***Please fill out the following information and Fax to 804-527-4502 ATTN: Long Term Care***

**Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider/Supplier Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CCN:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Point of Contact at Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Resident census at time of evacuation/event:***(ex. 30 residents)* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of residents/patients evacuated/relocated/discharged: *(****ex. 30 residents****)***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Place relocated/evacuated/discharged to:** *(ex. 10 residents discharged home to family, 10 residents evacuated to the evacuation center located at 99 Evacuation Drive, Boston*

*Massachusetts, 02101, 10 residents transferred to Mount Sinai NY, NY, etc.)*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Number of residents/patients still in the facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date returned back to facility and/or date operations returned to normal: \_\_\_\_\_\_\_\_\_**

**Number of residents/patients returned to facility: \_\_\_\_\_\_\_\_\_\_**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **I. ASSESSING AGENCY DATA** |
| Facility Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Immediate Needs Identified:  Yes  No****Identify in Section XV on next page** |
| Assessor Name/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Email or Other Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **II. FACILITY TYPE, NAME AND CENSUS DATA** |
| Facility Type  Hospital  SNF  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Operation hours\_\_\_\_\_\_\_\_\_\_ |
| Date Opened \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ (mm/dd/yr) Date Assessed \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ (mm/dd/yr) Time Assessed \_\_ \_\_ : \_\_ \_\_  am  pm |
| Assessment  Initial  Follow-up  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City / County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_ \_\_ Zip Code \_\_ \_\_ \_\_ \_\_ \_\_  |
| Facility Contact / Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Fax \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ E-mail or Other Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Census \_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Capacity \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Staff / Volunteers \_\_\_\_\_\_\_\_\_\_ Is staffing adequate? Yes/NoPlease identify census per patient type: (i.e. Medical-Surgical, post-partum, pediatric)­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Identify Services that were previously provided that cannot be supported currently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **III. EXECUTIVE SUMMARY** |
| Provide an Executive Summary of damages incurred and current status of operations: |
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| Identify significant challenges that impact operations: (i.e. roof leak, structural damage, flooding, staffing, unsafe conditions) |
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| **IV. FACILTY** | **V. FOOD** |
| Is the facility currently able to provide services?  Yes  No  | Preparation on site  Yes  No  Unk/NA |
|  If YES, please continue If NO—STOP here | Safe food source  Yes  No  Unk/NA |
|  | Adequate supply  Yes  No  Unk/NA |
| Significant Structural damage  Yes  No  Unk/NA | Appropriate storage  Yes  No  Unk/NA |
| Roof damage  Yes  No  Unk/NA | Adequate Refrigeration  Yes  No  Unk/NA |
|  If yes, identify current status: (tarp in place, repaired, replaced, other) | Appropriate temperatures  Yes  No  Unk/NA |
|  | Hand-washing facilities available  Yes  No  Unk/NA |
| Electrical grid system operational  Yes  No  Unk/NA | Safe food handling  Yes  No  Unk/NA |
| Back-Up Power Source: | Dishwashing facilities available  Yes  No  Unk/NA |
| Generator(s) in use  Yes  No  Unk/NA | Clean kitchen area  Yes  No  Unk/NA |
|  If yes, how many are in use: | **VI. WATER** |
|  Back-Up Power Source if generator(s) fail(s) | Adequate water supply  Yes  No  Unk/NA |
|  | Adequate ice supply  Yes  No  Unk/NA |
| Fuel supply on site to supply for \_\_\_\_\_\_days | Safe water source  Yes  No  Unk/NA |
| If tanks are fully fueled, how long with this supply sustain \_\_\_\_\_\_\_\_\_\_\_\_ days |  \_\_\_\_Municipal \_\_\_\_\_Cistern \_\_\_\_Bottled \_\_\_\_\_\_Other (specify)\_\_\_\_\_\_\_\_\_ |
| HVAC system operational  Yes  No  Unk/NA | **VII. HEALTHCARE WORKERS** |
|  Indoor temperature \_\_\_\_\_\_\_\_\_ o F  | Are staffing levels of healthcare workers (HCW) adequate  Yes  No  Unk/NA |
|  Identify any HVAC problems  |  If no, please explain  |
|  | Are HCW working unusual or extra shifts  Yes  No  Unk/NA |
| Hot water available  Yes  No  Unk/NA | Is a program in place to provide and monitor HCW health and safety, including  |
| Free of pest / vector issues  Yes  No  Unk/NA | Mental Health?  Yes  No  Unk/NA |
| Acceptable level of cleanliness  Yes  No  Unk/NA | Are staffing levels of healthcare workers (HCW) adequate  Yes  No  Unk/NA |
|  | If no, please explain |
|  |  |
| **VIII. SANITATION** | **XII. LABORATORY/RADIOLOGY** |
| Sewage Disposal Adequate  Yes  No  Unk/NA | Laboratory services fully functional  Yes  No  Unk/NA |
|  Type: \_\_\_\_Municipal Sewer \_\_\_\_Septic \_\_\_\_Pumping \_\_\_Other (specify) | If No, please specify  |
|  |  |
| Toilet Supplies Available  Yes  No  Unk/NA | Blood Bank services fully functional (including refrigeration)  Yes  No  Unk/NA |
| Adequate number of hand-washing stations  Yes  No  Unk/NA | If No, please specify |
| Adequate laundry services  Yes  No  Unk/NA |  |
| Acceptable level of cleanliness  Yes  No  Unk/NA | Radiology services fully functional  Yes  No  Unk/NA |
|  | If No, please specify |
|  |  |
| **IX. WASTE GENERATION AND DISPOSAL** | **XIII. PHARMACY SERVICES** |
| Adequate number of collection receptacles  Yes  No  Unk/NA | Is there an adequate supply of medications  Yes  No  Unk/NA |
| Appropriate separation  Yes  No  Unk/NA | If No, please specify |
| Appropriate storage  Yes  No  Unk/NA |  |
| Appropriate disposal  Yes  No  Unk/NA | Are medications safely & securely stored  Yes  No  Unk/NA |
| Biohazard waste collection on site  Yes  No  Unk/NA | If No, please specify |
| Bio-Medical waste safe storage  Yes  No  Unk/NA |  |
| Bio-Medical waste disposal  Yes  No  Unk/NA | Are storage temperatures appropriate  Yes  No  Unk/NA |
| Timely removal of ALL waste  Yes  No  Unk/NA | If No, please specify |
|  |  |
| **X. LIFE SAFETY CODE** | **XIV. MEDICAL RECORDS** |
| Emergency egress available and clear of debris  Yes  No  Unk/NA | Has there been damage to medical records  Yes  No  Unk/NA |
| Fire alarm systems fully functional  Yes  No  Unk/NA |  |
| Sprinkler system fully functional  Yes  No  Unk/NA | Are you able to provide records on transfer or request  Yes  No  Unk/NA |
| Medical gas systems functional  Yes  No  Unk/NA | If no, please explain |
| Patient Call System functional  Yes  No  Unk/NA |  |
| Fire Hydrants and Pump Functional  Yes  No  Unk/NA | Is there a plan to preserve or re-create medical  Yes  No  Unk/NA |
|  | If no, please explain |
|  |  |
| **XI. INFECTION CONTROL** | **XV. CRITICAL NEEDS / SIGNIFICANT CHALLENGES** |
| Are procedures in place for infectious waste handing  Yes  No  Unk/NA | Please identify any critical needs, significant challenges or other shortfalls currently |
| If No, please specify | Experienced or anticipated in the near future:  |
|  |  |
| Can you provide isolation for potentially infectious patients  Yes  No  Unk/NA |  |
| If No, please specify |  |
|  |  |
| Is there an adequate supply of Personal Protective  Yes  No  Unk/NA |  |
| Equipment (PPE) available |  |
| If No, please specify |  |
|  |  |
| Do you have equipment sterilization capabilities  Yes  No  Unk/NA |  |
| If no, please specify sterile equipment use and supply source |  |
|  |  |
|  |  |
| Is there a program in place to monitor for infection rates  Yes  No  Unk/NA |  |
| If no, please explain |  |
|  |  |
| Has there been a noted increase in infection rates  Yes  No  Unk/NA |  |
| If yes, please explain |  |
|  |  |
| Are Negative Pressure Rooms available for use  Yes  No  Unk/NA |  |
|  |  |
| Morgue fully functional  Yes  No  Unk/NA |  |
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|  |  |
| **Assessment completed by:** |  |
| **Date/time of assessment completion:** |  |
|  |  |
| **SARAF ASSESSMENT INFORMATION** | **POSSIBLE CoPs or CfCs OUT OF COMPLIANCE** |
| Based on the above information and initial survey, please identify areas that may  | Patient Rights: |
| Need further investigation to ensure quality and safety are provided: |  |
|  | Admission/Transfer/Discharge |
|  |  |
|  | Resident Behavior & Facility Practices |
|  |  |
|  | Quality of Life |
|  |  |
|  | Resident Assessment |
|  |  |
|  | Quality of Care |
|  |  |
|  | Nursing Services |
|  |  |
|  | Dietary Services |
|  |  |
|  | Physician Services |
|  |  |
|  | Specialized Rehab Services |
|  |  |
|  | Dental Services |
|  |  |
|  | Pharmacy Services |
|  |  |
|  | Infection Control |
|  |  |
|  | Physical Environment |
|  |  |
|  | Administration |

SARAF Survey Notes: