>Family Waiting Area</td>
<td>Location for resident family members to await information</td>
<td>Director of Social Services</td>
<td>OT Suite</td>
<td></td>
</tr>
<tr>
<td>Family Support Center</td>
<td>Location for staff support activities</td>
<td>Psychosocial Unit Leader</td>
<td>Social Service Office</td>
<td>1160</td>
</tr>
<tr>
<td>Incident Facility</td>
<td>Mission</td>
<td>Responsible Officer</td>
<td>Pre-planned Location</td>
<td>Room Name/Telephone</td>
</tr>
<tr>
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</tr>
<tr>
<td>Labor Pool &amp; Credentialing Area</td>
<td>Mobilization point and credentialing area for medical and non-medical personnel and volunteers</td>
<td>Administration Staff</td>
<td>Reception Area</td>
<td>1124</td>
</tr>
<tr>
<td>Ambulance Loading Area</td>
<td>Loading point for residents being discharged out of the facility</td>
<td>Transportation Unit Leader</td>
<td>Loading Dock Area</td>
<td>1001</td>
</tr>
<tr>
<td>Ambulance Off-Loading Area</td>
<td>Off-loading point for residents arriving at the facility by ambulance</td>
<td>Transportation Unit Leader</td>
<td>Loading Dock Area</td>
<td>1001</td>
</tr>
<tr>
<td>Discharge Area</td>
<td>Mobilization and control area for residents being discharged</td>
<td>Admit/Transfer &amp; Discharge Unit Leader</td>
<td>Loading Dock Area</td>
<td>1001</td>
</tr>
<tr>
<td>Staff Information Center</td>
<td>Emergency information update/rumor control center for staff</td>
<td>Public Information Officer</td>
<td>Administration Offices</td>
<td>1102</td>
</tr>
<tr>
<td>Staff Rest and Nutrition Area</td>
<td>Calm, relaxing environment for staff support and nutrition</td>
<td>Dietary Unit Leader</td>
<td>Employee Lounge</td>
<td></td>
</tr>
<tr>
<td>Debriefing Area</td>
<td>Location for critical incident stress debriefings for staff</td>
<td>Psychosocial Unit Leader</td>
<td>Social Services Office</td>
<td>1160</td>
</tr>
<tr>
<td>Dependent Care Area</td>
<td>Location for sheltering and feeding staff and volunteer dependents</td>
<td>Dietary Unit Leader</td>
<td>Break-Out Room</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX G. AIRBORNE INFECTIOUS ISOLATION ROOM (AIIR) MATRIX – FOR FUTURE USE

<table>
<thead>
<tr>
<th>Unit</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 2</td>
<td>203, 212, 215, 217, 225</td>
</tr>
<tr>
<td>Unit 3</td>
<td>303, 312, 315, 317, 325</td>
</tr>
<tr>
<td>Unit 4</td>
<td>403, 412, 415, 417, 425</td>
</tr>
<tr>
<td>Unit 5</td>
<td>503, 512, 515, 517, 525</td>
</tr>
<tr>
<td>Unit 6</td>
<td>603, 612, 615, 617, 625</td>
</tr>
</tbody>
</table>
37 APPENDIX H. EMERGENCY RESPONSE RESOURCE INVENTORY

37.1 Medical Supplies
Including, but not limited to: intravenous (IV) administration devices, airway maintenance and oxygen administration supplies, incontinence products, alcohol-based hand sanitizer, and medical and surgical supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

37.2 Medical Equipment
Including, but not limited to: ventilators (adult, pediatric, transport, other); intravenous pumps; IV poles; oxygen cylinders and regulators; cardiac monitors; portable suction units; beds; stretchers; wheelchairs

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Poles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Equipment Room on each unit</td>
<td></td>
</tr>
<tr>
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</tbody>
</table>
37.3 Pharmaceutical Supplies
Including, but not limited to: analgesics, antibiotics, antiemetics, antipsychotics, antitoxins, anxiolytics, chemical antidotes, intubation medications, IV fluids, life-support medications, narcotics; ocular medications, respiratory medications, and vaccines

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
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<tbody>
<tr>
<td>IV Solution</td>
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</tbody>
</table>

37.4 Food and Potable Water
Including, but not limited to: variety of non-perishable food and supplies, that represents a good diet; meals-ready-to-eat (MRE); enteral supplies for those residents requiring enteral and/or parenteral feeding; one (1) gallon of water per person per day for residents and staff; disposable, single service or single use articles for food and beverage service

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
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</tbody>
</table>

11 List of commonly used medications during disasters:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062753/table/tab1/
### 37.5 Power Failure Supplies

Including, but not limited to: flashlights, batteries, chemical lightsticks; headlamps; uninterruptible power supplies; phone charging stations; emergency telephones; electrical extension cords; alternate sources of energy (e.g., generators and fuel sources).

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
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</tbody>
</table>

### 37.6 Communications Equipment

Including, but not limited to: plug-in phones for POTS\textsuperscript{12} lines; radios for external contact (e.g., NYCEM 700 MHz radio); internal portable radios and chargers/spare batteries; cellular phones with text messaging capability; portable phone chargers and cords (including car chargers); bulletin and marker boards; battery-powered commercial radio and television.

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
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</tbody>
</table>

\textsuperscript{12} Plain old telephone service (POTS) refers to voice-grade telephone service employing analog signal transmission over copper wires that connect directly to the main telephone network.
37.7 Bedding and Linen Supply
Including, but not limited to: cots, blankets, mattresses, sheets, pillow cases, towels, wash cloths

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Towels</td>
<td>CleanTek</td>
<td>1200</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
<tr>
<td>Sheets</td>
<td>CleanTek</td>
<td>600</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
<tr>
<td>Pillow Cases</td>
<td>CleanTek</td>
<td>200</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
<tr>
<td>Fitted Sheets</td>
<td>CleanTek</td>
<td>60</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
<tr>
<td>Gowns</td>
<td>CleanTek</td>
<td>300</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
<tr>
<td>Blankets</td>
<td>CleanTek</td>
<td>60</td>
<td></td>
<td>Storage Room</td>
<td></td>
</tr>
</tbody>
</table>

37.8 Personal Protective Equipment Supply
Including, but not limited to: respirator (e.g., N95) masks; surgical masks; gloves; disposable gowns, hoods, and booties; face shields; eye protection

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
</tr>
</thead>
</table>

37.9 Other Emergency Resources
Including, but not limited to: board-up equipment; cash; cleaning equipment and supplies; duct tape; hand tools; hoses; lab supplies; plastic sheeting; pumps; toiletries/comfort kits

<table>
<thead>
<tr>
<th>Item</th>
<th>Primary Vendor</th>
<th>Backup Vendor</th>
<th>Par Level</th>
<th>On Hand</th>
<th>Storage Location</th>
<th>Access / Key #</th>
</tr>
</thead>
</table>
Policy Name: 24. Emergency Response Resource Inventory
Issue Date: 12.24.18
Revision Date: 
Reference: CPG 101 | CMS §483.73 (b)(1) | NYSDOH DAL 05-11 | TJC EM.02.02.03
### APPENDIX I. UTILITY-SPECIFIC SYSTEM FAILURE RESPONSE

<table>
<thead>
<tr>
<th>System Failure</th>
<th>Impact</th>
<th>Contingency Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooling Tower</td>
<td>Loss of air conditioning to affected area(s). IT services may be affected.</td>
<td>Move residents to zone in which cooling is still available and emergency doors between zones will be closed. Cold fluids will be available to all residents and staff.</td>
</tr>
<tr>
<td>Electrical Power, utility-supplied</td>
<td>Loss of electricity to affected areas</td>
<td>Emergency generator backup supports all essential systems</td>
</tr>
<tr>
<td>Elevators</td>
<td>Inability of non-ambulatory persons to move between floors without assistance</td>
<td>Use alternate elevator bank; use stairs. Deploy evacuation devices if movement of wheelchair or non-ambulatory residents is essential.</td>
</tr>
<tr>
<td>Electronic medical record (EMR) system</td>
<td>Inability to enter or view data on EMR</td>
<td>Access backup internal EMR (SigmaSafe)</td>
</tr>
<tr>
<td>Emergency Generator Power</td>
<td>Loss of backup electrical power capability</td>
<td>Portable generators brought in by OEM</td>
</tr>
<tr>
<td>Fire sprinkler system</td>
<td>Loss of automatic fire suppression capability</td>
<td>Notify fire alarm central monitoring station. Establish fire watch; each area of building must be visibly observed by a fire watch monitor once per hour.</td>
</tr>
<tr>
<td>Fire/smoke/carbon monoxide detection and alarm system</td>
<td>Loss of automatic fire/smoke/carbon monoxide detection capability</td>
<td>Notify fire alarm central monitoring station. Establish fire watch; each area of building must be visibly observed by a fire watch monitor once per hour.</td>
</tr>
<tr>
<td>HVAC/major air handler system failure</td>
<td>Loss of HVAC circulation / ventilation</td>
<td>Portable air handler brought in from outside service provider. Distribute fans to key areas. Establish cohorted warming/cooling areas as needed.</td>
</tr>
<tr>
<td>Natural gas, utility-supplied</td>
<td>Loss of all heat and hot water</td>
<td>Response is determined by external temperature and length of incident. In event that temperature isn’t life threatening, blankets will be supplied and all residents will be dressed appropriately. If temperature drops below life threatening levels, residents will be evacuated. In case of loss of hot water, sanitary wipes will be used.</td>
</tr>
<tr>
<td>Sewage system</td>
<td>All systems requiring sewage flow would be compromised</td>
<td>Reduce non-essential water use. Line toilets with disposable plastic liners for waste collection; establish contingency waste handling procedures for timely collection and storage of waste bags.</td>
</tr>
<tr>
<td>Telephone switch</td>
<td>No access to outside lines or emergency 911</td>
<td>Portable radios are in key areas and to be used. Authorize use of cell phones for facility communication and emergency calls.</td>
</tr>
<tr>
<td>Water [Pressure], utility-supplied</td>
<td>Loss of potable, non-potable, and fire sprinkler system water</td>
<td>Water trucked in from outside service provider (tankers for non-potable water; bottled water for potable water distribution). Distribute water drums to floors with buckets for toilet-flushing process. Establish fire watch.</td>
</tr>
</tbody>
</table>
39 APPENDIX J. NURSING HOME INCIDENT COMMAND SYSTEM (NHICS) OVERVIEW

39.1 Introduction

Every significant incident or event, whether large or small, and whether it is defined as an emergency, requires certain management functions to be performed. The Nursing Home Incident Command System (NHICS) is intended to be used by nursing homes and other long-term care facilities regardless of size or resident care capabilities, and to assist with their emergency planning and response efforts for all hazards. By embracing the concepts of incident command design outlined in NHICS, a nursing home is positioned to be consistent with NIMS and to participate in a system that promotes national standardization in terminology, response concepts, and procedures.

It is important to understand that ICS is a management system, not an organizational chart. It is predicated on a number of principal tenets:

- Every incident or event requires that certain management functions be performed. The problem encountered is evaluated, a plan to remedy the problem is identified and implemented, and the necessary resources assigned. Management by Objectives (MBO) is thus a critically important component to the successful implementation of an incident command system and involves the inclusion of both control and operational period objectives.

- The ICS organization frequently does not correlate to the daily administrative structure of the agency or nursing home. This practice is purposeful and done to reduce role and title confusion. Those positions activated in the response come together to serve as the Incident Management Team (IMT), whose purpose is to respond to and recover from the event through coordinated objectives and tactics.

- Position titles within the IMT should remain unchanged; this promotes interoperability between response partners, allowing for sharing of personnel resources among organizations.

- The IMT structure consists of the command, general, branch and unit staff, with sections clearly identified by the roles and responsibilities they carry out.
  - The Incident Commander is the only position always activated in an incident regardless of its nature. In addition to Command, which sets the objectives, devises strategies and priorities, and maintains overall responsibility for managing the incident, there are four other management functions.

o Operations conducts the tactical operations (e.g., resident services, cleanup) to carry out the plan using defined objectives and directing all needed resources.

o Planning collects and evaluates information for decision support, maintains resource status information, prepares documents such as the Incident Action Plan, and maintains documentation for incident reports.

o Logistics provides support, resources, and other essential services to meet the operational objectives set by Incident Commander.

o Finance monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

On small-scale incidents, the Incident Commander may be able to accomplish all five management functions alone, but on larger incidents effective management may require that the Incident Commander establish one or more of the four other functions and appoint Section Chiefs.

39.2 Building the IMT

The development of the IMT is based on the essential elements of ICS. The system is scalable and flexible, and uses a modular organization to respond to the event. As previously stated, the Incident Commander is the only position that is always activated. Activating additional positions is considered when the event duration increases, when situational information provides insight on the possible impact to the facility and when the span of control is exceeded.

Management tools have been developed to help determine the need for activating additional positions; these tools (Job Action Sheets, Forms, and Incident Response Guides) should be customized by individual facilities based on their staffing and possible response actions.

Position titles within the IMT define the role and the tasks assigned to that role. Titles identify the hierarchy within the chain of command. These titles include:

- **Commander**: there is only one commander position during the incident response, this being the Incident Commander
- **Officers**: officers are part of the command section. In NHICS, the officer roles are the Liaison Officer, Public Information Officer, Medical Director/Specialist and Safety Officer. Each of these positions reports directly to the Incident Commander.
- **Chiefs**: oversight for the section is provided by a Section Chief
- **Directors**: branches may be activated under the sections to maintain the chain of command and provide specific duties and actions as identified by the position title. For example, within the Operations Section, there is a Resident Services Branch and an Infrastructure Branch, with oversight provided by Directors.
### Leaders

Units may be activated within a branch when there is a specialized but complex set of duties that relate to a specific assignment. The person assuming responsibility for a Unit is a Leader.

#### 39.3 NHICS Responsibilities

The NHICS incident management team chart (See Appendix D) illustrates how authority and responsibility is laid out during an activation of the emergency plan. In traditional Incident Command, there are five sections: Command, Operations, Planning, Logistics, and Finance/Administration. The Incident Commander position is the only one that is always activated in an emergency and in small scale incidents, the Incident Commander may be able to accomplish all five management functions without the activation of additional positions. For large incidents, additional positions may be activated, with the overall goal to maintain the span of control and meet the needs of the facility based on the available resources. An important feature of the incident command system is its scalability. NHICS positions are assigned to personnel as indicated by the situation, and may be activated or deactivated as the incident unfolds and the needs change or become more clearly defined.
The Job Action Sheets, or job descriptions/checklists, found on the following pages are a key feature of the NHICS program. NHICS positions, and their corresponding Job Action Sheets, are assigned to personnel based on the objectives to be met for each specific incident. The job action sheet is designed to enable an individual with no previous background or experience in a function to carry out its leadership role. This is done through a clear, concise statement of the purpose of the position, and a prioritized list of the tasks to be accomplished. The job titles noted on the job action sheets correspond to those designated on the NHICS Table of Organization and in the Order of Succession matrix.

Each job action sheet contains the following information for the position:

<table>
<thead>
<tr>
<th>Section</th>
<th>Intent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>The purpose of the position</td>
</tr>
<tr>
<td>Position Reports To</td>
<td>The name and title of the position’s superior in the NHICS Table of Organization</td>
</tr>
<tr>
<td>FCC Location</td>
<td>The location and telephone number of the superior’s operations center or contact point</td>
</tr>
<tr>
<td>Immediate</td>
<td>Tasks to be carried out during the first two hours of the incident, or at the earliest possible opportunity</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Tasks to be carried out once the “immediate” tasks are completed or underway, or during hours 2-12 of the incident</td>
</tr>
<tr>
<td>Extended</td>
<td>Tasks to be carried out later in the operational period, or during the operational period beyond 12 hours</td>
</tr>
<tr>
<td>Demobilization/ System Recovery</td>
<td>Tasks to be carried out once incident operations have concluded, as demobilization progresses</td>
</tr>
</tbody>
</table>
APPENDIX L. EOP FORMS (BLUE PAGES)

NHICS Forms

NHICS forms are simple, self-explanatory forms not dependent on technology that are used to support NHICS position assignments. Although documentation is often perceived as a burdensome activity, it is through accurate record keeping that an event can be reconstructed so those lessons may be learned. Comprehensive documentation is also essential to enable the organization to track residents and care provided, monitor performance improvement and risk management issues, maintain business continuity, and pursue financial reimbursement after the incident.

<table>
<thead>
<tr>
<th>Form #</th>
<th>Form Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHICS 201</td>
<td>Incident Briefing and Operational Log</td>
<td>Document initial response information and actions taken at startup</td>
</tr>
<tr>
<td>NHICS 202</td>
<td>Incident Objectives</td>
<td>Define objectives and issues for operational period</td>
</tr>
<tr>
<td>NHICS 203</td>
<td>Organization Assignment List</td>
<td>Document staffing</td>
</tr>
<tr>
<td>NHICS 205</td>
<td>Incident Communication Plan</td>
<td>Document the internal/external communications equipment/channels to be used within the facility</td>
</tr>
<tr>
<td>NHICS 206</td>
<td>Staff Injury Plan</td>
<td>Outline resources for medical care of injured/ill facility personnel</td>
</tr>
<tr>
<td>NHICS 207</td>
<td>Organizational Chart</td>
<td>Document NHICS positions assigned</td>
</tr>
<tr>
<td>NHICS 213</td>
<td>Incident Message Form</td>
<td>Tracks key messages and information flow throughout the NHICS organization</td>
</tr>
<tr>
<td>NHICS 251</td>
<td>Facility System Status Report</td>
<td>Tracks operational status of physical plant, equipment, and systems</td>
</tr>
<tr>
<td>NHICS 252</td>
<td>Section Personnel Time Sheets</td>
<td>Tracking attendance, timekeeping, and overtime by staff and volunteers</td>
</tr>
<tr>
<td>NHICS 253</td>
<td>Volunteer Staff Registration</td>
<td>Documents identification, timekeeping, and tracking of volunteers</td>
</tr>
<tr>
<td>NHICS 254</td>
<td>Master Emergency Admit Tracking Form</td>
<td>Tracks resident identification and physical location</td>
</tr>
</tbody>
</table>
### EOP Forms

<table>
<thead>
<tr>
<th>Form #</th>
<th>Form Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHICS 255</td>
<td>Master Resident Evacuation Tracking Form</td>
<td>Record information concerning resident disposition during a facility/facility evacuation</td>
</tr>
<tr>
<td>NHICS 256</td>
<td>Procurement Summary Report</td>
<td>Tracks goods and services ordered and acquired, and their costs</td>
</tr>
<tr>
<td>NHICS 257</td>
<td>Resource Accounting Record</td>
<td>Records utilization and disposition of items/products</td>
</tr>
<tr>
<td>NHICS 258</td>
<td>Facility Resource Directory</td>
<td>List resources to contact as needed and maintain contact information</td>
</tr>
<tr>
<td>NHICS 259</td>
<td>Master Facility Casualty/Fatality Report</td>
<td>Document the number of injuries and fatalities</td>
</tr>
<tr>
<td>NHICS 260</td>
<td>Resident Evacuation Tracking Form</td>
<td>Document details and account for residents transferred to another facility</td>
</tr>
<tr>
<td>NHICS 261</td>
<td>Incident Action Plan Safety Analysis</td>
<td>Document hazards and define mitigation</td>
</tr>
</tbody>
</table>


#### 41.2 Facility Forms

RRECC has developed several additional forms for use in implementing the EOP. The following is an indexing of facility-specific additional forms and those positions intended to use them:

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Purpose of Form/Content</th>
<th>Prepared By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Emergency Operations Plan Form (DEOP)</td>
<td>Department specific, identifies mission and function of department. Initial department functions based on EOP level. Non-essential functions. Staffing, evacuation and fire plan.</td>
<td>Prepared by senior staff member in charge, reviewed annually. Available and displayed on wall of every department</td>
</tr>
<tr>
<td>Status Report Form (STATREP)</td>
<td>Staff and type available. Available beds, technology and resources available and possible problems</td>
<td>Prepared by senior staff member in charge within 15 minutes of EOP activation, and periodically thereafter</td>
</tr>
</tbody>
</table>
# 42 INCIDENT RESPONSE GUIDES / CRITICAL EVENT ANNEXES (for insertion or future development)

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>42.1 All-Hazards Advance Preparations Checklist</td>
<td>This checklist incorporates the content of the Advance Preparations section of the CEMP into a tool for use in advance of an anticipated threat/incident.</td>
</tr>
<tr>
<td>2.0</td>
<td>42.2 Severe Weather / Natural Emergencies</td>
<td>Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for severe weather and nature-caused emergencies, including those related to temperature extremes, wind, precipitation, flooding, and earthquake.</td>
</tr>
<tr>
<td>3.0</td>
<td>42.3 Multiple Casualty Incident (MCI) / Patient or Resident Influx</td>
<td>Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for managing a mass casualty influx, regardless of cause. Includes the facility’s surge plan.</td>
</tr>
<tr>
<td>4.0</td>
<td>42.4 Mass Fatality Management Annex</td>
<td>Annex sets forth the facility’s preparedness, response, and recovery activities related to mass fatalities.</td>
</tr>
<tr>
<td>5.0</td>
<td>42.5 Alternate Care Site Operations</td>
<td>Annex sets forth the selection, activation, operation, and demobilization of an external alternate care site.</td>
</tr>
<tr>
<td>Number</td>
<td>Title</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 6.0    | Hazardous Materials Incident (Chemical-Radiological-Nuclear; External) | • Emergency Procedures in Chemical Hazard Emergencies: Rapid Reference  
• Appendix 1. Protocol for Initial Response to Arriving Contaminated Patients  
• Appendix 2. Flow Chart for Management of Arriving Contaminated Patients  
• Appendix 3: Chemical Incidents Including Weapons of Mass Destruction (WMD) Agents  
• Appendix 4: Radiological and Nuclear Incidents  
• Action Guide 1: Contaminated Persons Outside or Enter the Facility -- Directed Self-Decontamination |
| 7.0    | Biological Incident Annex | • Point of Dispensing (POD) Appendix  
• Pandemic Influenza Appendix  
• Alternate Triage Site (ATS) Appendix |
| 8.0    | Response to Fire, Smoke, or Explosion | • Appendix 1. Unit-Specific Instructions for Unaffected Units  
• Appendix 2. Initial Response Flow Chart |
| 9.0    | Facility Evacuation Annex | • Appendix 1. Facility Recovery and Inspection Guidelines  
• Appendix 2. Tools and Matrices |
| 10.0   | Bomb Threat, Explosive, or Suspicious Device [Confidential Distribution] | • Attachment 1. Bomb Threat Response Checklist  
• Attachment 2. Suspicious Package Poster  
• Attachment 3. Bomb Threat Stand-Off Distances  
• Attachment 4. Bomb Search Procedure |
| 11.0   | Biological Agent Threat or Device | Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for biological incidents and emergencies, including biological (e.g., “white >
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<tr>
<td>12.0</td>
<td><strong>42.12 Active Shooter, Barricaded Person, Hostage Situation, or Deadly Weapons</strong> [Confidential Distribution]</td>
<td>Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for an extreme workplace violence situation involving threat or use of deadly physical force.</td>
</tr>
<tr>
<td>13.0</td>
<td><strong>42.13 Security Emergency Response Annex</strong> [Confidential Distribution]</td>
<td>Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for security-related emergencies and EOP-related activities. Elaborates on or corresponds to related content incorporated in the EOP. Does not replace the facility’s security program, policies, or planning activities.</td>
</tr>
<tr>
<td>14.0</td>
<td><strong>42.14 Telecommunications Systems Failure</strong></td>
<td>Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for telecommunications (telephone) system disruption or failure.</td>
</tr>
<tr>
<td>15.0</td>
<td><strong>42.15 Information Technology Systems Failure</strong></td>
<td>Annex sets forth the facility’s operational mitigation, preparedness, response, and recovery activities for information technology (IT) system disruption or failure. It does not replace the need for an IT-based plan for system management and data protection/recovery.</td>
</tr>
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</table>
### Critical Event Annexes

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<th>Number</th>
<th>Title</th>
<th>Description</th>
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| 16.0   | **42.16 Essential Services and Utilities Failure** | - Power Failure/Loss of Electricity  
- Emergency Generator Failure  
- Water Distribution Failure  
  - Potable Water  
  - Non-Potable Water  
- Boiler Failure  
- Plumbing Failure/Emergency Repairs  
- Heating, Ventilation, Air Conditioning System Failure  
- Natural Gas Disruption  
- Fuel Oil Disruption  
- Oxygen System Failure  
- Medical Air and Vacuum System Failure  
- Elevator Failure  
- Fire Alarm System Failure  
- Sewer System Failure  

Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for disruption of a wide range of critical utilities and mechanical systems. |
| 17.0   | **42.1796-Hour Self-Sufficiency Annex** | - Critical Category 1: Communications  
- Critical Category 2: Resources and Assets  
- Critical Category 3: Safety and Security  
- Critical Category 4: Staff Responsibilities  
- Critical Category 5: Utilities Management  
- Critical Category 6: Resident Clinical and Support Activities  

Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities for loss of community support for at least 96 hours. Incorporates tracking of critical inventories and arrangements with vendors. |
| 18.0   | **42.18 Continuity of Operations Annex** | - Mission Critical Systems and Functions  
- Activation and Relocation  
- Leadership Sustainability and Succession  
- Alternate Facility Operations  
- Vital Files, Records, and Databases  
- Devolution  
- Reconstitution  
- Operational Checklists  

Annex sets forth the facility’s mitigation, preparedness, response, and recovery activities to ensure the continuity of mission-essential functions and leadership during a catastrophic disruption. |
| 19.0   | **42.19 Multi-Year Training and Exercise Plan (MYTEP)** | Annex sets forth a supporting training and exercise strategy to the facility CEMP that is consistent with the Homeland Security Exercise and Evaluation Program (HSEEP) and the CMS/State’s requirements. |
43 APPENDIX M.

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<tr>
<th>Policy Name:</th>
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HAZARD ANNEX A: ACTIVE THREAT

An active threat is an individual or group of individuals actively engaged in killing or attempting to kill people in a confined and populated area, often through the use of firearms.

Preparedness

- Conduct a walk-through of the facility to determine vulnerabilities (e.g., publicly accessible entrances), identify emergency escape routes, and determine necessary security measures (e.g., additional locks, cameras).
- Train staff on security-related responsibilities and empower staff to report unusual, dangerous, or suspicious activity.
- Train staff on the “Run, Hide, Fight” options to enable staff to quickly act during a real-world situation.  

Create and implement policies for access control and security:

- Require all persons to display an authorized identification badge or pass.
- Ensure locked doors remain closed and locked.
- Control dissemination of keys and/or keypad code access.

- Identify emergency escape routes for each facility office, which may or may not be the same as normal fire evacuation routes.

- Identify outside gathering areas within a half mile of the facility and communicate location to staff members for staff, residents, and visitors to convene during an active threat, as appropriate.

- Conduct drills with law enforcement officials to familiarize first responders with the facility (e.g., entrances/exits, building layout, notification procedures).

Response

In response to an active threat, each individual (staff, residents, and visitors) will determine the most appropriate response based on their proximity to the threat and their mobility level.

- **RUN**: If it is safe to do so, staff and residents should move as far away from the threat as possible until they are in a safe location.

- **HIDE**: If running is not a safe option—or for residents with mobility options—individuals should hide in as safe a place as possible (e.g., thicker walls, fewer windows, lock or barricade doors).

- **FIGHT**: If neither running nor hiding is a safe option, as a last resort and when confronted by the assailant, individuals in immediate danger should consider trying to disrupt or incapacitate the assailant by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc.

The Regional Office or Watch Center should not be contacted as the event is in progress. All DOH or Watch Center notifications should be done after law enforcement has deemed the situation safe.

The facility will call 9-1-1 if there is a suspected or actual threat to the facility, staff, or residents and will provide as much of the following information as possible:

- Facility name and address;
- Location and number of attacker(s);
- Description of attacker(s), gender, clothing, among other points;
- Number and location of any victims.
- Type(s) of weapons if known.

After notifying authorities of the emergency, the facility will use its notification methods to warn visitors, off-site staff, and others.

The facility will notify residents, visitors, and staff when law enforcement has determined that the threat has been neutralized.
HAZARD ANNEX B:  BLIZZARD/ICE STORM

A blizzard has a wind speed of 35 mph or higher with blowing snow and extremely limited visibility. An ice storm also reduces visibility and can immobilize ground and air transportation leaving a facility isolated. Ice storms include freezing rain and sleet, both of which cause sheets of ice to form on the ground, which can cause falls. Ice may also build on tree limbs, wires, and awnings. Blizzards and ice storms can cause extreme cold and power outages, and impede travel to and from the facility, impacting delivery of vital services and supplies.

### Preparedness

- Procure sufficient rock salt/snow melt to clear primary passageways.
- Monitor weather forecasts via radio and television (e.g., National Weather Service).
- Begin preparations for a blizzard/ice storm as soon as a watch (storm is 36 – 48 hours out) or warning (storm is occurring or will occur in 24 hours) is issued.

### Response

- Ensure all staff and residents remain inside the facility.
- Determine which staff will remain on site for up to 72 hours, as shift changes will not be possible during a blizzard due to blocked roads. Develop and disseminate a schedule to ensure all staff have breaks to rest, eat, and sleep.
- If the heating system fails, prepare to evacuate, if possible. Contact the NYSDOH Regional Office for guidance on whether to evacuate. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template*. 
HAZARD ANNEX C: COASTAL STORMS

Coastal storms may arrive as tropical depressions (maximum sustained winds of 38 mph or less), tropical storms (maximum sustained winds of 39-73 mph), or hurricanes (maximum sustained winds of 74 mph or more, ranging from Category 1-5). Hazards associated with coastal storms include: flooding; flying debris; extreme winds and tornados; torrential rain; and power outages due to downed trees and power lines.

## Preparadness

- Determine which buildings, infrastructure, and essential services would be at risk by flooding.

- Assess potential infrastructure impacts from winds and heavy rains:
  - Assess the ability of facility infrastructure to withstand extreme winds and rain.
  - Consider infrastructure-hardening measures (e.g., impact-resistant windows).

- In the days prior to landfall, review forecast information and intelligence, anticipated impacts, and facility resource levels to determine facility readiness to implement protective actions.

- Maintain communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive storm reports for the area.

- In the absence of direction from NYSDOH and local authorities (e.g., mandatory evacuation order), determine which protective action to implement.

- Implement protective action. Refer to *Error! Reference source not found.* Protective Actions in the Base Plan for more information. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*

- Reassess the situation at regular intervals (e.g., 96 hours, 72 hours, 48 hours, 24 hours) to determine whether additional protective actions are required.

## Response

- Evaluate conditions of staff and residents and identify needs and gaps in services.
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</table>

- [ ] Assess infrastructure damage and continued threats to staff and residents.
- [ ] Report status to external partners (e.g., NYSDOH Regional Office, County Office of Emergency Management) and/or relatives and responsible parties, as appropriate.
HAZARD ANNEX D: DAM FAILURE

The response to a dam failure will depend on the amount of warning time, which will depend on the cause and extent of flooding or primary dam failure. Heavy rains downstream may give a facility time to prepare for a dam failure while intense storms with flash flooding could cause failure within minutes. It is important to respond immediately to any kind of siren/alarm and/or warning coming from dam officials.

Preparedness

☐ Identify dams near the facility.

☐ Work with County Office of Emergency Management officials to identify the best preparedness actions specific to nearby dams.

☐ Identify which facility buildings, infrastructure, and essential services would be in the path of flood waters as the result of a dam failure.

☐ Consider mitigation activities in areas susceptible to water intrusion.

☐ Develop procedures for relocating resources, vital records, and equipment to assure continuation of services and to prevent damage or loss.

Response

☐ If the facility suffers structural damage or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to Error! Reference source not found. Protective Actions in the Base Plan for more information.

☐ Regularly seek updates on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility’s population.

☐ Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.

☐ Gather critical supplies to take to higher ground (e.g., medications, drinking water, health records, important personal items, communication devices, blankets).

☐ Do not allow electrical devices to come into contact with water.

☐ If the decision is made to evacuate, please refer to the NYSDOH Evacuation Plan Template.
## HAZARD ANNEX E: EARTHQUAKE

Earthquakes cannot be predicted and are considered “no-notice” incidents. Hazards associated with earthquakes include: tsunami (flooding); power outages; fires, and landslides.

### Preparedness

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<tbody>
<tr>
<td></td>
<td>Ensure structures are in full compliance with regional building codes.</td>
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<td>Implement earthquake protection measures for utilities:</td>
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<tr>
<td></td>
<td>- Repair defective electrical wiring.</td>
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<td>- Repair leaky gas lines.</td>
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<td>- Install automatic shut off valves triggered by strong vibrations.</td>
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<td>- Repair or replace inflexible utility connections and fittings.</td>
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<td>Protect staff and residents from movable objects:</td>
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<td>- Secure water heaters, refrigerators, furnaces and/or boilers, washing machines and dryers, and other gas appliances.</td>
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<td>- Secure top-heavy items.</td>
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<td>- Store large or heavy items on lower shelves.</td>
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<td>- Secure cabinets.</td>
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<td>- Secure overhead lighting.</td>
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<td></td>
<td>Stage multiple small fire extinguishers throughout the facility and provide training on fire extinguisher use and associated hazards.15</td>
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### Response

**During Earthquake**

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<table>
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<tbody>
<tr>
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<td>Do not attempt to leave the building during an earthquake.</td>
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</table>
|   | Instruct residents in wheelchairs to lock their wheels in a safe position and cover their

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15 29 Code of Federal Regulations, 1910.157(g)(1) states that “Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire-fighting.” Paragraph (g)(2) states that the “education” required in paragraph (g)(1) “must be provided to employees upon initial employment and at least annually thereafter.”
head and neck with their arms if they are able to.

- Instruct residents in beds to remain in their beds.
- Instruct personnel to take cover under a desk, table, in a doorway. Place hands over your head for protection. Stay away from windows, glass, and exterior doors.
- Encourage everyone to remain in place for a few minutes after the initial shock as aftershocks may occur.

### After Earthquake

- Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
- Assign staff to assess residents for any injuries that require immediate attention.
- Assess the facility for damage that requires immediate attention (e.g., gas leaks, fires, broken glass, spills).
- If there is a fire, follow facility protocol.
- If a gas leak is suspected, notify the Plant Manager.
- If electrical system damage is suspected, follow facility protocol.
- If sewage and water line damage is identified, follow facility protocol.
- Comply with public health notices/orders regarding water contamination and utilize emergency potable water resources.
- If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to Error! Reference source not found. Protective Actions in the Base Plan for more information.
- If the decision is made to evacuate, please refer to the NYSDOH Evacuation Plan Template.
- Seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility’s population.
HAZARD ANNEX F: EXTREME COLD

Extreme cold can occur independent of any snow, ice, or storm systems. Extreme cold events involve an extended period with temperatures at or below 32°F. The risk to health and personal safety during extreme cold is exacerbated by utility service interruption or loss. Therefore, the facility maintains its building systems ahead of any extreme weather projections. The facility acknowledges and prepares for the possibility of short staffing due to road conditions.

Preparedness

- Conduct regular building maintenance and inspection, including maintenance of heating and air conditioning systems and thermostats.
- Test all generators involved in supplying power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator for the period of extreme cold.
- Routinely monitor the indoor facility temperature when the outdoor temperature is below 65 degrees Fahrenheit to ensure the indoor temperature in residents’ rooms and all common areas is maintained at a minimum of 75 degrees Fahrenheit.\(^\text{16}\)
- Develop resident assessment protocol, including vital sign checks focusing on core temperature and comfort checks.
- Develop procedures for internal relocation of residents to warmer parts of the facility.
- Document vendors for additional heating units. Establish agreements and/or contracts with vendors, as possible.

\(^{16}\) 10 NYCRR 415.5 and 42 CFR 483.15 The regulations contained in 10NYCRR Part 713 require nursing homes to be equipped with a heating system capable of maintaining all resident areas at a minimum temperature of 75 degrees Fahrenheit.
Response

Conserve heat:
- Avoiding unnecessary opening of doors/windows
- Close off unoccupied rooms
- Cover windows

If the facility experiences heating equipment malfunctions during normal business hours, immediately contact heating equipment service provider and notify the NYSDOH Regional Office. For malfunctions that occur on nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518-292-2200.

If heating equipment has failed, regularly monitor individual room temperatures.

Initiate actions to safely increase resident comfort (e.g., provide additional blankets to residents); offer warm liquids (keeping in mind relevant dietary modifications/restrictions).

Assess residents for signs of distress and/or discomfort.

If the internal temperature of the facility remains low and potentially jeopardizes the safety and health of residents, consider internal relocation to a warmer part of the facility (on sunny side; downwind) or evacuation.

If the decision is made to evacuate, refer to the NYSDOH Evacuation Plan Template.
HAZARD ANNEX G: EXTREME HEAT

Extreme heat events are defined as periods when the heat index is 100°F or higher for one or more days, or when the heat index is 95°F or higher for two or more consecutive days. Prolonged periods of this heat accompanied by high humidity create a dangerous situation for vulnerable populations. Elderly residents and those with chronic medical conditions such as cardiopulmonary conditions, high blood pressure and residents with mental illness are at increased risk for heat exhaustion, heat stroke and heat cramps.

Preparedness

- Regularly inspect the building’s HVAC system.
- Maintain cooling supplies:
  - Portable fans and temporary cooling devices
  - Non-perishable foods and fluids
- Develop procedures to monitor the physical environment of the facility (e.g., temperature, humidity, sun screening, ventilation).
- Develop procedures for relocation to cooling centers inside the facility. Procedures for the internal relocation of residents to air-conditioned, or cooler areas, of the facility.
- Educate staff on risks of extreme heat, including: heat cramp, heat exhaustion, heat stroke, sunburn, and dehydration.
- Develop resident assessment protocol, including vital sign checks focusing on core temperature, comfort checks, and checking for resident dehydration.

Response

- Conduct wellness checks and safety precautions:
  - Check rooms regularly to ensure that air-conditioning is operational.
  - Keep drapes and windows closed.
  - Decrease physical activity for residents.
  - Keep residents inside facility.
Monitor resident exposure and reactions to heat. Follow protocol for transfer to hospital if resident appears to be suffering from heat-related illness such as heat cramps, heat exhaustion, or heat stroke.

Consider re-locating residents to the coolest locations in the facility or creating “cooling centers” where residents can congregate with limited air conditioning, cool cloths, cold beverages, and similar measures.

If the internal temperature of the facility remains high and potentially jeopardizes the safety and health of residents, notify the NYSDOH Regional Office. On nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518-292-2200.

If the decision is made to evacuate, please refer to the NYSDOH Evacuation Plan Template.

Encourage residents to drink fluids to maintain hydration.
HAZARD ANNEX H: FIRE

Fires may occur within the facility or may be a result of external fire activity, including wildfires.

### Preparedness

Identify fire and life safety hazards inside the facility:
- Missing or broken fire safety equipment
- Blocked fire doors and evacuation routes
- Accumulated trash
- Burned out exit lights

Plant Manager will document and inspect facility’s fire and life safety emergency systems, including:
- Manual pull alarms
- Smoke detectors
- Exit doors and stairwells
- Sprinklers System
- Fire extinguishers
- Fire alarm monitoring service
- Self-closing fire doors

Test the facility’s fire alarm system and record outcomes, as required by NYSDOH regulation.

Train all staff on the type of fire extinguishers in the building, their location, how to access them, and the types of fires they should be used on.

Conduct quarterly fire drills at unexpected times, under varying conditions, and on each shift.

### Response
If the fire alarm system is out of service for more than four hours in a 24-hour period, notify the Authority Having Jurisdiction, evacuate the building, or if approved, implement a fire watch until the fire alarm system has been returned to service.

- Rescue those in immediate danger in accordance with the facility’s fire rescue procedures.
- Pull the fire alarm and then alert residents and staff members.
  - Contain the fire if possible.
    - Shut off air flow, as much as possible.
    - Close all fire doors and shut off fans, ventilation systems, and air conditioning/heating systems.
    - Use available fire extinguishers if the fire is small and this can be done safely.
- Relocate oxygen-dependent residents away from fire since oxygen supply lines (whether portable or central) may lead to combustion in the presence of sparks or fire. If necessary, remove oxygen and reconnect one resident in a safe area.
- If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template*. 
HAZARD ANNEX I: FLOOD

Floods may be the result of coastal, lake, river, inland, or indoor flooding.

### Preparedness

Implement indoor flooding protection measures for buildings:
- Repair and replace leaky or broken pipes.
- Perform maintenance inspections on water heaters and washing machines.
- Identify clogged sewer or drain lines and contact plumbing services, as needed.

Determine which buildings, infrastructure, and essential services may be at risk of flooding.

Consider mitigating risks associated with flooding:
- Elevate the furnace, water heater, emergency generator, and electrical panel if susceptible to flooding.
- Install sewer backwater valves to prevent sewer backups.
- Build barriers to prevent floodwater from entering the facility.
- Utilize waterproofing materials to seal walls in basements or identified rooms.

### Response

Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive flooding reports for the area.

If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to *Error! Reference source not found.* Protective Actions in the Base Plan for more information.

If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template*.

If the decision is made to internally relocate, gather critical supplies to take to higher ground (e.g., medications, drinking water, resident records, important personal items, communication devices, blankets).
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- Regularly seek updates from staff to determine if other protective actions are needed for some or all of the facility’s population.
- Unplug non-essential appliances, equipment, and computers. Do not allow electrical devices to come into contact with water.
- If a gas leak is suspected, notify the Plant Manager.
- Check for water line ruptures and sewage contamination and report utility problems to the utility company.
- If water lines are disrupted, consider the water supply to be contaminated and utilize the facility’s emergency potable water resources.
- Comply with public health notices regarding water contamination (e.g., Boil Water, Do Not Drink Water, Do Not Use Water).
- Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.
HAZARD ANNEX J: CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR, EXPLOSIVE (CBRNE)

CBRNE incidents occur when a hazardous substance is released into the environment, causing potential harm to the staff and residents of the facility. CBRNE emergencies are particularly dangerous for facilities, as populations are typically confined indoors with compromised health and immune systems. Released toxic substances, even in small amounts, can further weaken the health and well-being of residents.

**Preparedness**

- Determine the facility’s proximity to potential sources of CBRNE exposure (e.g., transportation corridors, nuclear power plant).
- Work with local emergency management, public health, environmental health, and other identified stakeholders to develop a decontamination plan.
- Properly dispose of potentially toxic substances like unused chemicals, pharmaceuticals, and other substances.
- Conduct trainings on safe handling, transportation, and disposal of hazardous wastes.

**Response**

- Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalitions to receive updated CBRNE threat information for the area.
- Based on the type and location of incident, assess potential impacts of a hazardous materials release.
- Review threat information and intelligence, anticipated impacts, and resource levels to determine facility readiness to implement protective actions. Refer to *Error! Reference source not found*. Protective Actions in the Base Plan for more information.
- If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template*.
- Assess the need to set up “hot, warm, and cold” zones for which access would be restricted. Secure zones accordingly.
Provide guidance and implement protective measures for food handling, mass feeding, and sanitation.

Preemptive methods to mitigate exposure to hazardous substance outside the facility:
- Close all windows, doors, and vents.
- Limit the amount of foot traffic in and out of the facility.
- Do not allow residents outside, as possible.
- If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intake.

Carry out established decontamination procedures, as needed.

Monitor staff and residents for delayed physical responses as a direct result of the incident.

Assess residents for worsened health outcomes as an indirect result of the incident.
HAZARD ANNEX K: INFECTIOUS DISEASE

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi. The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary by multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionality.

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility in fully developing your CEMP Annex E, planning and response checklist for infectious disease and pandemic situations. The information within this Annex includes the identified priorities and focus areas.

Under the Pandemic Emergency Plan (PEP) requirements of Chapter 114 of the Laws of 2020, special focus is required for pandemics. Please use the template’s Appendix E and this Hazard Annex, with prompts for the PEP requirements, to ensure that the plans developed meet all requirements.

Chapter 114 of the Laws of 2020 (full text):

Section 2803 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) each residential health care facility shall, no later than Ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

(a) to update authorized family members and guardians of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and guardians on the number of infections and deaths at the facility, by electronic or such other means as may be selected by each authorized family member or guardian; and

(b) that includes a method to provide all residents with daily access,

At no cost, to remote videoconference or equivalent communication methods with family members and guardians; and
(ii) protection plans against infection for staff, residents and families, including:

(a) a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

(b) a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(iii) a plan for preserving a resident's place in a residential healthcare facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

(b) the residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter.

The commissioner shall review each residential healthcare facility for compliance with its plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

(c) within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential healthcare facility shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential healthcare facility complies with its plan of correction and the applicable regulations.

(d) the commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

§ 2. This act shall take effect immediately.

1. Communicable Disease Reporting:

1.1. Importance of Reporting

- NYSDOH is charged with the responsibility of protecting public health and ensuring the safety of health care facilities.

- Reporting is required to detect intra-facility outbreaks, geographic trends, and identify emerging infectious diseases.
The collection of outbreak data enables the NYSDOH to inform health care facilities of potential risks and preventive actions.

Reporting facilities can obtain consultation, laboratory support and on-site assistance in outbreak investigations, as needed.

1.2. What must be reported?

**NYSDOH Regulated Article 28 nursing homes:**

- Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.17

- Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an *Infection Control Nosocomial Report Form (DOH 4018)* on the DOH public website.
  - Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an *Infection Control Nosocomial Report Form (DOH 4018)*.

- Reports must be made to the local health department in the county in which the facility is located (as the resident’s place of residence) and need to be submitted within 24 hours.

17 A list of diseases and information on properly reporting them can be found below.
of diagnosis. However, some diseases warrant prompt action and should be reported immediately by phone.

- Categories and examples of reportable healthcare-associated infections include:
  - An outbreak or increased incidence of disease due to any infectious agent (e.g. staphylococci, vancomycin resistant enterococci, Pseudomonas, Clostridioides difficile, Klebsiella, Acinetobacter) occurring in residents or in persons working in the facility.
  - Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.
  - Foodborne outbreaks.
  - Infections associated with contaminated medications, replacement fluids, or commercial products.
  - Single cases of healthcare-associated infection due to any of the diseases on the Communicable Disease Reporting list. For example, single cases of nosocomial acquired Legionella, measles virus, invasive group A beta hemolytic Streptococcus.
  - A single case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.
  - Clusters of tuberculin skin test conversions.
  - A single case of active pulmonary or laryngeal tuberculosis in a nursing home resident or employee.
  - Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions.
  - Closure of a unit or service due to infections.
- Additional information for making a communicable disease report:
  - Facilities should contact their NYSDOH regional epidemiologist or the NYSDOH Central Office Healthcare Epidemiology and Infection Control Program for general questions and infection control guidance or if additional information is needed about reporting to NORA. Contact information for NYSDOH regional epidemiologists and the Central Office Healthcare Epidemiology and Infection Control Program is
located here:  
https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm. For assistance after hours, nights and weekends, call New York State Watch Center (Warning Point) at 518-292-2200.

- Call your local health department or the New York State Department of Health’s Bureau of Communicable Disease Control at (518) 473-4439 or, after hours, at 1 (866) 881-2809; to obtain reporting forms (DOH-389), call (518) 474-0548.

- For facilities in New York City:
  o Call 1 (866) NYC-DOH1 (1-866-692-3641) for additional information.
  o Use the downloadable Universal Reporting Form (PD-16); those belonging to NYC MED can complete and submit the form online.

### 2.0 PEP Communication Requirements

As per the requirements of the PEP, a facility must develop external notification procedures directed toward authorized family members and guardians of residents.

To adequately address this requirement, the facility will need to develop a record of all authorized family members and guardians, which should include secondary (back-up) authorized contacts, as applicable.

Under the PEP, facilities must include plans and/or procedures that would enable them to (1) provide a daily update to authorized family members and guardians and upon a change in a resident’s condition; and (2) update all residents and authorized families and guardians at least once per week on the number of pandemic-related infections and deaths, including residents with a pandemic-related infection who pass away for reasons other than such infection (e.g., COVID positive residents who pass away for reasons other than COVID-19).

Such updates must be provided electronically or by such other means as may be selected by each authorized family member or guardian. This includes a method to provide all residents with daily access, at no cost, to remote videoconference or equivalent communication methods with family members and guardians.

### 3.0 PEP Infection Control Requirements

In addition to communication-related PEP requirements address above, the facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a two-
month (60 day) supply of personal protective equipment based on facility census, including consideration of space for storage; and (2) hospitalized residents to be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80.

Additional infection control planning and response efforts and that should be addressed include:

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.

- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC’s website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Supplies to be maintained include, but are not limited to:
  - N95 respirators;
  - Face shield;
  - Eye protection;
  - Gowns/isolation gowns;
  - gloves;
  - masks; and
  - sanitizers and disinfectants (EPA Guidance for Cleaning and Disinfecting):

Other considerations to be included in a facility’s plans to reduce transmission regard when there are only one or a few residents with the pandemic disease in a facility:

- Plans for cohorting, including:
  - Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway.
  - Discontinue any sharing of a bathroom with residents outside the cohort

- Proper identification of the area for residents with COVID-19, including demarcating reminders for healthcare personnel; and

- Procedures for preventing other residents from entering the area.

4.0 Other PEP Requirements
PEP further requires that facilities include a plan for preserving a resident’s place at the facility when the resident is hospitalized. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).
HAZARD ANNEX L:  IT/COMMUNICATIONS FAILURE

IT/Communications systems failure can impact the following critical systems: computer network; telephone network; on-site data storage; medical devices; medication replenishment; and HVAC system.

An IT/communications failure incident may hinder standard notification methods. Alternate forms of notification with staff, residents and external agencies include: pagers, hand-held radios, runners, personal cell phones, and social media.

Preparedness

☐ Utilize cloud-based or off-site servers to store data that also meet resident confidentiality requirements.

☐ Provide staff with training on use of facility computers and potential risks of personal use (e.g., opening attachments from unknown senders).

☐ Ensure redundant communications mechanisms:
  ▪ Consider procurement of handheld radios or walkie-talkies.
  ▪ Store paper-based versions of critical forms and documentation, including contact lists.

☐ Identify and protect resident care systems and records, including resident management systems, medical/resident records, resource availability, etc.

☐ Identify and protect clinical support systems including:
  ▪ Computer desktops, laptops, and tablets at nursing stations, hallways, bedside, laptops, etc.
  ▪ Electronic and automatic transfer of information between IT systems, dietary, etc.

☐ Identify and protect administrative systems including:
  ▪ Telephones, fax machines, databases, networks, wireless network, modems, etc.
  ▪ Fire protection systems, security access, external email, website, etc.
Response

☐ Implement the facility’s business continuity plan, if one exists.

☐ If the disruption is deliberate, contact local law enforcement, the Federal Bureau of Investigation’s Cyber Division, and the state cyber terrorism division, as appropriate.

☐ Conduct a risk assessment of affected environmental systems (e.g., utilities) and implement plans to maintain affected systems that support operations. If necessary, consider the implementation of a protective action. Refer to Error! Reference source not found. Protective Actions in the Base Plan for more information.

☐ Isolate and repair, replace, or remove affected systems from the facility network.

☐ Address social media issues as warranted and use social media for messaging as situation dictates.

☐ Implement manual documentation systems (e.g., paper-based systems).

☐ Implement manual inventory and resupply processes, including medication distribution.

☐ In the event of heating or air conditioning system failure and/or failure of medical devices, it may be necessary to evacuate some or all residents. If the decision is made to evacuate, please refer to the NYSDOH Evacuation Plan Template.
HAZARD ANNEX M: LANDSLIDE

Landslides occur when masses of rock, earth, or debris move down a slope. Mudslides, also known as debris flows, are a fast-moving landslide. Landslides can occur within mere minutes and can travel several miles. Hazards associated with landslides include:

- Rapidly moving water and debris that can lead to injury;
- Broken electrical, water, gas, and sewage lines that can result in injury or illness; and
- Disrupted roadways and railways that can endanger motorists and disrupt transport and access to health care.

**Preparedness**

- Evaluate the facility for landslide hazards (e.g., recent wildfires or other incidents that have destroyed ground cover, which mitigates against landslides).
- Ensure structures are in full compliance with regional building codes.
- Educate staff on landslide warning signs, including:
  - Springs or saturated ground in areas that are not usually wet.
  - Bulges in the ground; buckling in the ground.
  - Increasing space between soil and foundations.
  - Cracks in foundation.

**Response**

- If indoors, staff and residents should take cover under desks, tables, or other heavy pieces of furniture. Residents with wheelchairs should be told to lock their wheels. If outdoors, staff and residents should get out of the path of the mudflow and get to high ground.
- Monitor surrounding area for flooding.
- Direct emergency response personnel to possible victims.
- Check building and surrounding area for damage or other safety issues once given the “all clear” by emergency response personnel.
- Listen to local radio and TV for emergency information and updates.
- Report broken utilities and damaged roadways to local authorities.
HAZARD ANNEX N: POWER OUTAGE

Loss of electrical services may be the result of natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems. Natural hazards and weather-related incidents that often cause with power outages include: coastal storms; floods; tornados; and blizzards/ice storms.

**Preparedness**

- Regularly inspect and test all generators involved in supplying emergency power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator.

- See Hazard Annex L: IT/Communications Failure for additional preparedness activities.

**Response**

- Assess the situation. Consult decision support considerations (information and intelligence, anticipated impacts, resources).

- Maintain contact and communication with the utility company, County Office of Emergency Management, and Health Emergency Preparedness Coalition to receive utilities restoration reports.

- Based on facility decision-making criteria, consider the implementation of a protective action. Refer to Error! Reference source not found. Protective Actions in the Base Plan for more information. If the decision is made to evacuate, refer to the NYSDOH Evacuation Plan Template.

- Continually seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility’s population.

- The emergency generator will start automatically within [Time] of an outage.

- If the emergency generator does not start automatically, notify the Plant Manager. If necessary, attempt to start the generator manually by following instructions posted at [Location].

- Use available flashlights as temporary sources of light. These can be found at [Location].

- Take all reasonable steps to protect food and water supplies and maintain a safe environment of care for residents and staff.
HAZARD ANNEX O: TORNADO

A tornado is a violently rotating column of air touching the ground, usually attached to the base of a thunderstorm. Winds of a tornado may reach 300 miles per hour. Damage paths can be in excess of one mile wide and 50 miles long.

Preparedness

☐ Develop procedures for quickly moving residents away from spaces with flat, wide-span roofs (e.g. cafeterias, auditoriums), which can collapse in the event of a tornado.

☐ Train staff on what not to do during a tornado, e.g. move to higher floors or shelter in corners, both of which are dangerous.

☐ Monitor local news and radio outlets for tornado watches or warnings issued by the National Weather Service.

Response

If a tornado watch is issued:

☐ Ensure all residents and assigned staff are inside the facility and accounted for.

☐ Check outdoors and indoors for any objects that might become projectiles.

☐ Ensure that windows are kept tightly closed.

☐ Move residents, staff, and visitors away from windows, skylights, and exterior walls, as possible.

☐ After tornado impact, assign staff to assess residents for any injuries that require immediate attention. Encourage staff to keep residents as calm as possible.

☐ Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.

☐ Look for electrical system damage. If there are sparks or broken or frayed wires, or the smell of hot insulation, turn off the electricity at the main fuse box or circuit breaker. If you have to step in water to get to the fuse box or circuit breaker, call an electrician before proceeding. Panel(s) can be found at [Location(s)].
HAZARD ANNEX P: WILDFIRE

Wildfires threatening the facility may emerge with or without warning, however a wildfire evacuation will most likely occur very quickly, as opposed to a coastal storm.

**Preparedness**

- Implement wildfire protection measures:
  - Clean roof surfaces and gutters
  - Use only fire-resistant materials on the exterior of the facility
  - Consider fire-resistant landscaping

**Response**

- Maintain contact and communication with County Office of Emergency Management or Health Emergency Preparedness Coalition to receive wildfire-related updates.
- Monitor local news for evacuation reports and instructions.
- Based on facility decision-making criteria, consider the implementation of a protective action. Refer to *Error! Reference source not found. Protective Actions* in the Base Plan for more information.
- In case of immediate threat, move residents to a pre-designated staging area for rapid evacuation. If a gas leak is suspected, notify the Plant Manager.

Preemptive methods to mitigate smoke and fire risk:

- Close all windows, doors, and vents.
- Limit the amount of foot traffic in and out of the facility.
- Do not allow residents outside, as possible.
- If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intakes.

Regularly seek updates from staff to determine if protective actions are needed for some or all of the facility’s population. If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template*. 
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- Monitor residents and staff for complications related to smoke exposure.
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