Kaleida Health
Comprehensive Emergency Management Plan
Site Emergency Plan Annex

DeGraff Skilled Nursing Facility

May 2024

TABLE OF REVISIONS

The contents of this manual are subject to change without prior notice. Should revisions become necessary, written updates will be distributed as needed. Leaders are responsible for updating their copies of the plan within their areas of responsibility, keeping them current, and being familiar with their content. Leaders and supervisory personnel shall ensure that all staff members are updated and current on their facility's Emergency Operations Plan.

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

Date	Section/Page(s)	Change	Revised By
2012	All	Initial publication	JR
May 2013	All	Review	T.K.
May 2014	All	Review	TK
May 2015	All	Review	TK
May 2016	All	Review	TK
May 2017	All	Revised to reflect plain language changes	TK
December 2017	All	Revised to interface with elopement procedures, special needs populations, and partner/employee contact info	TK
November 2018	All	Review	T.K.
February 2019	All	Updated to reflect the 2019 HVA	T.K.
July 2019	All	Review	T.K.
June 2020	All	Review	DM
May 2021	all	review	T.K.

May 2022	All	Updated to reflect the 2022 HVA	T.K.
Feb 2023	All	Updated to reflect the 2023 HVA	T.K.
May 2024	All	Updated to reflect the 2024 HVA	T.K.

I. Introduction

It is the policy of Kaleida Health that staff at this site has established plans prior to emergencies for those events deemed likely to occur. It is expected that on site Administration will provide the primary Emergency Management direction for most situations until outside help arrives. Communication between the "Liaison" Personnel and outside Agencies will be maintained for the safest conclusion for all Kaleida Health staff. The facility will use an appropriate Incident Command Structure based on the Incident Command System (ICS) model and the National Incident Management System (NIMS). The Kaleida CEMP base plan will be the guiding document for this plan. The CEMP is based on the emergency management principles of mitigation, preparation, response, and recovery.

II. Audience

This plan applies to the **D.M.H. S.N.F.**, located at **445 Tremont St. North Tonawanda, NY 14120**

III. Communication and Responsibility

D.M.P. Site Safety Committee, in concert with DeGraff SNF leadership, shall be responsible for the oversight of the planning process and plan documentation.

HAZARD VULNERABILITY ANALYSIS

The hazard vulnerability analysis (HVA) is to be used by an individual facility to identify and rank various risk and mitigating factors related to nursing home emergency preparedness. The purpose of the HVA is to evaluate the ability of the medical facility to provide medical care for the community and/or current residents and staff in the event of an emergency or disaster. The ratings are subjective and are designed to reflect the general preparedness of a facility to respond to an event. Facilities should utilize the results of this HVA to perform a gap analysis of their preparedness for emergencies. This gap analysis may then be used for prioritizing projects related to emergency preparedness. Additionally, the SNF works cooperatively with Federal, State and local emergency preparedness agencies and officials in order to identify likely risks to the community (e.g., natural disasters, mass casualties, terrorist acts, etc.), to anticipate demands and resources needed by the hospital emergency services, and to develop plans, methods and coordinating networks to address those anticipated needs. This Facility is an active member of the WNY L.T.C. Mutual aid coordination group, as well as the WNY healthcare emergency planning coalition.

The HVA will be conducted in the beginning of every year. The top 5 vulnerabilities are: 2024

Blizzard
Ice storm
Snow Fall

Emerging Infectious Disease/Pandemic
Resident elopement

INCIDENT FACILITIES

The nursing home has pre-established specific locations on the campus where predetermined incident management activities will occur. The following table 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 HCC and all concerned parties. DeGraff Medical Park will also be considered as a resource for any reciprocal logistical needs. Also, see facility COOP plan.

D.M.H. S.N.F.	*Mission*	*Pre-planned Location*	*Telephone*
Incident Command Center (ICC)	Command and control point for overall incident management. Location of incident commander, command staff, and section chiefs.	First floor conference room	690-2574
Logistics Section Center	Operations control point for Logistics Section	First floor conference room	690-2574
Ambulance/ Wheel Chair Van Loading Area	Loading point for residents being discharged out of the nursing home to another facility/area.	Main Entrance (Wheel Chair Bound)	N/A
Labor (personnel) Pool Area	Mobilization point and credentialing area for non-medical personnel and volunteers. Includes a check-in location where personnel register and receive briefings and assignments.	Nursing staffing office	690-2080
Dependent Care Area	Location for sheltering and feeding staff and volunteer dependents	Second floor dining room	690-2084
Public Information Area	Briefing area for media	Main Lobby or first floor day room	

D.M.H. S.N.F.	*Mission*	*Pre-planned Location*	*Telephone*
Planning Section Center	Operations control point for Planning Section	First floor conference room	690-2574
Residents Information Area	Briefing area for visitors and families regarding status and location of residents	Second floor dining room	690-2084
Family Waiting Area	Waiting area for families picking up discharged Residents	Second floor dining room	690-2084
Debriefing Area	Location for critical incident stress debriefings for staff, residents, and visitors	Second floor dining room	690-2084
Finance Section Center	Operations control point for Finance Section	First floor conference room	690-2574
Operations Section Center	Operations control point for Operations Section	First floor conference room	690-2574
Discharge Area for residents	Mobilization and control area for residents being discharged	Main Lobby	
Pharmacy Services Area	Operations control point for pharmacy services	Nurses Station	
Human Services Center	Operations control point for human services and staff support	Nursing staffing office	690-2080
Staff Information Center	Emergency information update/rumor control center for staff	Nursing staffing office	690-2080
Staff Rest and Nutrition Area	Calm, relaxing environment for staff support and nutrition	The second floor PT gym	690-2363
Missing person Assignment Location	One staff member from every unit will report to receive a search area sheet and any other instructions	Nurses station	

Departmental Responsibilities (General)

The following are general emergency responsibilities listed by department, and are included in, or support, the department emergency operations plans. Duties involving suspension of non-essential functions or disruption of normal activities or services shall only be implemented when so directed by the Incident Commander or ICS leadership.

All Departments will continue Emergency Plan activities until discontinued through alternate means or until notified to resume operations by the Command Center (CC).

Director Long Term Care / Administrator on Call

- Responsible for the overall organization and coordination of services during an emergency and for oversight of post emergency activity and critique.

Administrative Departments

- Based on departmental procedure all available staff report to the Personnel pool with information regarding staff available and any equipment pertinent to the emergency event.

Communications (Security)

- Receive call from Nursing Manager/Supervisor On-Site, Facilities Manager or Director Long Term Care on call.
- Insure notification of Director Long Term Care on call.
- Maintain an updated list of those departments and individuals to be notified at all times.
- Notify all participants upon receipt of plan activation.
- Announce all relevant plain language Codes via multiple communications methods.
- Re-route emergency related calls to either the HCC or to the Media room if the calls are media related.
- Discontinue all non-emergency paging on overhead unless approved by the CC.
- If communication is interrupted, all communication will be established via cellular phones located on-site. Security 2-way radios will also be used.
- Keep consistent contact with the CC.
- Paging via pager system will be done to coordinate off-site staff.
- Follow all other departmental emergency functions.

Contact information locations. Kaleida health, and all its affiliates, interface with many different entities. We ensure that contact information is available for all necessary operations both during every day events, as well as emergency scenarios. Please see below as sources to obtain such contact information:

- Kaleida staff and physician contact information is obtained via the H.R. Lawson data base system, as well as site/department level phone lists

- Volunteer information would be obtained at the site level through the volunteer department
- Approved vendor information would be obtained through the Kaleida purchasing department
- Resident/patient information is obtained by accessing the electronic medical record
- Community Hospital partners, first responder agencies, government agencies, etc. would be obtained by referencing:
  - The mutual aid coordinating group plan
  - The W.N.Y. Regional Mutual Aid plan
  - This communications plan
  - Additionally for the SNF- J-drive/ LTC reports/DeGraff/emergency contacts

Special needs populations

- Kaleida Health recognizes the unique needs of the diverse population we serve. Kaleida Health facilities note their special needs populations and consider their needs in emergency situations (evacuation, etc.) examples of special needs populations include:
  - ***Pediatric patients***
  - ***Bariatric***
  - ***Psychiatric/emotionally impaired***
  - ***Infectious/Contaminated- see chemical and biological annex plan***
  - ***Frail elderly-*** *Also refer to the resident profile and resident population acuity portions of the Facility Assessment.*
  - ***Pregnant women***
  - ***Dialysis***
  - ***Walking wounded, severely injured but stable, suffering from life threatening injuries, beyond care- see patient surge annex plan.***

- ***Skilled Nursing Residents:*** *See annual site HVA for elopement risk calculations as well as associated elopement policy LTC A.11.*

Environmental Services

- Environmental Services Manager should check in at the CC Logistics Section to determine needed equipment and / or personnel.
- Initiate staff recall as need is identified.

Food & Nutrition Services

- Nutritional Services should check in at the CC with the Logistics Chief to determine needed equipment and / or personnel.
- Initiate staff recall. The number of staff to be recalled will be determined by emergency command based on the magnitude and anticipated duration of the emergency.
- Maintain service for all residents.

Materials Management

- Responsible for the distribution and up-keep of all supplies needed in an emergency situation. Responsible for assisting in procurement of supplies off-site.
- Initiate staff recall as necessary. The number of staff to be recalled will be determined by emergency command based on the magnitude and anticipated duration of the emergency.
- Prepare additional supply and linen carts for delivery to nursing units and alternate treatment areas.
- Vendors to be contacted for urgent delivery of any needed supplies.

Medical Records

- Send additional clerical staff to Personnel Pool (Support Services Pool) for assignment.
- Initiate staff recall. The number of staff to be recalled will be determined by emergency command based on the magnitude and anticipated duration of the emergency.
- Upon notification of emergency plan activation, prepare to curtail non-essential functions.
- Be prepared to assist with preparation of Emergency Medical Tags (E-Finds), if required.

Nursing Supervisor

- The Nursing Supervisor will often be the incident command until further assistance arrives. The Initial Facility Incident Commander will be the internal communications liaison to all appropriate parties until the CC is activated. The Nursing Supervisor will activate the CC within the designated location. If this location is not accessible the Nursing Supervisor will choose a suitable alternate site with appropriate communications capabilities. In many cases, this position will be assigned the role of planning chief as the situation develops.
- Under the Direction of the Nursing Supervisor a Clinical Personnel Pool Coordinator will be chosen. Support Services Personnel should be directed until a designee is assigned, if staff is short notify the CC regarding this need.
- Assess the bed availability on all units. Nursing Units should gather this information and within the Nursing Office.
- Assess the staffing levels on all units.
- Establish waiting room for families. Notify staff to manage the area. Assist with identifying if Kaleida Behavioral Health is needed to assist with Crisis Counseling.
- Follow departmental plan.
- Send any available staff to the Clinical Personnel Pool. Leave equipment at the designated triage location.

Nursing

- Call staff in only when directed to do so by CC.
- Maintain updated call list.

- Assess all residents for potential discharges (if appropriate).
- Prepare unit for potential admissions.

Nursing Units

- Each unit should gather information from ICS Status Report
- Any available Nursing Staff reports to the Clinical Personnel Pool. Leave equipment at the designated triage location.
- All Nurse Managers will report to the CC immediately for instructions.
- Use resident telephones to inform families of resident discharges.
- Strip and remake beds following discharges.
- Evaluate staffing needs. Notify Nursing Office.

Other Departments

- Assist in the emergency event as necessary for safety of visitors and staff.
- All available personnel should report to the Support Staffing Pool with the number of personnel available and status of any applicable equipment. (i.e. wheelchairs)
- All representatives to the Support Staffing Pool as needed. Initiate Departmental Call Back Procedures as identified.

Pharmacy

- Initiate staff recall. The number of staff to be recalled will be determined by emergency command based on the magnitude and anticipated duration of the emergency.
- Staff will prepare to dispense medications for additional resident areas. Arrangements should be made with vendors for additional supplies as needed.

Physical Therapy/Occupational Therapy

- Upon emergency plan activation, return all residents to their rooms immediately.
- The Director will assist with transferring or positioning residents in the triage area.
- Assist in an emergency as needed. Follow departmental plan.
- Report a minimum of one person to the Personnel Pool to identify personnel and equipment available.
- All available representatives to the Personnel Pool (as needed). Initiate Departmental Call Back Procedures.

Plant Operations

- For any internal emergency, Plant Operations Management will provide the initial assessment of the compromise in service specifically related to the physical plant and immediately take any action necessary to correct the problem.
- Maintain uninterrupted water, electrical, heat/ventilation/air conditioning, steam, and other required utility services. Maintain the environment of care.
- Assist with Security, as needed.

- If assigned to Damage Assessment and Control, determine the extent of damage to the facility.
- Rapidly make repairs that will return the nursing home to as close to normal operations as possible.
- Plant Operations Management staff will respond to the CC to participate as part of the logistics section. Plant Operations will delegate tasks for managing the Support Services labor Pool.
- Plant Operations Management staff will be in direct contact with the Facility Incident Commander via 2-way radio or cellular phone to update Command with regard to the following items:
- Evaluate any potential danger to residents, visitors, or staff and communicate the findings to the nursing office for appropriate action to be taken.
- Communicate the nature of the service interruption and the service areas affected.
- Communicate the estimated interval of time for corrective action to take place.
- Ensure all further permanent corrective action is completed in a timely manner.
- Plant Operations Management will follow their specific department plans related to any compromise in utilities or the physical plant.

Public Relations / Press Releases

- PR Staff will be notified and called to either the CC or the media information center and assume the role of Public Information Officer.
- The media information center shall be established only after Public Relations personnel are on site.
- All media will be escorted by Security or designated volunteer after it is established.
- Establish communications with the CC. Public Relations staff or designee will be present in the designated area to appropriately address information requests from the media.
- Public Relations will be solely responsible for the release of emergency information to the media.

Respiratory Therapy

- Initiate staff call in. The number of staff to be called will be determined by emergency command based on the magnitude and anticipated duration of the emergency.
- Assemble all portable equipment including ventilators for delivery to area designated by the CC.
- Place requests for additional equipment from other facilities or Purchasing Department as needed.

Security / Traffic Control

- Security commander on-site will bring emergency communication equipment to disperse.
- Establish communications with the CC.

- Security will communicate to the local police department the facility's emergency status and put the police on standby for additional assistance as soon as any disturbance of traffic or security is identified.
- Maintain access control for the facility complex.
- Institute external traffic control, keeping areas of egress accessible.
- Security officers will keep unauthorized individuals and vehicles form the triage, observation and immediate care areas.
- Escort media to the designated area after the Kaleida Representative is present.
- Security will request additional assistance as required from the Local Authority having jurisdiction.
- Initiate call back procedures per departmental policy.

Social Work

- Primary responsibility is to communicate with residents and family on-site.

Operations

Staff Support Functions

- **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 may be set up in appropriate areas of the facility. As needed, the Planning Section will help develop staff schedules that establish appropriate downtime periods, and staff members will be rotated out of their work duties for planned downtime.

- **Communications**

Staff members may be required to remain on duty for long durations or be housed by the nursing home during an event. When possible, communication mechanisms (e.g., phones, e-mail) will be established so that staff members can remain in contact with their families or to conduct essential business (e.g., banking, bill payment). Information about the event and its impact on staff duty hours will be provided at regular intervals so that ongoing family support needs (e.g., elder care, child care, pet care) can be arranged.

- **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, or establishment of security perimeters. When needed, the ICS Transportation Unit shall coordinate transportation resources and arrangements through the CC If necessary, ambulances may be used, and the jurisdictional Emergency Operations Center should be contacted to assist in providing regional transportation arrangements or coordinating nursing home

and outside agency transportation assets. UBER for business may be utilized, via the Corporate Emergency Management team

- **Dependent Care**

Nursing home staff members who also provide care for personal dependents are expected to have their own arrangements for dependent care when they must report for duty. The nursing home 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 nursing home will strive to provide on-site child and elder dependent care for staff dependents, enabling the staff members to report for duty. Staff should call their respective Department for incident-specific information.

Adult and pediatric dependent care areas will be established as needed. These areas will be supervised by the Dependent Care Unit Leader, and staffed by nursing home volunteers. If the volunteers are not available, designated nursing home 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 (at the Care Center) for sheltering of dependent family members by using volunteers and personnel from the Nursing home 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.

1. 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 nursing home due to an internal or external event threatening the facility or its occupants; an external incident producing a resident load that exceeds the facility's in-resident capacity for care; an event where special circumstances, such as a communicable disease threat, require separation of some residents from the general nursing home 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.

When activated, the following general procedures shall be implemented:

(1) The emergency management plan will be activated. Notification will be made to local/State government oversight agencies, and WNY LTC Mutual Aid Agreement partners.

(2) A suitable command structure will be established and staffed for each alternate care site. The site commander will be known as the [alternate site name] 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.

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

(4) 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.

(5) The Public Information Officer shall ensure that appropriate notifications are made to residents and their families when they are relocated to or from an alternate care site.

(6) The Planning Section will be responsible for planning and documentation needs, including management of resident tracking and records. HICS standard forms and NYS EFINDS will be used for tracking and incident documentation.

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

2. Loss of Local Community Support

There may be incidents or times when the local community is unable to support the nursing home 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.

Logistics

3. 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/decontamination support. Annexes to this plan provide department, system, or event-specific details of logistical functions. The jurisdictional EOC may be called upon for additional support in the event that the nursing home requires external assistance in logistical support.

4. Staffing Augmentation

By their very nature, unusual events tend to be staff-intensive, as additional resources are needed for a multitude of tasks. It is Kaleida Health's protocol to consider any employee on the premises during an emergency 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.

- Emergency Shift Schedule

At the determination of the Incident Commander, all or some staff members may be changed to 12-hour emergency shifts in order to maximize staffing. These shifts may be scheduled as shown below, or as needed to meet nursing home emergency objectives:

Emergency Shift	*Work Hours*	*Normal Shift of Staff Assigned*
Emergency Shift I	12:00am-1200pm 7:00am-7:30pm	All Shift I (12:00am-8:00am, 7:00am-7:30pm, 7:00am-3:30pm, 9:00am-7:30pm) staff Shift II (8:00am-4:00pm, 3:00pm-11:30pm, 11:00am-11:30pm, 3:00pm-1:30am) staff
Emergency Shift II	1201-2400 1930-0700 hours	Half of Shift II (8:00am-4:00pm, 11:00am-11:30pm, 3:00pm-11:30pm, 3:00pm-1:30am) staff All Shift III (4:00pm-12:00am, 3:00pm-3:30am, 7:30pm-7:00am, 11:00pm-7:30am) staff

- 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 12-hour shifts
- Call back off-duty staff from earlier shift
- Contract additional agency nurses
- Cancel staff days off (first one per week, then both)
- Cancel holidays and vacation leaves
- Coordinate through the County E.O.C. and the Long term care mutual aid group for staffing support from outside the nursing home (consider credentialing needs) – including other nursing homes; home-based care staff; Medical Reserve Corps; and staff from an unaffected area of the County/region/state/country

5. Administrative and Temporary Clinical Privileges – Licensed Independent Practitioners

During emergency plan activation, the Chief Executive Officer or Chief Medical Officer (or their designee) as needed may grant “Disaster Privileges”. Granting such privileges will be on a case-by-case basis at the CEO or CMO’s discretion. The privileges should be effective immediately and continue through the completion of the resident care needs or until the orderly transfer of the resident's care to an appropriately credentialed member of the medical staff can be accomplished.

Following approval for emergency credentialing privileges the practitioner should be provided and maintain on his or her person written verification of said privileges for ready identification. The practitioner shall take direction from the Department Chairman (or designee) in their clinical specialty 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.

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" nursing home.

Identification requirements for those practitioners requesting “Disaster Privileges” shall include at least one of the following:

- A current nursing home photo-identification card.

- A current license to practice and a valid photo-identification issued by a state, federal, or regulatory agency.
- 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 organizations or groups.
- Identification indicating that the individual has been granted authority to render resident care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.
- Presentation by current nursing home or medical staff member(s) with personal knowledge regarding the volunteer practitioner's identity and qualifications.

As soon as practical (but not more than 72 hours from the time the volunteer practitioner presents to the nursing home, 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 Empire County Nursing home’s Disaster Privileges Policy. This verification should include:

- Current New York licensure verification, and
- DEA and state narcotics registration verification.
- National Practitioner Data Bank (NPDB) discovery
- Federation of State Medical Boards (FSMB)
- NYS 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 nursing home affiliation.

The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. The Medical Staff Department will be consulted as necessary in the credentialing process. Nursing home identification indicating “Volunteer 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.

6. Non-Licensed Independent Practitioners

During EOP activation, the need for use of volunteer non-licensed independent practitioners may arise. A volunteer practitioner is defined as a person who is qualified to practice a health care profession (e.g., a registered nurse) and is engaged in the provision of care and services. Practitioners are required by law and regulation to have a license, certification, or registration to practice their profession. Kaleida Health may modify the usual process for determining qualifications and competencies of volunteer non-licensed independent practitioners if necessary to meet immediate resident needs

during an emergency. Assigning disaster responsibilities to volunteers shall be made on a case-by case basis, taking into consideration the needs of the organization and the resident. Should the use of volunteer non-licensed independent practitioners become necessary, they will still be subject to the same identification and primary source verification requirements as those listed above for licensed independent practitioners. 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.

The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. The Corporate Human Resources Department will be consulted as necessary in the credentialing process. Nursing home identification indicating "Volunteer 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.

7. Resource Levels

During an event, the Resource Unit (Planning Section) shall monitor resource usage and proactively communicate anticipated needs to its suppliers/vendors. This shall be done in coordination with the appropriate department heads of Telecommunications, Materials Management, Pharmacy, and Facilities Management. In the event that resource shortfalls are projected, the following actions may be implemented at the direction of the Incident Commander:

- Procurement from alternate or non-traditional vendors
- Procurement from communities outside the affected region
- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request external stockpile support from the County Department of Health logistics cache
- Request external stockpile support from NYS Responds, the State Department of Health Medical Emergency Response Cache (MERC), or the Strategic National Stockpile (these requests go through the jurisdictional EOC) (see the CHEMPACK and Strategic National Stockpile annex for additional information)

Planning
The Planning Section's responsibilities include gathering, analyzing, and interpreting information about current events, projecting information on future events, and maintaining related documentation. Planning Section oversees such functions as staffing; resident tracking; and resident information.

8. Ongoing Assessment and Incident Planning

For incidents that extend beyond a single operational period (e.g., a work shift), the Planning Section Chief shall institute a formal planning cycle and process. This process will include regular, scheduled planning meetings among the command and general staff, as well as other appropriate participants, and development of a written incident action plan that is updated at least daily as conditions evolve. The ongoing planning process is intended to direct the focus of the nursing home and its resources toward the swift resolution of conditions and through the recovery process.

9. Situation and Resource Status Tracking

The Situation Unit Leader is responsible for tracking ongoing events and resources, and maintaining such records in the HCC.

10. Incident Documentation

Regular, updated status reports are to be sent to the HCC. These will be evaluated and actions taken as needed. Scribing and collection of data will be done throughout the incident. Each section leader will be responsible for their section. All data and documentation will be collected and compiled at the end of the incident, and will be included in the after-action report as needed.

FINANCE

11. Continuity of Operations (Business Continuity)

A key element of this emergency management plan is maintaining the business continuity of the nursing home. To that end, the response to an incident is escalated or de-escalated based on the impact that the incident is having on the organization. The departments affected will depend upon the incident. To the extent possible, based on the level of activation and the need for human or material resources, non-involved departments will continue with business as usual.

Safety
All damaged areas will be evacuated and kept clear until the Incident Commander, in consultation with the Safety Officer and the Logistics Section Chief determines that the area is safe to re-enter. The Environmental Services Department is responsible for cleaning of damaged areas, once it has been determined that it is safe to do so. If extensive contamination or hazardous materials are present, a remediation contractor may be required.

Security
During emergency plan activation, the Security Branch Director will be responsible for controlling personnel and traffic flows, securing and ensuring access control and proper identification for access to the campus, crowd control on the campus, securing and safeguarding of damaged areas, evidence, and crime scenes until properly relieved by a law enforcement agency, and liaison with law enforcement agencies.

All visitors on resident floors may be asked to leave nursing home grounds upon activation of the EOP. Families should be told that they will be notified by the nursing home if they are needed. Where human compassion dictates, families/visitors will be permitted to remain with residents if it is at all possible.

Nursing home Security Officers and police officers will be assigned to all entrances to control visitors. Social Work personnel, volunteers, and chaplains will be assigned to assist visitors. Officers should be alert to the potential for news media presence, and be prepared to escort credentialed members of the press to the Media Information Area.

Media Interaction and Public Information

- Media Access

When emergency plan activation generates media interest, the Public Information Officer shall establish a Media Information Area in the designated area. This will be the only area of the facility available to members of the press. The Public Information Officer will be in charge of this area, and will release information to the media as directed by the CEO or designee.

As a general policy, members of the press will not be allowed elsewhere inside the nursing home without prior approval from the Incident Commander.

- Public Information System and Joint Information Center

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 joint information system provides accurate, timely, and coordinated information to incident leadership and the public.

At the discretion of the local jurisdiction or Department of Health, this may be accomplished using a Joint Information Center (JIC). In a JIC, the public information officers of all health care partners and jurisdictional authorities, including Kaleida Health (if we are 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.

De-escalation / Demobilization

As the incident resolves, procedures are in place to facilitate the orderly return to normal operations.

The Incident Commander, the Section Chiefs, and other HICS 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.

12. Incident Termination

As information is received at the Nursing home Command Center regarding resolution of the incident, a decision is made by the Incident Commander to secure the nursing home from emergency plan activation status, terminate the plan response, and resume normal nursing home operations. This decision will be made based upon assessments of intra-nursing home conditions (as reported by each department and evaluated by the Nursing home 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 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.

Recovery and Resumption of Normal Activities

The Incident Commander, in consultation with key nursing home leaders, will make the determination of when to transition from the response phase to the recovery phase and when to terminate the recovery phase. The Nursing home Command Center will remain active and staffed through the recovery process, or until the Incident Commander deems it appropriate to secure.

Department managers shall initiate an inventory of all supplies and equipment, and should request repair, replacement, or replenishment as needed from appropriate departments; this should be done by on-duty personnel immediately after the emergency plan activation 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.

As circumstances allow, personnel should be released from emergency duties to resume normal duties, to be sent home, or to attend critical incident stress debriefings. Personnel from other departments that were temporarily reassigned should be returned to their own departments for instructions. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.

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

HICS JOB ACTION SHEETS

The Job Action Sheets, or job descriptions/checklists, found on the following pages are a key feature of the HICS program. HICS 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 HICS Table of Organization and in the Order of Succession matrix.

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

Section	Intent
Mission	The purpose of the position
Position Reports To	The name and title of the position's superior in the HICS Table of Organization
HCC Location	The location and telephone number of the superior's operations center or contact point
Immediate	Tasks to be carried out during the first two hours of the incident, or at the earliest possible opportunity
Intermediate	Tasks to be carried out once the "immediate" tasks are completed or underway, or during hours 2-12 of the incident
Extended	Tasks to be carried out later in the operational period, or during the operational period beyond 12 hours
Demobilization/ System Recovery	Tasks to be carried out once incident operations have concluded, as demobilization progresses

The HICS Job Action Sheets are located in a binder that is taken to the Nursing home or Facility Command Center during activation.

HICS FORMS

This section contains the various forms used with the HICS job assignments. The forms are simple, self-explanatory, and not technology-dependent. While paper work is often portrayed as burdensome, 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 quality improvement and risk management issues, maintain business continuity, and pursue financial reimbursement after the incident.

HICS and ICS standard forms are located in a binder and will be taken to the Nursing home or Facility Command Center upon activation. They are also available online through:

http://www.calnursing homeprepare.org/hics-forms
http://training.fema.gov/EMIWeb/is/ICSResource/icsforms.htm

Nursing Home Incident Command System - Forms

- HICS 201 - Incident Briefing
- HICS 202 - Incident Objectives
- HICS 203 - Organization Assignment
- HICS 204 - Branch Assignment List
- HICS 205 - Incident Communication Log
- HICS 206 - Staff Medical Plan
- HICS 207 - Organization Chart
- HICS 213 - Incident Message Form
- HICS 214 - Operational Log
- HICS 251 - Facility System Status Report
- HICS 252 - Section Personnel Time Sheets
- HICS 253 - Volunteer Staff Registration
- HICS 254 - Disaster Victim Resident Tracking Form
- HICS 255 - Master Resident Evacuation Tracking Form
- HICS 256 - Procurement Summary Report
- HICS 257 - Resource Accounting Record
- HICS 258 - Nursing home Resource Directory
- HICS 259 - Nursing home Casualty Fatality Report
- HICS 260 - Resident Evacuation Tracking Form
- HICS 261 - Incident Action Plan Safety Analysis

HICS ORDER OF SUCCESSION- D.M.H. S.N.F. 2024- SEE SITE COOP PLAN

For each position that may be activated in the HICS Table of Organization, three tiers of succession have been provided. While the "first tier" staffing is considered optimal, providing a second tier assures that each position can be staffed, if needed, at any time utilizing managerial, supervisory, or senior trained staff on duty in the facility. 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 as needed.

PLAN NOTIFICATION MATRIX

Item #	Plan Reference	Notification To	Notification When	Contact Info Location	When Made	Responsible Person	Tracked By
1		Emergency Services					
2		Government Agencies (NYSDOH, Public Health, Office of Emergency Management)					
3		Off duty staff					
4		Receiving facilities					
5		Transportation resources					
6		Families / Responsible parties					
7		Media					
8		Ombudsman					
9		Primary physicians					
10		Vendors					