

REGIONAL OFFICE USE ONLY:

Date received from facility: ___ / ___ / ___ Project # (if applicable): _____
 Reviewer: _____ Date Reviewed: ___ / ___ / ___
 RO Log #: _____ Date Approved: ___ / ___ / ___ Actual Completion Date: ___ / ___ / ___

Instructions

- Facilities should use this template when submitting a resident safety plan to their New York State Department of Health Regional Office.
- Fill out this template in its entirety. Any blank information will result in delays and possible rejection of the plan.
- Attach all supporting documentation with this form.
- Once the project is completed, the facility must inform the Regional Office of the Actual Completion Date.
- Any questions can be directed to your Regional Office.

Facility: _____

Contact: _____ Phone: _____ E-mail: _____

Proposed Project: _____

Proposed Start date: ___ / ___ / ___ Anticipated completion date: ___ / ___ / ___

#	Task	Included in Plan? If not, explain why in Comments.	Comments	(For Regional Office Use Only) Acceptable?
1	Provide a project description. Attach floor diagram, if applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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2	Provide the approximate timeline for completion of the project.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Provide the name of the contractor or company responsible for completing the work. Have they been in-serviced and agree to the approved Resident Safety Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Indicate in your plan that once approval is obtained, an In-service for staff on the Resident Safety Plan will be performed. Maintain documentation of training on file for review by surveillance staff.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Obtain all required New York State building permits from the Authority Having Jurisdiction. Submit copies to the New York State Department of Health Regional Office.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Describe what the facility will do to ensure residents will not have access to enter the work areas, contractor's equipment, dangerous tools, chemicals and any other hazard.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Describe how personal items, if applicable, in resident rooms and closets will be protected. Has the facility offered to remove anything that can be safely removed, inventoried and placed where it will be secure?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Describe the procedures the facility will use if work is being performed in resident rooms. Will residents have access to common area space when/if work is being completed in their room? How will those residents who choose not to relocate be supervised if there is work being completed in their room?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Describe any changes to the facility's Emergency and Disaster Plan to accommodate the work being done. Have staff been in-serviced on the new Emergency and Disaster Plan? [Maintain documentation of training on file for review by surveillance staff.]	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

#	Task	Included in Plan? If not, explain why in Comments.	Comments	(For Regional Office Use Only) Acceptable?
10	Describe how the facility will notify residents and families of the work prior to the start of work. Describe how the facility will accommodate and respond to residents and families that have questions. Who will be responsible for daily oversight of the work, and meet with the contractor for any concerns that arise from residents, families and staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Describe what time of day the work will be performed and how the contractor and facility will minimize any disruption/distractions, including excessive noise, dust, odors. Describe how the facility will address any blocking of routes of entry into the building, access roads, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Describe how all ladders, trip hazards and heat dangers will be kept out of the way of residents, staff and visitors.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Describe how the facility will ensure residents have full access to all doors for safe exiting of the building if there is a fire or any other emergency or event that warrants evacuation and how the facility will ensure existing egress routes are not blocked by construction materials, tools and/or debris during and at the end of each day. Describe how construction materials will be brought into the facility and how debris will be removed.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Describe how the facility will ensure the contractor cleans up each night so that there is full access to rooms and emergency exits, etc. Indicate where tools and supplies will be stored and secured.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Provide the date the local fire department will be made aware of work being performed including start and end dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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16	Provide the date the fire panel monitoring company has been made aware of the installation/construction after Department approval. Describe or confirm facility staff will respond to alarms in accordance with their Disaster Plan regardless of whether they are accidental and will make immediate corrections as needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Describe the facility's procedures for any interruption in fire safety equipment (fire alarms, smoke detectors, sprinkler system), including but not limited to staffing increase and modification of staff duties to include fire watch rounds and documentation of those rounds.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Describe the procedure if any smoke detectors are covered by the contractor while work is in progress and how the facility will ensure all covers are removed at the end of each day. Include verification that smoke detector covers if removed will be documented each day in the facility records.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
19	The Operator has made a statement that the facility remains responsible for resident safety throughout the project.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
20	Upon final completion of the work, the Operator will submit final approval and compliance certifications from the local code office. Submit from the contractor(s) certifications stating equipment was installed per the manufacturer's specifications and is properly operating.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

- Please be advised that this may not include all information that the Department of Health will need to review your plan. The Department reserves the right to request any additional information that may be needed to make a final determination.

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Based upon the information submitted above, is the facility required to submit Adult Care Facility Common Application Schedules 1, 4, 5 and 6?

Yes No

(if yes, please provide a copy of this form to the Bureau of Licensure and Certification in Central Office)