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PRESS RELEASE

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FLORIDA NURSING HOME TRAGEDY PROMPTS QUESTIONS ABOUT DISASTER PREPAREDNESS IN SENIOR FACILITIES

The death of eight residents in a Hollywood, Florida senior facility days after Hurricane Irma struck left everyone from government officials to family members of the deceased with questions. How could a rehabilitation center with more than 150 patients survive one of the most catastrophic hurricanes in recent history, only to have eight frail, elderly people die three days afterward and force an evacuation of the rest of the patient population in the facility? The senior citizens who died did not drown in flood waters or starve from lack of food. Instead, all eight died of heat exhaustion because the storm had knocked out the transformer that powered the facility's air conditioning system.

Cambridge Chairman Jeffrey Davis, who has worked with senior facility operators across the US including Florida, was saddened to hear of the deaths. "Our sincerest sympathies go out to the families of the individuals who passed away," he offered.

Compounding the tragic nature of the deaths and subsequent evacuation was the fact that the Florida government had proactively tried to prevent such an event from occurring. Governor Rick Scott issued an order to two state entities, the Agency for Health Care Administration and the Department of Elder Affairs, to implement emergency measures designed to keep residents safe in health care facilities, including seniors' facilities. The measures were to include having backup generators on standby that could sufficiently power the needs of the facility.

The rehabilitation center in question did have some electrical power left, so staff quickly set up fans and mobile air conditioners to mitigate the intense Florida heat. Apparently, those efforts were not sufficient, as one by one residents began to succumb to the stifling temperatures. It isn't known how many residents actually suffered symptoms of heat exhaustion, but it is clear that at least eight died from complications resulting from prolonged heat exposure.

The US government has previously produced a set of requirements that all nursing homes must meet in order to be prepared for a large-scale disaster. A recent report by the Department of Health and Human Services indicates that 92 percent of the country's facilities are in compliance with the regulations. However, the federal Office of Investigations (OOI) conducted an investigation into these preparedness guidelines and found gaping holes in the plan itself that may leave seniors exposed to the risk of death and health problems anyway. One such oversight was a lack of clear instructions on how to accurately label and identify individual patients during the act of an evacuation. Another was the absence of a uniform or cohesive plan for identifying and/or transporting an individual patient's medications during an evacuation.

These "holes" disturb Davis, who would like to see the language in the federal guidelines tightened up so that there will be no oversights or misinterpretations in the future. "It is unfortunate that it often takes a tragedy such as this one to correct problems within federally-mandated plans."

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