ESTAN HEALTHCARE SERVICES, INC.

Individual Service Plan

Name of Individual: **Client Copy**

Location of Service: **Client Copy**

Type of Service:
Community Assistance Service (CAS) Personal Attendant Services (PAS) Family Care Services (FC)
Personal Assistance Service (PAS) Private Pay PAS Personal Assistance Care (PAC)

- ☐ 01 Bathing
- ☐ 02 Dressing
- ☐ 03 Exercise
- ☐ 04 Feeding, Eating
- ☐ 05a Shaving, Oral Care
- ☐ 05b Routine Hair Care
- ☐ 06 Toileting
- ☐ 08 Transfer
- ☐ 09 Walking
- ☐ 10 Cleaning
- ☐ 11 Laundry
- ☐ 12 Meal Preparation
- ☐ 13 Escort
- ☐ 14 Shopping
- ☐ 15 Assist w/Meds

Note: The PHC Program, CAS Program, and FC Program only provides the tasks allowable in the program as described in §277.41 of this chapter (relating to Allowable Tasks) / PAC Program per DFPS Contract and agreed to on the Services Plan; and the Provider Agency is not responsible for meeting the Individual's needs other than tasks allowed under the PHC/CAS/FC/PAC Program.

Primary Home Care (PHC); Community Attendant Services (CAS); Family Care (FC); Personal Assistance Care (PAC)

Total weekly authorized hours: _____ Frequency of Services: _____ Days/Week
Planned date of Service Initiation: _____ Duration of Service: ☐ Long-Term / ☐ Short-Term
Charges for Services Rendered: Paid by Medicaid, Private Insurance, Private Pay, Adult Protective Services
Individual input on Frequency of Sup. Visit: ___(a) 6 months ___(b) 9 months ___(c) 12 months

☐ Other Frequency of Sup. Visit: _____

Service Schedule: ☐ is variable ☐ is not variable Select If: ☐ PP (Private Pay) or ☐ APS

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
In							
Out							
Total Hours							

X Client Copy
Signature of Individual

Date

Client Copy
Signature of Agency Rep.

Date

Rev 01/03/25

ESTAN HEALTHCARE SERVICES, INC.

Attendant Orientation

Individual Name: **Client Copy** Individual No: _____

Date of Orientation: _____ Attendant Name: _____

Freq. of Sup Visits: Q Months Level of Sup. Visit: None Skill

Method of Orientation: ☐ In Person / ☐ By Phone / ☐ Office ☐ With / ☐ Without the Participation of the Individual

Description of Personal Assistance Care Individual's symptoms and functional limitations which cause need for personal care:

_____

_____

_____

_____

A. Tasks/Service Plan:

☐ **01** Bathing ☐ **02** Dressing ☐ **03** Exercise ☐ **04** Feeding, Eating ☐ **05a** Shaving, Oral Care

☐ **05b** Routine Hair Care ☐ **06** Toileting ☐ **08** Transfer ☐ **09** Walking ☐ **10** Cleaning

☐ **11** Laundry ☐ **12** Meal Preparation ☐ **13** Escort ☐ **14** Shopping ☐ **15** Assist w/Medications

Assistive devices or medical equipment the individual uses:

☐ Cane ☐ Walker w/Seat ☐ Scooter ☐ Shower Chair ☐ Diapers ☐ Oxygen

☐ Walker ☐ Wheelchair ☐ Bedside Commode ☐ Safety Bar ☐ Disposable Underpads

☐ _____

☐ Attendant instructed about client's health condition and how it may affect provision to tasks.

☐ Attendant instructed about task to be provided, work schedule and safety and emergency procedures including Universal Precautions.

☐ Attendant instructed to report to Administrator or Supervisor at 281-498-8280 on the following conditions:

- ☐ Individual Hospitalized
- ☐ Changes in Individual needs
- ☐ Incidents that affect the individual conditions
- ☐ Unable to work schedule
- ☐ Individual absent from home/moved
- ☐ Suspicious or allegations of abuse, neglect, or exploitation of the individual

☐ Individual provided with a verbal explanation and written copy of the agency's complaint procedure.

☐ Attendant competent to provide personal care tasks.

☐ Number of hours attendant is to provide _____

☐ Total number of hours Individual is authorized to receive _____

Service Schedule: ☐ is variable ☐ is not variable

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
In							
Out							
Total Hrs							

Documentation for Attendant Relationship Requirement

Please check as applicable:

☐ I am NOT the individual's legal parent

☐ I am NOT the individual's spouse

☐ I am NOT the individual's legal foster parent

☐ I am NOT designated as a "DO NOT HIRE

X **Client Copy** _____

Signature-Individual

Client Copy _____

Signature-Supervisor

X **Client Copy** _____

Signature-Attendant

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ESTAN HEALTHCARE SERVICES, INC.

Only the authorized Allowable Tasks apply to the individual.

Personal care tasks related to the care of the individual's physical well-being. The PHC Program, CAS Program, FC Program, and PAC Program include the following tasks:

(1) assistance with ADLs, including:

- ☐ **Bathing, which is:**
  - drawing water in sink, basin or tub;
  - hauling or heating water;
  - laying out supplies;
  - assisting in or out of tub or shower;
  - sponge bathing and drying;
  - bed bathing and drying;
  - tub bathing and drying; and
  - providing standby assistance for safety.
- ☐ **Dressing, which is:**
  - dressing the person;
  - undressing the person; and
  - laying out clothes.
- ☐ **Meal preparation, which is:**
  - cooking a full meal;
  - warming up prepared food;
  - planning meals;
  - helping prepare meals; and
  - cutting person's food for eating.
- ☐ **Feeding/Eating, which is:**
  - spoon-feeding;
  - bottle-feeding;
  - assisting with using eating and drinking utensils and adaptive devices, not including tube feeding; and
  - providing standby assistance or encouragement;
- ☐ **Exercise, which is:**
  - walking with the individual;
- ☐ **Grooming, shaving, or oral care which is:**
  - shaving;
  - brushing teeth;
  - shaving underarms and legs, when requested;
  - caring for nails; and
  - laying out supplies;
- ☐ **Routine hair or skin care, which is:**
  - washing hair;
  - drying hair;
  - assisting with setting, rolling, or braiding hair, not including cutting or chemical processing of hair;
  - combing or brushing hair;
  - applying nonprescription lotion to skin;
  - washing hands and face;
  - applying makeup; and

ESTAN HEALTHCARE SERVICES, INC.

Only the authorized Allowable Tasks apply to the individual.

Personal care tasks related to the care of the individual's physical well-being. The PHC Program, CAS Program, FC Program, and PAC Program include the following tasks:

Routine hair or skin care, which is (Cont'd):

- laying out supplies;

☐ **Assistance with self-administration of medication** as defined in 26 TAC §558.2 (relating to Definitions)**:**

- reminding person to take a medication at the prescribed time;
- opening and closing a medication container;
- pouring a predetermined quantity of liquid to be ingested;
- returning a medication to the proper storage area;
- assisting in reordering medications from the pharmacy; and
- administration of any medication when the person has the cognitive ability to direct the administration of their medication and would self-administer if not for a functional limitation;

☐ **Toileting, which is:**

- changing diapers;
- changing colostomy bag or emptying catheter bag;
- assisting on or off bedpan;
- assisting with the use of a urinal;
- assisting with feminine hygiene needs;
- assisting with clothing during toileting;
- assisting with toilet hygiene, including the use of toilet paper and washing hands;
- changing external catheter;
- preparing toileting supplies and equipment, not including preparing catheter equipment; and
- providing standby assistance;

☐ **Transfer, which is:**

- non-ambulatory movement from one stationary position to another, not including carrying;
- adjusting or changing the person's position in a bed or chair (positioning); and assisting in rising from a sitting to a standing position; and

☐ **Ambulation, which is:**

- assisting in positioning for use of a walking apparatus;
- assisting with putting on and removing leg braces and prostheses for ambulation;
- assisting with ambulation or using steps;
- assisting with wheelchair ambulation; and
- providing standby assistance; and

(2) assistance with IADLs, including:

☐ **Cleaning, including:**

- cleaning up after the individual's ADLs;
- emptying and cleaning the individual's bedside commode;
- cleaning the individual's bathroom;
- changing the individual's bed linens and making the individual's bed;
- cleaning floor of living areas used by individual;
- dusting areas used by individual;
- carrying out the trash and setting out garbage for pick up;

ESTAN HEALTHCARE SERVICES, INC.

Only the authorized Allowable Tasks apply to the individual.

Personal care tasks related to the care of the individual's physical well-being. The PHC Program, CAS Program, FC Program, and PAC Program include the following tasks:

Cleaning, including (Cont'd):

- cleaning stovetop and counters;
- washing the individual's dishes; and
- cleaning refrigerator and stove;

☐ **Laundry, including:**

- doing hand wash;
- gathering and sorting;
- loading and unloading machines in residence;
- using laundromat machines;
- hanging clothes to dry;
- folding and putting away clothes; and

☐ **Shopping, including:**

- preparing a shopping list;
- going to the store and purchasing or picking up items;
- picking up medication; and
- storing the individual's purchased items; and

☐ **Escort, including:**

- accompanying the individual outside the home to support the individual in living in the community;
- arranging for transportation, not including direct person transportation;
- accompanying the individual to a clinic, doctor's office, or location for medical diagnosis or treatment; and
- waiting in the doctor's office or clinic with an individual if necessary due to client's condition or distance from home.

Note: The PHC Program, CAS Program, and FC Program only provides the tasks allowable in the program as described in §277.41 of this chapter (relating to Allowable Tasks) / PAC Program per DFPS Contract and agreed to on the Services Plan; and the Provider Agency is not responsible for meeting the Individual's needs other than tasks allowed under the PHC/CAS/FC/PAC Program.

Primary Home Care (PHC); Community Attendant Services (CAS); Family Care (FC); Personal Assistance Care (PAC)

Client Copy	**X**		
Printed Name of Client		Client Signature	Date
Client Copy	**X**		
Printed Name of Attendant		Attendant Signature	Date
Client Copy			
Printed Name of Supervisor		Supervisor Signature	Date

ESTAN HEALTHCARE SERVICES, INC.

Consent to Treatment/Financial Authorization

Client Name: **Client Copy** Client #: _____
Last First

Consent to Treat

I hereby authorized the Agency and its contractors to carry out all procedure as ordered by my physician on the **PLAN OF TREATMENT** and/or to perform non-skilled services as requested by me/responsible party and/or physician and approves through the Agency. I understand that I have been given an opportunity to ask question about my condition, alternative forms of treatment, the procedures to be used and the risks and hazard involved and I believe that I have sufficient information to give this informed consent.

Release of Records

I hereby authorize the release of a copy or fax of all the Agency records to be reviewed by authorized representatives of my party payor, physicians, regulatory agencies, or other health care providers related to my care. I understand that my records may include information relating to treatment for HIV/AIDS, sexually transmitted disease, psychiatric and chemical dependency condition. I authorized the review of my records for any agency audit and the release of a copy of the physician Plan of Treatment and Discharge Summary from my Medical Records upon transfer to or from another health care facility. I do authorize the Agency to leave telephone messages for me at home. I certify this request have been made voluntarily. I understand that I may revoke this authorization at any time, unless records have already been released in reliance on this authorization. Re-disclosure of my medical records by those receiving the above authorization information may not be accomplished without my further written consent.

Acknowledgment

1. I understand that the first visit is an evaluation visit to determine eligibility for home care services based on admission criteria and does not obligate to admit me to services.
2. I have received a copy of my rights and responsibilities as a patient, personal emergency information and have been informed of, and received a copy of the home safety measures; I have been informed of the grievance procedure.
3. I have been informed of my rights to take part in medical-decision making through the Living Will and other Advance Directives.
4. I certify that the information given by me in applying and authorizing payment for services is correct.

Assignment of Benefits

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to the Agency all rights, title and interest in all benefits, payable by Medicaid or Insurance Payor for services/supplies rendered.

Financial Authorization

I have been informed that I will not incur any charges relating to my provider services rendered to me. All charges will be billed to Medicaid department or Insurance Payor.

X **Client Copy** _____ _____
Signature of Patient or Responsible Person and Relationship to patient Date

ESTAN HEALTHCARE SERVICES, INC.

Individual Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, **Client Copy**, understand that as part of my health care, the agency originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment, I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third-party payer can verify that services billed were actually provided and**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I understand and have been provided with a Notice of Information Practices that provides more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- **The right to review the notice prior to this consent,**
- **The right to object to the use of this information for directory purposes, and**
- **The write to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations**

I understand that the agency is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the agency reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the agency change their notice, it will send a copy of any revised notice to the address I have provided (whether U.S mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

NONE

I wish to allow the following individuals to have access to my health information:

N/A

I understand that as part of this organization's treatment, payment, or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

X Client Copy
Patient's Signature

Date

Client Copy
Staff Signature

Date

FOR OFFICE USE ONLY
( ) Consent received by _____ on _____
( ) Consent refused by patient, and treatment refused as permitted
( ) Consent added to the patient's medical record on _____

ESTAN HEALTHCARE SERVICES, INC.

Individual Authorization to Use or Disclose Protected Health Information

I, **Client Copy**, understand that this agency is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of this agency, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

( ) The patient's entire medical records
(NOTE: This requires an explanation why the entire record may be disclosed)

(X) The patient's demographic information (check all that applies):
(X) Name (X) Address (X) State/Zip code only (X) Telephone
(X) Age (X) Gender (X) Race ( ) Other: _____

( ) Medical Data/Information as related to:
( ) Specific condition(s): _____
( ) Specific professional service(s): _____
( ) Specific medication(s): _____
( ) Other: _____

( ) Other: _____
_____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:
N/A

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:
ADMINISTRATORS

Purpose(s) of the information:

ESTAN HEALTHCARE SERVICES, INC.

Individual Authorization to Use or Disclose Protected Health Information

Client Name: **Client Copy**

(X) (Check if applicable) this authorization is to be used for our use, and this agency will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

( ) (Check if applicable) the patient understands that this agency may receive financial gain as a result of disclosing this information due to _____

_____

( ) (Check if applicable) this authorization permits this agency to send the protected health information ONLY to this address or fax number:

_____

_____

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, this agency must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

This agency will accept written revocations of this authorization via:

(X) Certified U.S. mail

(X) Facsimile at this number (218) 498-8993

ALL revocations must be sent to this agency to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

This authorization shall expire on LONG-TERM. After this date, this agency can no longer use the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

X Client Copy _____ _____

Client's Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____

Authorization verified by _____ on _____

Rev 01/03/25

ESTAN HEALTHCARE SERVICES, INC.

Vulnerable Adult/Patient Abuse, Neglect and/or Exploitation

(Reporting Alleged ANE of a Medicaid Consumer changed effective September 1, 2023)

PURPOSE

1. To ensure that all suspected or known incidents of adult/patient abuse, neglect, and/or exploitation (ANE) are reported as required by state regulations.
2. To facilitate prompt internal investigation of suspected or known incidents of abuse, neglect and/or exploitation (ANE) of a vulnerable adult/patient.

POLICY

1. All employees and independent contractors of the "Agency" shall report suspected or known incidents of abuse, neglect and/or exploitation (ANE) of an adult/patient to an Agency Supervisor and appropriate state agency/agencies.

PROCEDURE

1. Definition

a. Vulnerable adult/patient: anyone 18 years or older who:
   1. Receives services from a home health care agency certified for participation under Title XVIII (Medicaid) of the Social Security Act, United States Code. Title 42, Section 1395 and 1396;
   2. Regardless of residence or type of service received, is unable or unlikely to report abuse, neglect and/or exploitation (ANE) without assistance because of impairment of mental or physical function or emotional status.

b. Abuse: any act that constitutes a violation of the constitution or criminal sexual conduct status; the intentional and non-therapeutic infliction of pain or injury or a persistent course of conduct intended to produce mental or emotional distress.

c. Neglect: Failure of a caretaker to supply the vulnerable adult with necessary food, clothing, shelter, health care, or supervision for a vulnerable adult.

d. Exploitation: means the illegal or improper act or process of a caretaker, family or other individual who has an ongoing relationship with the person using the resources of such person for monetary or personal benefit, profit, or gain without the informed consent of such a person.

e. Caretaker: An individual or facility responsible for the care of a vulnerable adult (i.e. family, such as a relative or spouse, or responsible for all or some of the care voluntarily or by contract or agreement, such as home health care agency personnel).

f. Facility: A hospital or other entity required to be licensed to serve adults/patients; an agency day care facility, or residential facility required to be licensed to serve adults/patients; a mental health program receiving funds; or a home health care agency certified for participation in Title XVII or XIX of the Social Security Act.

g. Report: Any report received by the local welfare agency, police department, county sheriff, or licensed agency; or other entity or individual submit a verbal and/or written statement of abuse, neglect and/or exploitation (ANE) that states:

Vulnerable Adult/Patient Abuse, Neglect and/or Exploitation

(Reporting Alleged ANE of a Medicaid Consumer changed effective September 1, 2023)

1. what has happened;
2. to whom it has happened;
3. when it happened;
4. where it happened;
5. who did or was responsible for the abusing, neglect and/or exploitation.

h. Individual mandated to report: A professional or the professional's delegate who is engaged in the care of vulnerable adults/patients (or education, social services, law enforcement or any related occupations), who have a knowledge of the abuse, neglect and/or exploitation (ANE) of a vulnerable adult/patient; have reasonable cause to believe that a vulnerable adult/patient is being or has been abused, neglected/exploited or have knowledge that a vulnerable adult/patient has sustained a physical injury by the caretaker or the caretakers of the vulnerable adult/patient.

2. Action

a. The individual mandated to report suspected adult/patient abuse, neglect and/or exploitation (ANE) must report.
   1. Any knowledge of adult/patient abuse, neglect and/or exploitation.
   2. Any knowledge of adult/patient self-abuse, neglect and/or exploitation.
   3. Reasonable cause to suspect adult/patient abuse, neglect and/or exploitation.
   4. Reasonable cause to suspect patient self-abuse, neglect and/or exploitation.
   5. Any knowledge that a patient has sustained an injury that is not reasonably explained by the adult's/patient's history of injuries.

b. The individual reporting suspected adult/patient abuse, neglect and/or exploitation must.
   1. Immediately inform the Agency Administrator of the suspected or known adult/patient abuse, neglect, and/or exploitation.
   2. Immediately document suspected adult/patient abuse/neglect, and/or exploitation on an Incident Report Form.
   3. Submit the completed Report to the Agency.

c. The Agency Administrator will refer to Social Services and/or contact the Department of Family and Protective Services (DFPS) as deemed necessary.

d. If the agency suspects or knows of incidents of adult/patient, abuse, neglect, and/or exploitation was committed by an employee, volunteer, contractor, or subcontractor of the Home and Community Support Services Agencies (HCSSA) including family members employed by the HCSSA, the Agency's staff will Self-report suspected or known incidents to the Texas Health and Human Services Commission (HHSC) by submitting a report online at https://txhhs.force.com/TULIP/s/ or by emailing ciicomplaints@hhs.texas.gov or calling 1-800-458-9858. After the initial report that must be submitted within twenty-four (24) hours of the suspected or known incident, the Agency's staff must submit the 3613 Incident Report Form within 10 days to HHSC.

ESTAN HEALTHCARE SERVICES, INC.

Vulnerable Adult/Patient Abuse, Neglect and/or Exploitation

(Reporting Alleged ANE of a Medicaid Consumer changed effective September 1, 2023)

e. If the agency suspects or knows of incidents of adult/patient, abuse, neglect, and/or exploitation was committed by someone other than HCSSA staff with an ongoing relationship with the adult/patient (e.g., a family member, friend, household member, etc.), the Agency's staff will report to the Department of Family and Protective Services (DFPS) online at www.txabusehotline.org or by calling 1-800-252-5400.

f. Adult/Patient, responsible party of Adult/Patient or concern person who knows of the Adult/Patient wishing to file a complaint can file a complaint online at https://txhhs.force.com/complaint/s/, via email at ciicomplaints@hhs.texas.gov or call 1-800-458-9858.

g. Agency's staff shall maintain confidentiality and the adult/patient rights during the reporting and investigation of suspected or known incidents of adult/patient abuse, neglect, and/or exploitation.

h. Home health care administration staff may not implement retaliatory action against any individual(s) who report suspected adult/patient abuse, neglect or exploitation.

i. An individual who is legally mandated to report suspected or known incidents of adult/patient abuse, neglect, and/or exploitation (ANE) and who intentionally fails to report such suspected or known incidents of ANE is guilty of a misdemeanor and liable for damages caused by the failure.
   1. Original report will remain in the Incident Report log.
   2. A copy of the report (g) shall be completed by the Agency's staff and submitted to QA/CAI Committee for review and/or further recommendations.
   3. If additional follow-up is deemed necessary, the Advisory Committee will be notified.

I acknowledge receipt of the information both orally and in writing regarding abuse, neglect and/or exploitation (ANE) and my rights to be free of ANE. I also understanding how to report any suspected or known incident(s) of ANE (per 2 (f) above listed).

Client Copy _____

Patient/Authorized Rep Name

X **Client Copy** _____ _____

Patient Signature/Authorized Rep Date

Client Copy _____ _____

Agency Representative Signature Date

ESTAN HEALTHCARE SERVICES, INC.

Patient Complaint/Grievance Procedure

The procedure below has been developed to assist any person who feels that she/or he has been subjected to discrimination prohibited by section 504 of the Rehab Act of 1973.

All persons are free and encouraged to file a complaint on his or her behalf or on behalf of another person if discrimination is suspected or occurs.

****Note that these steps are only suggested. The client has the right to take step 3 and 4 whenever he/she chooses to.**

Please use the following procedure when making a complaint.

Step 1. Any person who has a complaint regarding any matter, which affects him or her directly or indirectly should contact the Home Care Supervisor.
ADMINISTRATOR at 713-572-5463

Step 2. If the complaint is not resolved within 10 calendar days, you may request a Conference with the administrator.

Step 3. DFPS investigates complaints of abuse, neglect and exploitation (ANE) not investigated by HHS, (e.g., **a family member, friend, household member, etc. Non-Agency Staff)**. Call the **Texas Abuse Hotline at 800-252-5400,** or Fax for Long-term Care: **(877) 438-5827 or (512) 438-2724** or make a report online through their secure website at: **www.txabusehotline.org**.

Step 4. At any time **(HHS: regarding Agency staff, volunteer, contractor, or subcontractor)**, the **Texas Health & Human Services Commission** may be contacted toll free at **1-800-458-9858**,
or in writing to:

Texas Health and Human Services
Complaint and Incident Intake
Mail Code E249
P.O. Box 149030
Austin, TX 78714-9030

I have read and reviewed the above with my admitting personnel and I understand the process of filling a grievance.

Individual Name: **Client Copy**

X Individual Signature **Client Copy** Date _____

Agency Rep. Signature **Client Copy** Date _____

Rev 12/27/24

Estan Healthcare Services, Inc.

Rights and Responsibilities

You have the right to have this explained aloud or in other appropriate manners.

Part I – Your Rights

1. **Nondiscrimination** – If you think you have been treated unfairly such as being discriminated against because of race, color, national origin, age, sex, disability, political beliefs or religion, you can file a complaint. Contact HHSC Office of Civil Rights by e-mail at **HHSCivilRightsOffice@hhsc.state.tx.us**, or by:

   Mail: HHSC Office of Civil Rights
   701 W. 51st St. MC W-206
   Austin, TX 78751

   Phone (toll-free): 888-388-6332 877-432-7232 (TTY)

   You also can contact the U.S. Department of Health and Human Services:

   Mail: U.S. Department of Health and Human Services Office for Civil Rights
   1301 Young St., #1169
   Dallas, TX 75202-5433

   Phone (not toll-free): 214-767-4056 214-767-8940 (TTY)

2. **Right to Receive Services –** If funds are available for the services you requested and you are determined eligible, you have the right to receive services. If funds are not available when you request services, you have a right to have your name placed on an interest list for that service.

   You have the right to receive services if you are determined eligible when funds become available and your name appears on the interest list as being the next to receive services. The person on the interest list with the earliest date of request for services goes through the eligibility process first.

3. **Confidentiality of Information –** Information collected to determine eligibility for services, whether collected by HHSC staff or provider agencies, is confidential under state and federal statutes and regulations. This information may be released following state and federal statutes and regulations.

4. **Right to Participate in Service Planning –** You have the right to participate in planning your services. The development of your service plan will include determining what services you need, how often you need the services, what time of day you need the services and which days of the week you need the services.

5. **Right to be Notified of Changes in Service Plan or Eligibility –** You have the right to be informed, in writing, of your eligibility for the services you applied for. You also have the right to receive, from HHSC, written notice about increases or decreases in the number of hours or units of services you receive, loss of priority status or termination of your services. This notice is sent 12 days before the effective date of denial or termination unless:

   - you are no longer financially eligible for Community Attendant Services (CAS);
   - you are no longer Medicaid eligible;
   - you begin to receive services from another program;

Rights and Responsibilities

• your services are terminated because your behavior or the behavior of someone in your home threatens the health and safety of HHSC staff;
• you sign a waiver requesting that your services be terminated immediately; or
• required by state or federal state statutes and regulations.

You have a right to receive the written notice in accessible formats, if desired. You also have the right to receive the notice in a medium of communication that you can understand.

6. **Right to Fair Hearing** – If you think any action on your case is wrong and you did not get the correct services or were denied for services, you or someone acting for you can ask for a hearing. A hearing is a chance for you to tell a hearing officer the reasons you think the action is wrong. The hearing officer will decide if the right action was taken.

   You can continue to get the same services while you wait for the hearing if you ask for the hearing 12 days before the change occurs.

7. **Right to Complain or Voice Grievances –** You have the right to make a complaint, voice grievances or recommend changes in policy or service without restraint, interference, coercion, discrimination or reprisal. Your complaint, grievance or recommendation must be acknowledged within 14 days of the date it is received by HHSC and resolved within 60 days of that date. If you disagree with a decision the caseworker makes and you want to talk it over with the office supervisor, you have the right to do so.

   If you have a problem or complaint, we encourage you to first discuss it with the person, program or office involved. Phone numbers for your caseworker, the office supervisor and the program manager are listed on the last page of this form. Many times, staff can explain a specific policy or correct the problem immediately. If the agency's normal complaint process cannot or does not satisfactorily resolve the issue, **you can send a question or make a complaint with the Office of the Ombudsman:**

   Call: 877-787-8999 (Toll-Free). People who are deaf, hearing or speech impaired can call any HHSC office, by using the toll-free Texas Relay service at 7-1-1 or 800-735-2989.

   Online: hhs.texas.gov/about-hhs/your-rights/office-ombudsman/

   Mail: Texas Health and Human Services Commission Office of Ombudsman
   P.O. Box 13247, Mail Code H-700
   Austin, TX 78711-3247

   Fax: 888-780-8099 (Toll-Free)

   Relay Texas Assistance – Relay services involve a relay operator who uses both a standard phone and a TDD to type the voice message to the TDD user and read the TDD message to the standard phone user. To access Relay Texas Assistance, dial 7-1-1.

8. **Right to Privacy –** You have the right to privacy.

9. **Dignity and Respect –** You have the right to be treated with dignity and respect and to have your property treated with respect. If you think someone from HHSC or a provider agency has not treated you with respect, **you can make a complaint with the Office of the Ombudsman:**

   Call: 877-787-8999 (Toll-Free). People who are deaf, hearing or speech impaired can call any HHSC office, by using the toll-free Texas Relay service at 7-1-1 or 800-735-2989.

Rights and Responsibilities

Online: hhs.texas.gov/about-hhs/your-rights/office-ombudsman/

Mail: Texas Health and Human Services Commission Office of Ombudsman
P.O. Box 13247, Mail Code H-700
Austin, TX 78711-3247

Fax: 888-780-8099 (Toll-Free)

10. You have the right to get advance notice of all home visits unless there is indication of abuse, neglect or fraud.

11. **Freedom from Physical or Mental Abuse or Exploitation –** You have the right to be free of abuse, neglect and exploitation. If you think someone has abused, neglected or exploited you, please contact the Texas Department of Family and Protective Services (DFPS) Abuse Hotline at: 800-252-5400 or at: www.txabusehotline.org. The hotline number is toll-free and available 24 hours a day, seven days a week nationwide. The identity of the caller is confidential and the law requires DFPS to start a prompt and thorough investigation of any suspected need for protective services.

12. **Native Language –** You have the right to communicate in your native language including American Sign Language, with other people or employees to request services, apply for services and receive services.

13. **Service Delivery Option –** You can choose to have certain services delivered through a provider agency, the Consumer Directed Services Option (CDS) or the Service Responsibility Option (SRO). Under the CDS option, you are responsible for recruiting, hiring, firing, training, and managing your service providers. Under the SRO option, you are responsible for interviewing, selecting, supervising, and setting schedules for your service providers.

14. **Home-Delivered Meal Contribution –** You may contribute a monetary donation to your home-delivered meals service provider if you choose. If you choose to contribute towards the cost of your home-delivered meals, you have the right to be given a receipt of your contribution.

Part II – Your Responsibilities

1. **Provision of Information –** It is important to coordinate with your case worker and provide all information necessary to establish eligibility and to develop service plans for purchased services. Falsifying information is illegal and may cause criminal charges to be brought against you.

2. **Service Plan Compliance –** You must comply with the service plan, including refraining from engaging in behaviors that endanger you, staff, or provider agency employees. You must treat staff and provider agency employees with dignity and may not in any way harass or threaten staff or provider agency employees.

3. **Providing Changes –** You must report, within 10 days, any changes in income, living arrangements, family size, loss of assistance grants or Medicaid benefits or other changes that may affect your eligibility. If you willfully fail to report changes that affect your eligibility and receive services for which you are not eligible, you may be prosecuted for fraud, and you must pay for the services.

Estan Healthcare Services, Inc.

Rights and Responsibilities

Part III – Acknowledgement Signature Page

Applicant or Recipient information

Individual Name:_____ Individual#:_____

Language Preference: I prefer to receive all written communication in

☒ English ☐ Spanish

Acknowledgement Statement – The statements on this form and on any attachments if indicated have been explained to the applicant, recipient, or responsible person and they acknowledge they understand the content. A copy of this form and any indicated attachments have been provided to them.

Attachment(s) if applicable:

☐ _____

☐ _____

☐ _____

Name of Caseworker	Caseworker's Phone No.

_____ _____

Supervisor Signature **Date Form Explained, Given, or Mailed**

Client Copy

ESTAN HEALTHCARE SERVICES, INC.

Client Name: **Client Copy**

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of this Agency's Notice of Privacy Policies, detailing how my information may be disclosed as permitted under Federal and State Law. I understated the contents of the Notice, and I request the following restriction(s) concerning the use of my information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

X Signed: **Client Copy** Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of notice, please document the date and time the notice was presented to patient and sign below.
Presented on (Date and Time):_____
By: (Name and Title):_____

Acknowledgement of Receipt of the Hurricane and Disaster Preparedness Guide Information

I hereby acknowledge that Estan Healthcare Services Inc. has shared the information regarding the Hurricane and Disaster Preparedness Guide, given by the Office of Emergency Management, and if I want a printed copy, I can request it from Estan.

X Client Copy _____ _____
Signature – Client Date

Client Copy _____ _____
Signature – Witness (Staff) Date

ESTAN HEALTHCARE SERVICES, INC.

STATEMENT OF UNDERSTANDING

INDIVIDUAL NAME: **Client Copy**

ADDRESS: **Client Copy**

1. The Agency staff will perform Personal Assistance Services ordered by my Physician. Care and Services to be provided have been explained to me.
2. The Agency has strongly explained the nature of the services to be performed to me.
3. I understand and accept the responsibility of participating and co-operating in my care and acknowledge that no guarantee regarding the results of the services to be provided has been made.
4. I understand that this consent is valid from the date of the initial visit by the Agency personnel and that I may withdraw my consent at any time, and if I do so, the services will not thereafter be provided.

I have read or had read to me the following documents and have had each one explained to me. I understand my responsibilities there under and have received copies of:

_____ Patient's Bill of Rights/Responsibilities/Grievance Procedure/Elderly
Initials Rights/Abuse, Neglect and/or Exploitation.

_____ Home Safety/Emergency Preparedness/Infection Control
Initials

_____ Financial Obligation
Initials

_____ A Description of services to be provided
Initials

_____ Policy regarding Advanced Directives/Confined. Executed:
Initials ( ) Yes (X) No

_____ Receive information of five days of notice of transfer/discharge
Initials

_____ **X Client Copy** _____
Date Signature of Individual or Authorized Representative. Relationship

_____ **Client Copy** _____
Date Agency Representative Title

ESTAN HEALTHCARE SERVICES, INC.

PATIENT EMERGENCY CONTACT INFORMATION AND TRIAGE STATUS

Patient Name: **Client Copy** SOC: _____

Address: **Client Copy**

City, State, Zip: _____

Patient Phone Number: _____ Cell Phone: _____

Responsible Person's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Physician: _____ Phone Number: _____

EMERGENCY DISASTER PLAN

Does patient need evacuation assistance? Yes _____ No _____

If Yes, has patient registered with 211? Yes _____ No _____ NA _____

If needed were instructions provided to register with 211? Yes _____ No _____ NA _____

If needed, did agency staff assist with registering with 211? Yes _____ No _____ NA _____

STATUS: SELECT ONE

Level 1: High Priority Clients in this priority level need uninterrupted services.**

- ☐ Potential to be life threatening without care. (Tracheotomy, Skilled wound care)
- ☐ Requires ongoing treatment to preserve life.
- ☐ Unable to evacuate/transport self and no primary caregiver able/available to call for help.
- ☐ Unable to withstand any interruption in power supply. (Ventilator/CPAP)
- ☐ No readily available caregiver or caregiver unable to provide needed care.
- ☐ Requires transport to an acute care facility or specialized shelter situation.

Level 2: Moderate Priority Services for clients at this level may be postponed with telephone contact.

- ☐ Not immediately life threatening without service. Visits may be postponed for 24-48 hours with minimal adverse effect.
- ☐ Client's condition is somewhat unstable – requires daily care to some/most ADLs
- ☐ Client's primary caregiver is not available/able to provide/arrange for ADL assistance.
- ☐ Able to withstand up to 48-hour power interruption without life-threatening effects.
- ☐ Unable to transfer/transport self or no transportation available from caregiver.

Level 3: Low Priority The client may be stable and has access to informal resources to help them.

- ☐ The client does not require daily care. Needs met by self – family – facility staff – other _____
- ☐ Low potential for adverse effects if visits are delayed 48-72 hours.
- ☐ Transportation/arrangements available from family, friends, volunteers or caregiver.

Level 4: Lowest Priority

- ☐ Client lives in an assisted living or skilled nursing environment, facility EPRP supersedes
- ☐ Visits may be postponed 72 hours or more with little or no adverse effects.
- ☐ Willing and able caregiver readily available or client independent in most ADLs.
- ☐ Transportation/arrangements available from self, family, friends, volunteers or caregiver.

X Client Copy _____ _____

Patient Signature Date

Rev 01/03/25

ESTAN HEALTHCARE SERVICES, INC.

Patient Natural Disaster
Evacuation Plan

In the event of Natural Disaster, I, **Client Copy** _____
want the following to be arranged:

(A) ___ I do not want any evacuation plan to be arranged for me. I plan to stay in my home. I understand that I could be without electricity, safe drinking water, unsoiled food, and shelter if such event should occur. I have been provided with a list of what I will need in order to be prepared for such an event.

(B) ___ I wish that the following person(s) be contacted to arrange for my evacuation:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

(C) ___ I want the staff of **the agency** to assist me in determining a pre-planned evacuation destination and the emergency numbers I will need to obtain assistance in the event of a natural disaster. I also want the staff of **staff of the agency** to notify the evacuation team of my need for evacuation and/or shelter in the event of natural disaster. **In the event that this person or persons cannot be reached, I want option A or C to occur: (please check the preferred option): A___ C___**

X Patient Signature **Client Copy** _____ **Date** _____

Agency Staff **Client Copy** _____ **Date** _____

ESTAN HEALTHCARE SERVICES, INC.

256.04 Client/Staff Statement Regarding the Emergency Preparedness Policy and Procedures

I have been provided with a copy of the Agency policy on Emergency Preparedness, Planning and Implementation and I understand my role in implementing that policy.

Client Copy
Client or Staff Printed Name

X **Client Copy**
Client or Staff Signature

Client Copy
Administrative Staff Printed Name

Client Copy
Administrative Staff Signature

Date

285.00 Infection Control Policy

It is Agency's policy to promptly document infections that are contracted by its clients including:

1. the date that the infection was disclosed to the agency employee
2. the client's name
3. the treatment plan

This training is communicated to Staff via printed information or electronic communication by email, text, or within the record keeping software. A summary of infections is reported semi-annually in Quality Assurance Performance Improvements meetings.

COVID-19 Protocols:

Until the State of Texas Health and Human Services Commission and the Center for Disease Control say otherwise, each employee of the Agency will perform a self-screening prior to each shift and record in the record-keeping Software App. (Temperature, potential exposure, any symptoms of COVID-19). Agency will provide all necessary PPE to staff. PPE includes gloves, surgical masks and hand sanitizer. If a client is COVID-19 positive under investigation for COVID-19, Agency will also provide disposable gowns and face shields to staff caring for said client. Agency will keep an adequate supply of PPE at Agency location at all times and will deliver or ship necessary PPE as needed. Staff will keep Agency informed of PPE supply in the client's home.

All newly admitted clients, clients' household members, and newly hired employees are screened for COVID-19 symptoms prior to interview, orientation, admission, and before each shift worked. Temperature, potential exposure, and any symptoms suspicious of COVID-19 such as shortness of breath, sore throat or cough are recorded in the Agency's record-keeping software. Compliance will be measured during QAPI.

Upon determining that any employee has symptoms, potential exposure, or diagnosis of COVID-19, the employee will be ineligible to work for any client at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, at least 10 days have passed since symptoms first appeared; or if completely asymptomatic, 14 days after the confirmed exposure; or upon receiving negative COVID-19 test results. All clients who have been in contact with employee in the past 14 days, and all employees who work with those clients will be notified of potential exposure.

Upon determining that any client or member of a client's household has symptoms, potential exposure, or diagnosis of COVID-19, Agency instructs him/her to seek medical attention. Agency will evaluate the client's requirement for ongoing services until a negative test has been presented or client has been asymptomatic for 14 days. Client/Household Member may be placed on 14-day quarantine away from Agency and all employees. If a COVID-19 positive client requires continued assistance with activities of daily living that we are unable to provide, the Agency will ensure the client receives adequate care by a healthcare professional.

Employee or Client Statement: I, Client Copy agree to wear PPE provided to me by the Agency, such as masks and gloves, and to use universal precautions at all times to try to prevent the spread of COVID-19. I agree to follow Agency's Infection Control Procedures and COVID-19 screening protocol.

Client Copy	X Client Copy	
Employee or Client Printed Name	Employee or Client Signature	Date

ESTAN HEALTHCARE SERVICES, INC.

HUMAN RESOURCES CODE CHAPTER 102 RIGHTS OF THE ELDERLY

SEC. 02.001. DEFINITIONS

In this chapter:

(1) "**Convalescent and nursing home"** means an institution licensed by the Department of Aging and Disability Services under Chapter 242, Health and Safety Code

(2) **"Home health** services "means the provision of health services for pay or other Consideration in Client's residence regulated under Chapter 142, Health and Safety Code.

(3) **"Alternate care"** means services provided within an elderly individual's own home, Neighborhood, or community, including:

(A) day care;

(B) foster care

(C) alternate living plans, including personal care services; and

(D) supportive living services, including attendant care residential repair, or emergency response services.

(4) **"Person providing services"** means an individual, corporation, association, partnership, or other private or public entity providing convalescent and nursing home services, home health services, or alternate care services.

(5) **"Elderly individual"** means an individual 60 years of age or older.
Added by Acts 1983, 68th Leg., p.5159, ch. 936, Sec. 1, eff. Sept. 1, 1983.
Amended by Acts 1985, 69th Leg., ch. 264, Sec. 25, eff. Aug. 26,1985.

Amended by Acts *1991,* 72nd leg., Ch. 14, Sec. 284(20),(30), eff. Sept. *1,* 1991; Acts 1995. 74th Leg., ch. 76, Sec. 8. 101, eff. Sept. 1, 1995; Acts 1997, 75th Leg., eff. Sept. 1, 1997.

SEC. 102.002 PROHIBITION

(a) A person providing services to the Elderly may not deny an elderly individual a right guaranteed by this chapter.

(b) Each Agency that licenses, registers, or certifies a person providing services shall require the person to implement and enforce this chapter. A violation of this chapter is grounds for suspension or revocation of the license, registration or certification of a person of providing services.

Amended by 1985, 69th Leg., ch 264, sec. 26, eff. Aug. 26, 1985, Acts 1997, 75th Leg., eff. Sept. 1, 1997.

ESTAN HEALTHCARE SERVICES, INC.

HUMAN RESOURCES CODE CHAPTER 102 RIGHTS OF THE ELDERLY

SEC. 102.003 --- RIGHTS OF THE ELDERLY

(a) An Elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where unlawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

(b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:

(1) has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits and services;

(2) Has the right to be free from abuse, neglect and exploitation; and

(3) If protective measures are required has the right to designate a guardian or representative to ensure the right to quality steward ship of the individuals affairs.

(c) An elderly individual has the right to be free from physical and mental abuse, including corporal punishment or physical or chemical restraints that are administered for the purpose of discipline or convenience and not required treat the individual's medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the elderly individual or others from injury. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel.

(d) A mentally retarded elderly individual with a court-appointed guardian of the person may participate in a behavior modification program involving use of the restraints or adverse stimuli only with the informed consent of the guardian.

(e) An elderly individual may not be prohibited from communicating in the individual's native language with other individuals or employees for the purpose of acquiring or providing any type of treatment, care, or services.

(f) An elderly individual may complain about the individual's care or treatment. the complaint may be anonymously or communicated by a person designated by an individual. The person providing service shall promptly respond to resolve the complaint. The person providing services may not discriminate or take other punitive action against an elderly individual who makes a complaint.

(g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversation, meeting with family, and access to resident councils. An elderly person may send and receive an unopen mail, and the person providing services shall ensure that the individual's mail is sent and delivered promptly. If an elderly person is married and the spouse is receiving services, the couple may share a room.

(h) An elderly person may participate in activities of social, religious, or community groups unless the participation interferes with the rights of other persons.

(i) An elderly may manage the individual's personal financial affairs. The elderly individual may authorize in writing another person to manage the individual's money. The elderly individual may

choose the manner in which the individual's money is managed, including a money management program, a representative payee program, a financial power of attorney, a trust, or a similar method, and the individual may choose the least restrictive of these methods. A person designated to manage an elderly person's money shall do so in accordance with each applicable program policy, law, or rule. On request of the elderly individual or the individual's representative, the person designated to manage the elderly person' shall make available the related financial records and provide an accounting of the money. An elderly individual's designation of another person to manage the individual's money does not affect the individual's ability to exercise another right described by this chapter. If an elderly individual is unable to designate another person to manage the Individual's affairs and a guardian designated by a court, the guardian shall manage the individual's money in accordance with Probate Code and other applicable laws.

(j) An elderly individual is entitled to access to the individual's personal and clinical records. These records are confidential and may not be released without the elderly individual's consent, except the records may be released:

(1) To another person providing services at the time of the elderly is transferred; or

(2) if the release is required by another law.

(k) A person providing services shall fully inform an elderly individual, in language the individual can understand, of the individual's total medical condition and shall notify the individual whenever there is a significant change in the person's medical condition.

(l) An elderly individual may choose and retain a personal physician and is entitled to be fully informed and in advance about the treatment or care that may individual's well- being.

(m) An elderly individual may participate in individual plan of care that describes the individual's medical, nursing and psychosocial needs and how the needs will be met.

(n) An elderly individual may refuse medical treatment after the elderly individual"

(1) as advised by the person providing the service of the possible consequences of refusing treatment; and

(2) acknowledges that the individual clearly understands the consequences of refusing treatment.

(o) An elderly individual may retain and use personal possessions, including clothing and furnishings, as space permits. The number of personal possessions may be limited for the health and safety of other individuals.

(p) An elderly individual may refuse to perform services for the person providing services.

(q) Not later than the 30th day after the date the elderly individual is admitted for personal services, a person providing service shall inform the individual:

(1) Whether the individual is entitled to benefits under Medicare or Medicaid; and

(2) which items and services are covered by these benefits, including items or services for which the elderly individual may not be charged

(r) A person providing services may not transfer or discharge an elderly individual unless:

(1) the transfer is for the elderly individual's welfare, and the individual's needs cannot be met by the person providing services;

(2) the elderly individual's health is improved sufficiently so that services are no longer needed;

(3) the elderly individual's health and safety or the health and safety of another individual may be endangered if the transfer or discharge was not made

(4) the person providing services ceases to operate or to participate in the program that reimburses the person providing services for the elderly individual's treatment or care; or

(5) the elderly individual fails, after reasonable and appropriate notices, to pay for services.

(s) Except in an emergency, a person providing service may not transfer or discharge an elderly individual from a residential until the 30th day after the date providing services provide written notice to the elderly individual, the individual's legal representative, or a member of the individual's family stating:

(1) that the person providing services intends to transfer or discharge the individual;

(2) the reason for the transfer or discharge listed in subsection (r);

(3) the effective date of the transfer or discharge

(4) if the individual is to be transferred, the location to which the individual will be transferred; and

(5) the individual's right to appeal the action and the person to whom the appeal should be directed

(t) An elderly individual may:

(1) make a living will by executing a directive under the natural Death Act (Chapter 672, Health and Safety Code);

(2) execute a medical power of attorney for health care under Chapter 135, Civil Practice and Remedies Code; or

(3) designate a guardian in advance of need to make decision regarding the individual's care should the individual become incapacitated.

Added by acts 1983, 68th leg., p. 5159, ch. 936, Sec. 1, eff. Sept. 1, 1983.
Amended by Acts 1997, 75th leg., eff. Sept 1, 1997.

SEC. 102.004. LIST OF RIGHTS

(a) A person providing services shall provide each elderly individual with a written list of individual's rights responsibilities, including each provision of Section 102.003, before providing services or as soon after providing services as possible, and shall post the list in a conspicuous location.

(b) A person providing service must inform an elderly individual of changes or revision in the list.

Added by Acts 1983, 68th Leg., p.5159, ch. 936, Sec. 1, eff. Sept. 1, 1983. Amended by Acts 1997, 75th Leg., eff. Sept.1, 1997.

SEC. 102.005. RIGHTS CUMULATIVE.

The rights described in this chapter are cumulative of other rights or remedies to which an elderly individual may be entitled under the law.

Added by Acts 1997, 75th Leg., eff. Sept. 1, 1997

ESTAN HEALTHCARE SERVICES, INC.

Home Health Agency

*** Important Numbers ***

Police department 911
Fire department 911
Ambulance 911
Sheriff department 911

City of Houston (Water) 713-837-0311

American Red Cross 1-800-733-2767

Texas Department of Health 713-767-3000

Texas Dept of Aging And Disability 1-800-458-9858

Texas Dept. of family and Protective Services 1-800-252-5400

Rev 09/01/23

ESTAN HEALTHCARE SERVICES, INC.

DISASTER READINESS

Each year thousands of people are killed or seriously injured due to fires or to violent storms. The seriousness of these threats increased dramatically when mobility, strength, and vision or perception decline.

The purpose of this literature is to help your safety by providing you with information that lets you know exactly what you should do should an emergency situation occur. Study each page thoroughly and relate the information provided with the layout exist and safe locations within your home.

Fire prevention and Protection

Nothing is more devastating or deadly than a home fire. Too frequently, fire occurs at night, when a prompt escape is delayed due to sleep. Obviously, the best way to protect you and your family from fire is to prevent a fire. Here is a good fire prevention checklist to use in your home.

- No open flames around oxygen delivery systems
- No smoking in bed
- Fire extinguisher in the kitchen and workshop
- Electrical system safe and not overloaded
- Stove are kept free of grease or other flammable materials
- Rubbish and flammable materials kept in covered metal cans until disposal
- Candle used for atmosphere or other purposes, carefully extinguished
- Gas or electric room heaters turned off before retiring
- Strike anywhere (kitchen) matches kept in a box or other container
- Woodwork, within 18 inches of a furnace, stove, or heater, protected by an insulating shield
- Stove or heaters a safe distance from curtains or drapes

Smoke Detector

- Installation

The advent of the smoke detector ushered in a new level of fire protection in the home. Smoke detectors are simple devices that are easy to install, check and maintain

Install smoke detector on ceilings or on high walls in two main areas, in any room, such as the kitchen, where a fire may originate, and secondly, in a hallway preferably at the head of a stairway near enough to bedrooms to be heard.

ESTAN HEALTHCARE SERVICES, INC.

DISASTER READINESS

Battery Checks

Check each smoke detector (usually by passing a button) every six months to insure it is operational. If weakened or disabled, have a friend or relative perform this check for you.

Escaping a Fire

Guidelines

Escaping a home fire is not always easy, even for family members who are not weak or incapacitated. Many victims are untouched by flames, but are choked by smoke or gases. The only way to be reasonably sure of escaping a fire is to have a plan of escape.

The National Safety Council has established these guidelines, but naturally, you must develop your own escape plan because every home situation is somewhat different.

- Draw a floor plan of your home. On the plan, lay out an escape route for each room on each floor. Have alternate routes where possible, especially for bedrooms, should the planned escape be blocked by smoke or fire.
- Bedrooms of semi or totally incapacitated individuals should have access to more than one exit route…. A ground level window or easy access to that room from a roof.
- Devise a way to awaken other family members. A whistle by each bed is an excellent emergency alarm.
- Devise a plan to assist weak or disabled family members.
- Do not waste precious time gathering valuables or getting dressed. Simply get out!
- Keep bedroom closed at night to delay the spread of both flames and deadly smoke and gases
- Test for fire by touching the door knob. If it is warm or hot, leave the door closed and escape using another route.

If unable to exit the room, stuff wet towels or clothing into door cracks. Stay near a slightly opened window. In a room filled with smoke, cover nose and mouth with damp towel and get as low to the floor as possible.

TORNADO • FLASH FLOOD • EARTHQUAKE • WINTER STORM • HURRICANE • FIRE • HAZARDOUS MATERIALS SPILL

Emergency Preparedness Checklist

Federal Emergency Management Agency

The next time disaster strikes, you may not have much time to act. Prepare now for a sudden emergency.

Learn how to protect yourself and cope with disaster by planning ahead. This checklist will help you get started. Discuss these ideas with your family, then prepare an emergency plan. Post the plan where everyone will see it—on the refrigerator or bulletin board.

For additional information about how to prepare for hazards in your community, contact your local emergency management or civil defense office and American Red Cross chapter.

Emergency Checklist

Call Your Emergency Management Office or American Red Cross Chapter

- ❑ Find out which disasters could occur in your area.
- ❑ Ask how to prepare for each disaster.
- ❑ Ask how you would be warned of an emergency.
- ❑ Learn your community's evacuation routes.
- ❑ Ask about special assistance for elderly or disabled persons.

Also...

- ❑ Ask your workplace about emergency plans.
- ❑ Learn about emergency plans for your children's school or day care center.

Create an Emergency Plan

- ❑ Meet with household members to discuss the dangers of fire, severe weather, earthquakes and other emergencies. Explain how to respond to each.
- ❑ Find the safe spots in your home for each type of disaster.
- ❑ Discuss what to do about power outages and personal injuries.
- ❑ Draw a floor plan of your home. Mark two escape routes from each room.
- ❑ Show family members how to turn off the water, gas and electricity at main switches when necessary.
- ❑ Post emergency telephone numbers near telephones.
- ❑ Teach children how and when to call 911, police and fire.
- ❑ Instruct household members to turn on the radio for emergency information.
- ❑ Pick one out-of-state and one local friend or relative for family members to call if separated during a disaster (it is often easier to call out-of-state than within the affected area).
- ❑ Teach children your out-of-state contact's phone numbers.
- ❑ Pick two emergency meeting places.
  1) A place near your home in case of a fire.
  2) A place outside your neighborhood in case you cannot return home after a disaster.
- ❑ Take a basic first aid and CPR class.
- ❑ Keep family records in a water and fire-proof container.

Prepare a Disaster Supplies Kit

Assemble supplies you might need in an evacuation. Store them in an easy-to-carry container such as a backpack or duffle bag.

Include:

- ❑ A supply of water (one gallon per person per day). Store water in sealed, unbreakable containers. Identify the storage date and replace every six months.
- ❑ A supply of non-perishable packaged or canned food and a non-electric can opener.
- ❑ A change of clothing, rain gear and sturdy shoes.
- ❑ Blankets or sleeping bags.
- ❑ A first aid kit and prescription medications.
- ❑ An extra pair of glasses.
- ❑ A battery-powered radio, flashlight and plenty of extra batteries.
- ❑ Credit cards and cash.
- ❑ An extra set of car keys.
- ❑ A list of family physicians.
- ❑ A list of important family information; the style and serial number of medical devices such as pacemakers.
- ❑ Special items for infants, elderly or disabled family members.

Home Hazard Hunt

In a disaster, ordinary items in the home can cause injury and damage. Anything that can move, fall, break or cause a fire is a potential hazard.

- ❑ Repair defective electrical wiring and leaky gas connections.
- ❑ Fasten shelves securely and brace overhead light fixtures.
- ❑ Place large, heavy objects on lower shelves.
- ❑ Hang pictures and mirrors away from beds.
- ❑ Strap water heater to wall studs.
- ❑ Repair cracks in ceilings or foundations.
- ❑ Store weed killers, pesticides and flammable products away from heat sources.
- ❑ Place oily polishing rags or waste in covered metal cans.
- ❑ Clean and repair chimneys, flue pipes, vent connectors and gas vents.

If You Need to Evacuate

- ❑ Listen to a battery powered radio for the location of emergency shelters. Follow instructions of local officials.
- ❑ Wear protective clothing and sturdy shoes.
- ❑ Take your Disaster Supplies Kit.
- ❑ Lock your house.
- ❑ Use travel routes specified by local officials.

If you are sure you have time ...

- ❑ Shut off water, gas and electricity, if instructed to do so.
- ❑ Let others know when you left and where you are going.
- ❑ Make arrangements for pets. Animals may not be allowed in public shelters.

Prepare an Emergency Car Kit

Include:

- ❑ Battery powered radio, flashlight and extra batteries
- ❑ Blanket
- ❑ Booster cables
- ❑ Fire extinguisher (5 lb., A-B-C type)
- ❑ First aid kit and manual
- ❑ Bottled water and non-perishable high energy foods such as granola bars, raisins and peanut butter
- ❑ Maps, Shovel, Flares
- ❑ Tire repair kit and pump

Fire Safety

- ❑ Plan two escape routes out of each room.
- ❑ Practice fire drills at least twice a year.
- ❑ Teach family members to stay low to the ground when escaping from a fire.
- ❑ Teach family members never to open doors that are hot. In a fire, feel the bottom of the door with the palm of your hand. If it is hot, do not open the door. Find another way out.
- ❑ Install smoke detectors on every level of your home. Clean and test them at least once a month. Change batteries at least once a year.
- ❑ Keep a whistle in each bedroom to awaken household in case of fire.
- ❑ Check electrical outlets. Do not overload outlets.
- ❑ Purchase and learn how to use a fire extinguisher (5 lb., A-B-C type).
- ❑ Have a collapsible ladder on each upper floor of your house.
- ❑ Consider installing home sprinklers.

The Federal Emergency Management Agency's Community and Family Preparedness Program and the American Red Cross Community Disaster Education Program are nationwide efforts to help people prepare for disasters of all types. For more information, please contact your local emergency management office and American Red Cross chapter. This brochure and other preparedness materials are available by calling FEMA at 1-800-480-2520, or writing: FEMA, P.O. Box 2012, Jessup, MD 20794-2012. Publications are also available on the World Wide Web at:

FEMA's Web site: http://www.fema.gov
American Red Cross Web site: http://www.redcross.org

Your Local Contact is:

L-154
ARC 4471
Aug. 1993

HURRICANE • FIRE • HAZARDOUS MATERIALS SPILL

Federal Emergency Management Agency

EMERGENCY PREPAREDNESS CHECKLIST

TORNADO • FLASH FLOOD • EARTHQUAKE • WINTER STORM

United States
Environmental Protection
Agency

EPA530-F-98-025b
December 1998
www.epa.gov/osw

Solid Waste and Emergency Response (5305W)

EPA

Disposal Tips for Home Health Care

You can help prevent injury, illness, and pollution by following some simple steps when you dispose of the sharp objects and contaminated materials you use in administering health care in your home.

You should place:

- Needles
- Syringes
- Lancets
- Other sharp objects

in a hard-plastic or metal container with a screw-on or tightly secured lid.

Many containers found in the household will do, or you may purchase containers specifically designed for the disposal of medical waste sharps. Before discarding a container, be sure to reinforce the lid with heavy-duty tape. **Do not put sharp objects in any container you plan to recycle or return to a store, and do not use glass or clear plastic containers** (see additional information below). Finally, make sure that you keep all containers with sharp objects out of the reach of children and pets.

We also recommend that:

- Soiled bandages
- Disposable sheets
- Medical gloves

be placed in securely fastened plastic bags before you put them in the garbage can with your other trash.

Preventing Injury and Pollution

Containers with sharps are not recyclable

EPA promotes all recycling activities, and therefore encourages you to discard medical waste sharps in sturdy, nonrecyclable containers, when possible. If a recyclable container is used to dispose of medical waste sharps, make sure that you don't mix the container with other materials to be recycled. Since the sharps impair a container's recyclability, a container holding your medical waste sharps properly belongs with the regular household trash. You may even want to label the container, "NOT FOR RECYCLING." In addition, make sure your sharps container is made of nonbreakable material and has a lid that can be securely closed. These steps go a long way toward protecting workers and others from possible injury. (Although disposing of recyclable containers removes them from the recycling stream, the expected impact is minimal.)

Local Programs

Your state or community environmental programs may have other requirements or suggestions for disposing of your medical waste. You should contact them for any information you may need.

For additional copies of these disposal tips, please call the RCRA Hotline at 800 424-9346 or TDD 800 553-7672. In the Washington, DC metropolitan area, the number is 703 412-9810 or TDD 703 412-3323. The RCRA Hotline operates weekdays, 9 a.m. to 6 p.m., eastern time.

Respiratory Virus Guidance

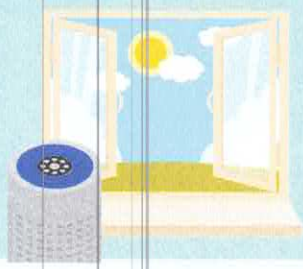
Core prevention strategi

CORE STRATEGIES

Immunizations

Hygiene

Steps for Cleaner Air



Additional prevention strategies

ADDITIONAL STRATEGIES

Masks

Distancing

Tests

Layering prevention strategies can be especially helpful when:

- ✓ Respiratory viruses are causing a lot of illness in your community
- ✓ You or those around you have risk factors for severe illness
- ✓ You or those around you were recently exposed, are sick, or are recovering

ESTAN HEALTHCARE SERVICES, INC.

256.00 Emergency Preparedness Policy and Procedure

Policy:
The Emergency Preparedness and Response Plan (EPRP) will be initiated for any emergency situation that interferes with normal operations and disrupts service delivery.
*This policy was updated **July 3, 2020** to comply with current Texas HHSC and CDC Emergency Preparedness Planning and Implementation Guidelines following Emergency Rules for COVID-19 pandemic.*

Purpose:
To maintain **Estan Healthcare Services, Inc.** operations and/or mitigate service disruption during emergency situations impacting the internal and external Agency's environment.

POLICY APPLICATION

Procedure:
Agency will take the following actions to develop, maintain and implement an EPRP.

1. The Administrator and other individuals designated by the Administrator will be involved in the development of the EPRP.
2. The **Administrator** will be the Agency's Disaster Coordinator. The **Alt Administrator** will be the Agency's Alternate Disaster Coordinator.
3. Agency has developed a continuity of business operations plan that address the emergency financial needs, essential functions for client services, critical personnel, and how to return to normal operations as quickly as possible.
   A. If the Agency office suffers damage, the office will be relocated to a site designated by the Administrator. Options include:
      i. The Owner's house.
      ii. The Administrator's house.
      iii. Another Agency office site as determined by the Administrator.
      iv. A temporary location that is undamaged by the emergency.
   B. Agency will notify the Texas Department of Health and Human Services (HHS) of the temporary location.
   C. All of the Agency computer records (including scheduling, client records, employee records, payroll records, accounts receivable, communication history, etc.) are kept in the cloud through a HIPAA compliant, password protected web application. If a disaster struck the building and destroyed the computer equipment, then the Agency would still be able to retrieve its data using any internet-capable device.
   D. All available administrative staff, including the Administrator, would commence working from the temporary location as they were able.
4. As part of the EPRP development Agency will conduct a risk assessment to identify the potential disasters from natural and man-made causes most likely to occur in its service area. See **256.01 for Risk and Hazard Vulnerability Assessment**.
5. The EPRP will include a description of the actions and responsibilities for Agency staff in each phase of emergency planning, including **M**itigation, **P**reparedness, **R**esponse, and **R**ecovery (MPRR) for the applicable potential disasters identified in the Agency's risk assessment and hazard vulnerability and responsibilities when warning of an emergency is not provided.

See **256.02 Staff Mitigation, Preparedness, Response and Recovery Plan**.

6. The Disaster Coordinator or an individual designated by the Disaster Coordinator will monitor disaster-related news and information (including after-business hours, weekends and holidays) to receive warnings of imminent and occurring disasters (when known). If there is no warning of a disaster the Disaster Coordinator will act in the same manner as soon as the disaster is discovered. Several methods, including, but not limited to, the following may be used to monitor such known or impending disasters:
   A. Television: WOAI, Emergency Alert System
   B. Radio: WOAI, Emergency Alert System
   C. Internet
      1. WOAI.com
      2. Smartphone Internet Access: "Ready South TX" or local Emergency Service Mobile App
      3. http://www.txdps.state.tx.us/dem/
   D. Amber Alerts
   E. Internal Agency communications
7. The following actions will occur as part of the response and recovery phase of the EPRP:
   A. The Administrator or designee may initiate each phase.
   B. The Administrator or designee(s) as part of the Agency's communication protocol (see 256.03 **Communication Tree**) will communicate with:
      i. Owner
      ii. Administrative Staff
      iii. Caregivers
      iv. Clients or someone responsible for a client's EPRP
      v. County and city emergency management officials if needed during and after an event
      vi. State and federal emergency management entities if warranted by the nature of the event
      vii. Other entities as applicable such as HHS, Emergency Medical Services and other health care providers.
   C. The primary mode of communication will be by phone or cell phone. If the primary mode of communication fails other methods may be used as available, including (but not limited to) the following:
      i. CB radios
      ii. Satellite phones
      iii. Internet technologies
      iv. HAM radio
8. Agency will discuss and provide the following information to each client upon admission to the Agency:
   A. The actions and responsibilities of Agency' staff during and immediately following an emergency;
   B. The client's responsibilities in the Agency's emergency preparedness and response plan. The client's responsibilities will be included as part of the "rights and responsibilities" given to each Agency client upon admission;
   C. A list of community disaster resources that can assist a client during a disaster-related emergency, such as those provided by HHS and local, state, and federal emergency management agencies, including the special needs registry maintained by the state; and

D. Materials that describe survival tips and plans for evacuating and sheltering in place.

9. Agency will release client information as allowed by state and federal law in accordance with the its current policy on "release of records" (See **301.01 Confidentiality of Client Records**).
10. Agency will triage clients using a four-class system (Level 1, 2, 3 and 4). This system will categorize clients based on services provided by the Agency, the need for continuity of services provided by the Agency and the availability of someone to assume responsibility for a client's emergency response plan and needed by the client. Each level is defined below:
    A. **Level 1**: Potential to be life threatening without care. Requires ongoing treatment to preserve life. Unable to evacuate/transport one's self. Unable to withstand any interruption in power supply. No readily available caregiver or caregiver unable to provide needed care. Requires transport to an acute care facility or specialized shelter situation.
    B. **Level 2**: Not immediately life threatening but the client may suffer adverse effects without service. Visits may be postponed for 24-48 hours with minimal adverse effect. Able to withstand up to 48-hour power interruption. Unable to transfer/transport self or no transportation available from caregiver.
    C. **Level 3**: Low potential for adverse effect if visits are delayed 48-72 hours. Able to care for self or willing and able caregiver readily available. Transportation available from family, friends, volunteers or caregiver.
    D. **Level 4**: Visits may be postponed 72 hours or more with little or no adverse effects. Willing and able caregiver readily available or patient independent in most ADLs. Transportation available from family, friends, volunteers or caregiver.
11. Agency will identify clients who may need evacuation assistance and maintain triage records in the event of an emergency in order to coordinate and communicate with the appropriate individuals and relevant state, federal and local officials if applicable. **Agency is not responsible for physically evacuating clients**. Clients will be provided with 211-Texas information so that they may be registered for Evacuation Transportation service.
12. Agency will ensure that all staff are trained and oriented about their responsibilities in the Agency's EPRP upon hire and whenever the plan is revised.
13. The Administrator and other individuals designated by the Administrator will review the plan at least annually, and after each actual emergency response, to evaluate its effectiveness and to update the plan as needed.
14. As part of the annual internal review, the Agency will test the response phase of the emergency preparedness and response plan in a planned drill if not tested during an actual emergency response. A planned drill will be limited to implementation of the Agency's "**Communication Tree" (See 256.03 Communication Tree)**.
15. Agency will make a good faith effort to comply with the requirements of this policy during a disaster. If the Agency is unable to comply with any of the requirements of this policy, then the Agency will document in the Agency's records attempts of staff to follow procedures outlined in the EPRP.
16. Certain emergency situations that are beyond the Agency's control, such as when roads are impassable or when a client relocates to a place unknown to the Agency may make it impossible to provide services. In the event that it is not possible to reach the Agency's Level 1 clients due to impassable roads the Agency will contact the appropriate county or city emergency management official to respond as appropriate. If the client relocates to an unknown location, the Agency will document attempts in the Agency's records to locate the client and inform the physician or practitioner if involved with the client's ongoing care.

17. If written records are damaged during disaster, the Agency will not reproduce or recreate paper client records. If electronic data is available, records may be reproduced as long as the following is included:
    A. Date the record was reproduced;
    B. The Agency staff member who reproduced the record; and
    C. How the original record was damaged.
18. Agency will provide the following information to HHS Home and Community Support Services Agencies licensing unit no later than five working days after any of the following temporary changes resulting from the effects of an emergency or disaster. The notice and information will be submitted by fax or e-mail. If fax and e-mail or unavailable, notifications will be provided by telephone, and followed up in writing as soon as possible. If communications with the HHS licensing unit is not possible, the Agency will fax, e-mail, or telephone the designated survey office to provide notification. The following must be communicated to HHS:
    A. Temporary Relocation of the Agency:
        i. The license number for the place of business and the date of the temporary relocation;
        ii. The physical address and phone number of the temporary location; and
        iii. The date an Agency returns to a place of business after temporary relocation.
    B. Temporary expansion of the service area to provide services during disaster:
        i. The license number and revised boundaries of the original service area;
        ii. The date of temporary expansion; and
        iii. The date an Agency's temporary expansion of its service area ends.

ESTAN HEALTHCARE SERVICES, INC.

285.70 Universal Precautions, PPE Protocol

These procedures were adapted from CDC.gov website.

A. Handwashing and Hand Hygiene Methods

1. CDC recommends using Alcohol Based Hand Rubs (ABHR) with greater than 60% ethanol or 70% isopropanol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink.

2. Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom, and as often as possible when in any public setting.

3. Gloves should be worn for all personal care involving potential for contact with bodily fluids. Change gloves between tasks.
   a. Remove gloves by using the inside cuff that is touching the wrist of Hand A and pulling the glove inside out.
   b. Then hold that glove in Hand B and pull the second glove off using the inside cuff that is touching the wrist of Hand B.
   c. Discard in the trash and wash your hands or use ABHR immediately, before donning a clean set of gloves.

4. Hand Hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis

5. Cleaning your hands reduces:
   a. The spread of potentially deadly germs to patients
   b. The risk of healthcare provider colonization or infection caused by germs acquired from the patient

6. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations.

7. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.

8. During Routine Patient Care:
   a. Use an Alcohol-Based Hand Sanitizer any time a hand-washing station is not available
   b. Wash with Soap and Water
      i. Immediately before touching a patient
      ii. When hands are visibly soiled

iii. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
iv. After caring for a person with known or suspected infectious diarrhea
v. Before moving from work on a soiled body site to a clean body site on the same patient
vi. After known or suspected exposure to spores (e.g. B. anthracis, C difficile outbreaks)
vii. After touching a patient or the patient's immediate environment
viii. After contact with blood, body fluids or contaminated surfaces
ix. Immediately after glove removal