System Overview

August 2026

safely.living

THE SYSTEM

From Call for Aid to Connected Health and Safety

Call for aid button
(per apartment)

Wearables
(optional)

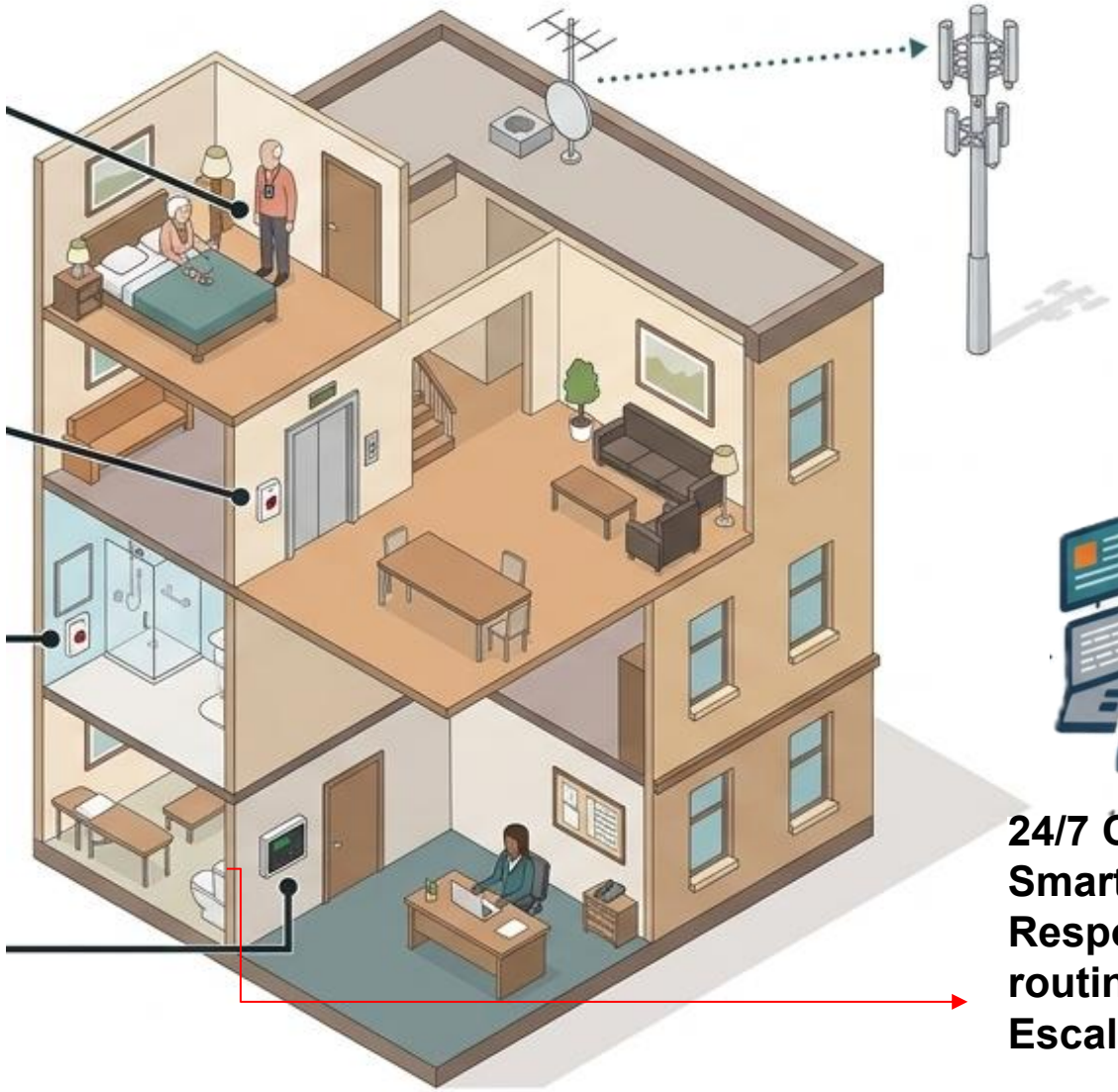
Base station
(Property office)

Wearable or wall mounted devices in every unit

Additional coverage for hallways and common areas (including pools)

Water and moisture resistant systems in bathrooms

Connects to central panel in Property Office and Care Team



24/7 Care Team
Smart Triage
Response
routing
Escalations

THE SYSTEM

How It Works: Three Integrated Layers

TECHNOLOGY

Wireless Infrastructure

› Pendant & wall-mounted call-for-aid buttons (COTS)

› AES-128 encrypted, 1,200 ft range

› 5-year battery — installed in one day

› HUD NSPIRE / UL and HIPAA compliant

ENGAGEMENT

24/7 Health & Safety Navigation

› Real people answer in under 20 seconds

› Proactive outreach 2× monthly

› SDOH screening & Level 1–4 triage

› Multi-lingual, fully redundant teams

INTEGRATION

Care Data Pipeline

› Real-time EHR API integration

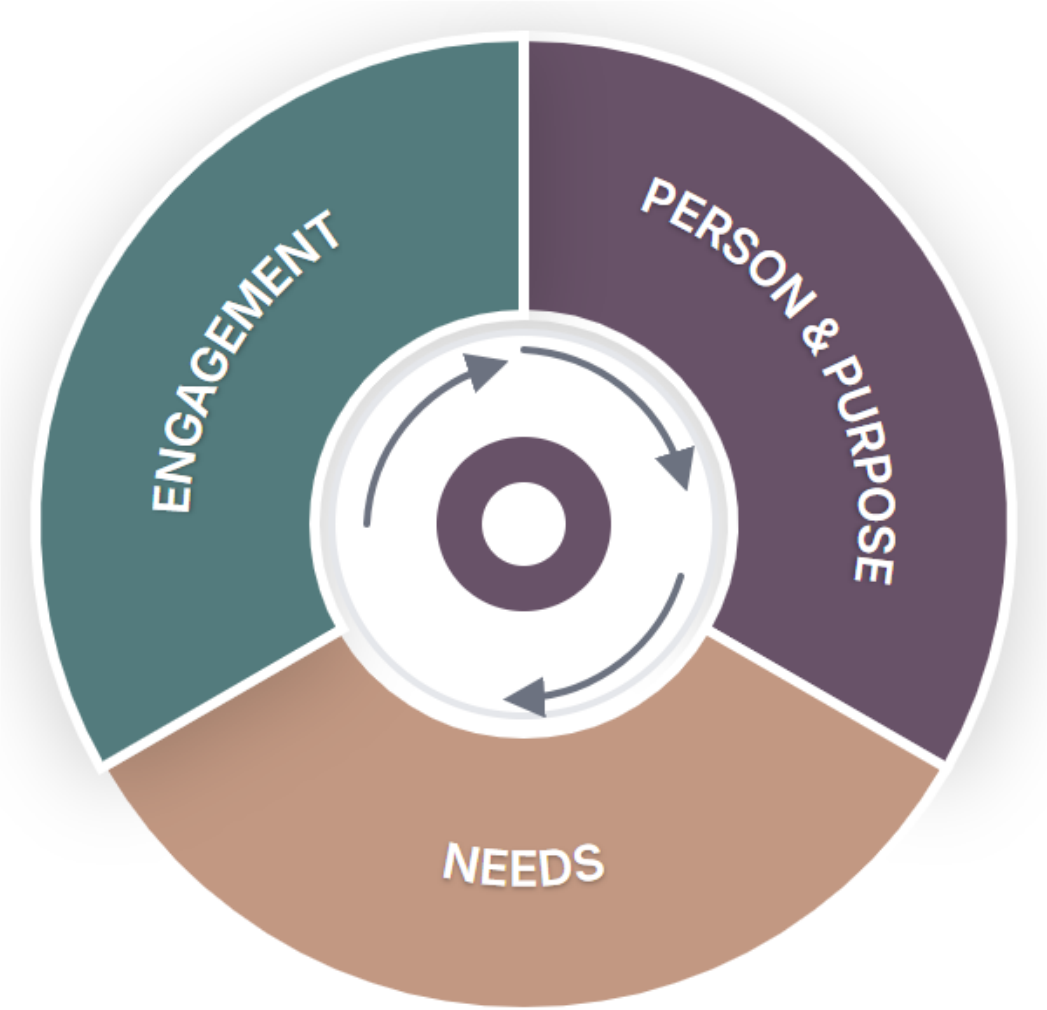
› Z-code & resolution code delivery

› Level 3/4 escalation to care team

› ACO quality reporting ready

THE SYSTEM

Connected Health Circle



1. We build living resident profiles that coordinators and care teams can act on immediately — person and purpose data, care network, and ancillary services in one place.

2. Every interaction surfaces potential behavioral, physical or social health issues - Not just emergencies—early signals of isolation, unmet needs, or declining stability.

3. Every button press or outreach triggers the appropriate care protocol.
Actions are taken, resolution codes are captured, and next steps are identified—creating continuity, accountability, and measurable outcomes.

THE SYSTEM

Living Profiles Care Teams Can Learn From and Act On

1.

Person & Purpose

The Living Profile

- Who they are
- What matters to them
- Care preferences
- Goals & aspirations
- Key relationships
- Daily routines

Care Network

- Primary care provider
- Specialists & therapists
- Pharmacy & medications
- Home care team
- Emergency contacts
- Community supports

Support Ecosystem

- Transportation resources
- Meal & nutrition services
- Medical equipment
- Faith & community groups
- Local services & programs

THE SYSTEM

Every Interaction Expands Health and Safety Dataset

Useful for predicting patterns and early signals of need

2.

Needs

Social Determinants

- Housing stability
- Food security
- Transportation access
- Social isolation
- Financial strain
- Caregiver burden

Behavioral & Emotional

- Depression screening
- Anxiety & stress
- Grief & loss
- Cognitive changes
- Suicide risk assessment
- Substance concerns

Physical & Functional

- Chronic disease management
- Medication adherence
- Fall risk & mobility
- Pain management
- Post-hospital follow-up
- Elder abuse indicators

THE SYSTEM

Data Power Interventions and Closes The Loop

3.

Engagement

Surface Pre-Emergent Issues

- Proactive wellness calls
- Early warning detection
- Mood & tone changes
- Missed check-ins
- Escalating concerns
- Pattern recognition

Triage & Stay Connected

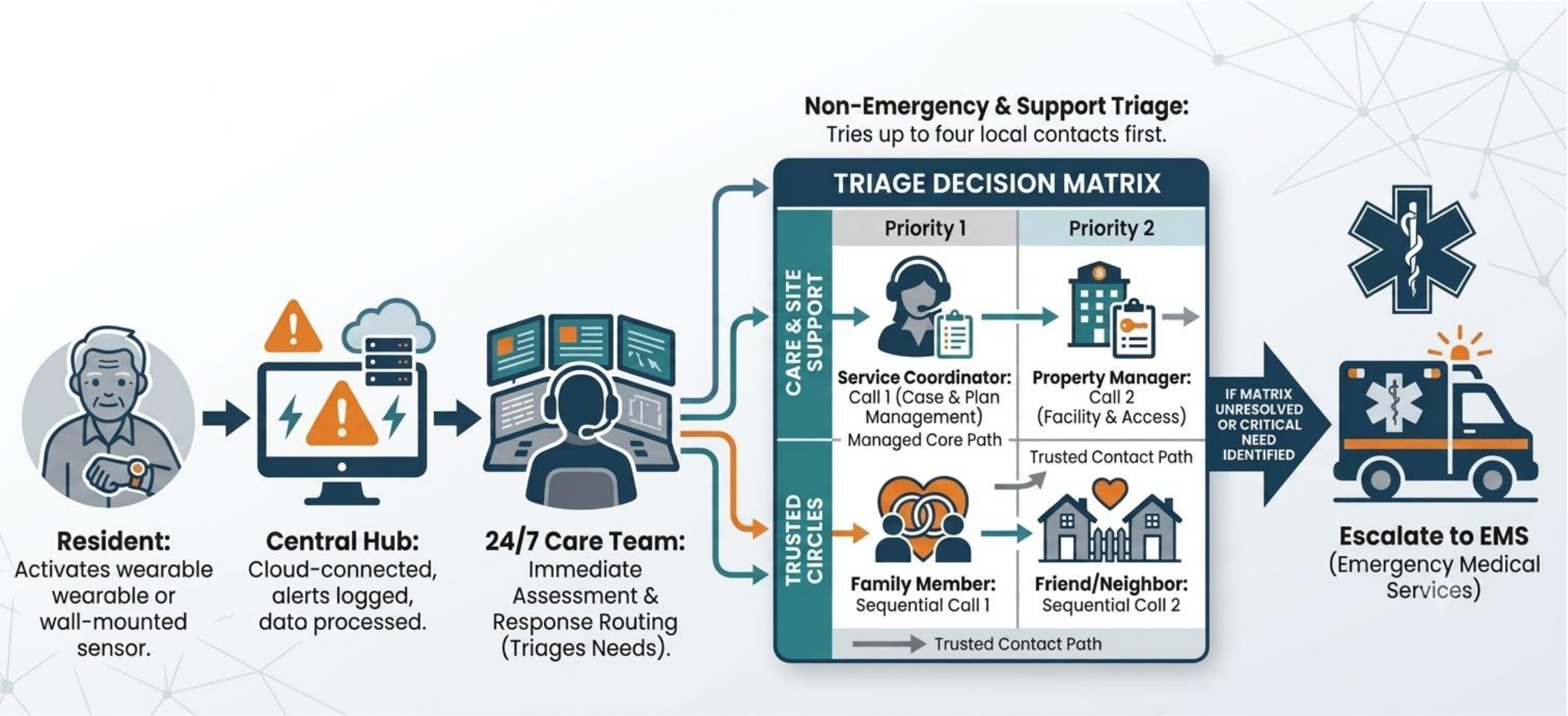
- Priority-based routing
- Care team alerts
- Warm handoffs
- Follow-up scheduling
- 24/7 response coverage
- Family notifications

Analyze & Act

- Outcomes tracking
- Population insights
- Intervention effectiveness
- Risk stratification
- Z-code reporting
- Continuous improvement

HOW IT WORKS

Our connected health and safety processes



HOW IT WORKS

From First Call to Ongoing Care

ONBOARDING

- In-home, professional installation
- Introductions and service walk-through
- Complete differentiated Resident profile (example below)
- ID needs / and eligibility (benefit activation)

FIRST 30 DAYS

- Continued interaction, driving rapport
- ~2 proactive outbound calls
- Probing social determinants to inform best practice care protocols and anticipate solutions to Resident issues before they occur

ONGOING CARE

- Ongoing communication to close loop on needs (min one outbound call per month)
- Facilitate access to ongoing care (virtual visit scheduling)
- As needed care team escalations

INSIGHTS & DATA

- Resident reporting and real-time data access via APIs
  - Resident specific care logs
  - Resident satisfaction surveys
  - Resident engagement & utilization
- Ongoing communication with case managers, home health and support coordinators as applicable

INTERVENTION

- Appropriate and real time escalation of emergent (e.g. chest pain) and non-emergent (e.g. psychosocial episodes) issues to the point of intervention
- Three-way calls with care managers and Resident via device

Ongoing interactions prompt interventions as needed

Enabling “care by exception” model for scalability

HOW IT WORKS

We Handle the Calls — You Get the Right Escalations

LEVEL 1: INFORMATIONAL / REASSURANCE

Social connection, light coaching, check-ins, information gathering

LEVEL 2: NON-EMERGENT INTERVENTION

Care network notifications, community services, support coordinator hand off, care manager referral

LEVEL 3: URGENT CLINICAL CONCERN

Care network notifications + Nurse line, provider notification, same-day follow-up.

LEVEL 4: EMERGENT

Care network notifications + Crisis line, EMS, emergency protocols

We build off standard triage and escalation protocols. We tailor protocols to any customer-defined parameters.

Can implement specialized care protocols tied to top conditions (Diabetes, COPD, Anxiety / Depression, CHF/Stroke, Hip / Knee replacement)