San Joaquin County
Long Term Care Facility Evacuation Plan

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San Joaquin County Emergency Medical Services Agency
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1. PURPOSE AND AUTHORITY

This plan is intended for all Long Term Care Facilities in San Joaquin County, including facilities which are licensed by the State of California and operating under Title 22 CCR. They are hereafter referred to in this document as "Facility". This plan is issued under the joint authority of the San Joaquin County Emergency Medical Services Agency Administrator and the San Joaquin County Public Health Officer (*California Health and Safety Code, Division 2.5, Article 4, Sections 1797.150)* requiring the development of medical and health disaster plans for the Operational Area.

The San Joaquin County Emergency Medical Services Agency oversees and regulates the provision of all pre-hospital care and medical transport *(California Health and Safety Code, Division 2.5, Article 4, Section 1797.220, 1797.222 and 1798 to 1798.6*).

The San Joaquin County Public Health Officer will oversee all decisions made by "at risk" facilities and may under the emergency powers granted by State law (*California Health and Safety Code, Division 101, Section 101040 and 101080*) order evacuations or sheltering-in-place or countermand decisions to evacuate.

2. OBJECTIVE AND RELATED POLICIES

The objective of this plan is to ensure the orderly and timely movement of patients/residents from single or multiple facilities which need to be evacuated to a safe location. The following related policies will be the basis for conducting facility evacuations.

2.1 Use of Incident Command System

It is the policy of San Joaquin County that once the decision is made to evacuate a facility, the facility will be designated an incident site**.** A Unified Incident Command will be established at the facility, which will be comprised of facility officials and other public safety agencies with jurisdictional or statutory authority (EMS, Public Health, Fire, Law, etc.).

2.2 Control of Patient Dispersal

During a single facility emergent evacuation San Joaquin General Hospital, acting as the Operational Area Disaster Control Facility, will determine all patient destinations other than movement to home settings. The Disaster Control Facility will use modified Multi-Casualty Incident (MCI) procedures as specified in this document.

During single or multiple facility planned evacuations patient dispersal will be coordinated by the EMS Agency Duty Officer (Medical Health Operational Area Coordinator) in conjunction with the facility officials, and the Incident Commander(s).

2.3 Mutual Aid

Medical mutual aid requests will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) in compliance with the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).

2.4 Emergency Evacuation Designation Categories

Each facility will prepare a list of patient/resident Emergency Evacuation Designation Categories, which indicate the level of care needed, types of facility, and types of transportation required for each patient/resident (See Appendix A, Form LTC 401). The three Emergency Evacuation Designation Categories are as follows:

1) LEVEL I: Patients/residents are usually transferred from inpatient medical treatment facilities and require a level of care only available in hospital or Skilled Nursing or Sub-Acute Care Facilities. These patients/residents are transported by Advance Life Support (ALS) ambulances.

   A. Examples:
   - Bedridden, totally dependent, difficulty swallowing
   - Requires dialysis
   - Ventilator-dependent
   - Requires electrical equipment to sustain life
   - Critical medications requiring daily lab monitoring
   - Requires continuous IV therapy
   - Terminally ill

2) LEVEL II: Patients/residents have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in home setting or public shelters. These patients/residents are transported by Basic Life Support (BLS) ambulances, wheel chair van, car, van or bus.

   A. Examples:
   - Bedridden, stable, able to swallow
   - Wheelchair-bound requiring complete assistance
   - Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject
   - Requires assistance with tube feedings
   - Draining wounds requiring frequent sterile dressing changes
   - Oxygen dependent; requires respiratory therapy or assistance with oxygen
   - Incontinent; requires regular catheterization or bowel care

3) LEVEL III: Patients/residents are able to meet own needs or has reliable caretakers to assist with personal and/or medical care. These patients/residents are transported by car, van or bus.

A. Examples:
- Independent; self-ambulating or with walker
- Wheelchair dependent; has own caretaker if needed
- Medically stable requiring minimal monitoring (i.e., blood pressure monitoring)
- Oxygen dependent; has own supplies
- Medical conditions controlled by self-administered medications
- Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment

2.5 Evacuation Status Categories

During planned multiple facility evacuations field level response personnel, under the direction of the Incident Commander, will make contact with each Long Term Care Facility in the evacuation zone. Each facility will be evaluated on their ability to evacuate and placed into one of four Evacuation Status Categories (See Appendix B, Form LTC 402). The four Evacuation Status Categories are as follows:

1) STATUS A: The facility has a destination identified for its patients/residents and can evacuate/transport without assistance from outside agencies

2) STATUS B: The facility does not have a destination identified for its patients/residents but can evacuate/transport its residents without assistance from outside agencies if provided a destination.

3) STATUS C: The facility has a destination identified for its patients/residents and only requires evacuation/transportation assistance from outside agencies.

4) STATUS D: The facility does not have a destination identified for its patients/residents and requires evacuation/transportation assistance from outside agencies.

3. EVACUATION PROCEDURES – SINGLE FACILITY

These procedures apply to the movement of patients/residents from one facility only. Such evacuations are classified as "emergent" or "planned". Emergency situations may also warrant the use of a "shelter-in-place" protective action.

3.1 Emergent Evacuation

An emergent evacuation is defined as unplanned spontaneous movement of patients/residents out of the facility due to an immediate threat that renders the facility unsafe for occupancy. Because an emergent evacuation is caused by an unforeseen event, other emergency response agencies should be immediately activated to assist.

Example: A fire breaks out in the facility prompting the immediate evacuation of all patients/residents and staff. Property damage is severe and the facility is determined to be unsafe for occupancy. Patients/residents are transported to other facilities for care.

3.1.1. Notification Requirements

1) Facility notifies

   A. 9-1-1

   B. Once it is assured that all patients/residents have been removed from harm's way, the evacuating facility is responsible to notify applicable State and county authorities.

STATE LICENSING AUTHORITIES

California Department of Public Health
Licensing & Certification (Sacramento District Office) (916) 263-5800
- Toll Free . . . . (800) 554-0354
- Fax . . . . (916) 341-6840
- Fax . . . . (916) 341-6841
- Duty Officer Pager (After Hours & Weekends) . (916) 328-3605

Dept. of Social Services/Community Care Licensing
- Residential Care Facilities for Elderly (RCFE) . (209) 948-3627
- Adult/Children Residential Facilities (ARF) . . . . (916) 263-4700

COUNTY AUTHORITIES

Emergency Medical Services Agency . . . . (209) 468-6818
- Duty Officer (After Hours and Weekends). . . . . (209) 234-5032
- Duty Officer (Secondary After Hours Contact) . (209) 236-8339

Public Health Services (Health Officer) . . . . (209) 468-3411
- After Hours and Weekends . . . . (209) 468-6000

Human Services Agency Ombudsman
- 24 Hour Crisis Line . . . . (800) 231-4024

Behavioral Health Services/Public Conservator Office
- 24 Hour Crisis Clinic/Administrator Officer . . . . (209) 468-8686

2) Medical Group Supervisor notifies

   A. Disaster Control Facility

3) Disaster Control Facility notifies

   A. EMS Agency Duty Officer

   B. Acute Care Hospitals

4) Acute Care Hospitals notify

   A. Designated Skilled Nursing Facilities (See Appendix C and D)

5) Incident Commander

   A. Other resources as required

3.1.2. **Patient/Resident Movement** (Single Facility)

Patients/residents will be evacuated to the closest safe area outside of the facility, e.g. parking lot, lawns, or other buildings, in accordance with the facility's Emergency Operations Plan.

During an emergent evacuation the Operational Area Disaster Control Facility (San Joaquin General Hospital) will be contacted for final patient/resident destination decisions. Contact with the Disaster Control Facility will be made by the Medical Group Supervisor or Patient Transportation Group Supervisor.

The county designated EMS dispatch center is the single point of contact for all EMS and transportation resources. Suitable transportation will be determined by the Medical Group Supervisor, e.g. ambulance, wheel chair van, bus or other.

3.2. **Planned Evacuation** (Single Facility)

A planned evacuation is defined as a situation where the threat to the facility is not immediate and time is available to conduct orderly patient/resident movement. Patients/residents can remain within the facility without danger to their well being for a limited amount of time until relocation arrangements are made.

Example: A facility experiences an air conditioning system failure at 6:00 AM. Temperatures are forecasted to reach a high of 110 degrees by 4:30 PM. Facility officials determine that if they are unable to repair the air conditioning system in time they will need to evacuate patients/residents to another facility. Adequate time is available to make arrangements for patients/residents to be moved to other facilities in the area.

3.2.1. **Notification Requirements**

1) Facility notifies

Emergency Medical Services Agency . . . . (209) 468-6818
- Duty Officer (After Hours and Weekends). . . . . (209) 234-5032
- Duty Officer (Secondary After Hours Contact) . (209) 236-8339

A. Facility officials are responsible to notify applicable State and county authorities.

STATE LICENSING AUTHORITIES

California Department of Public Health
Licensing & Certification (Sacramento District Office) (916) 263-5800
- Toll Free . . . . (800) 554-0354
- Fax . . . . (916) 341-6840
- Fax . . . . (916) 341-6841
- Duty Officer Pager (After Hours & Weekends) . (916) 328-3605

Dept. of Social Services/Community Care Licensing
- Residential Care Facilities for Elderly (RCFE) . (209) 948-3627
- Adult/Children Residential Facilities (ARF) . . . . (916) 263-4700

COUNTY AUTHORITIES

Human Services Agency Ombudsman
- 24 Hour Crisis Line . . . . (800) 231-4024

Behavioral Health Services/Public Conservator Office
- 24 Hour Crisis Clinic/Administrator Officer . . . . (209) 468-8686

2) EMS Agency Duty Officer notifies

A. The EMS Agency Duty Officer will notify the local fire and law enforcement agencies.

B. The Duty Officer will also notify other outside agencies based upon the situation (Public Health Services, Ambulance Providers, OES, etc.).

3.2.2 **Patient/Resident Movement** (Single Facility/Planned)

The evacuating facility will implement its Emergency Operations Plan. The senior facility administrator will remain available to work with the responding EMS Agency Duty Officer to form a Unified Command. The facility administrator working as part of the Unified Command must have the authority to evacuate the facility and make time critical financial decisions. There will be three destination options for patient/resident movement: (1) Home Setting, (2) Like Facility, or (3) Temporary Medical Care Shelter.

Patients/residents will not be moved to acute care hospitals unless their medical condition requires it. The Medical Group Supervisor will make arrangements for patients/residents requiring transport to an acute care hospital in accordance with established pre-hospital care protocols. In the event that multiple patients/residents need to be transported to an acute care hospital the Region IV Multi Casualty Incident (MCI) Plan will be activated and patient dispersal decisions will be made by the Disaster Control Facility.

3.2.2.1 Movement of Patients/Residents to a Home Setting

During planned evacuations, the facility will contact the families of those patients/residents whose condition places them into Emergency Evacuation Destination Category Level III. This would indicate that their medical condition will allow for the temporary removal from the Long Term Care Facility. These patients/residents should be identified in advance.

The evacuating facility will contact families directly and provide the needed transportation and care information. If there are undue delays in contacting the families or their arrival, the patient will be transferred to another facility.

3.2.2.2 Movement of Patients/Residents to Like Facilities

Patients/residents in all three Emergency Evacuation Destination Category Levels are suitable for transport to a like facility. Facility officials will contact other like facilities with whom they have agreements with to make arrangements to receive patients/residents. The facility will also make arrangements with contracted transportation companies for the movement of patients/residents.

In the event that the facility is unable to identify like facilities to take patients/residents the EMS Agency Duty Officer will assist the facility in finding suitable facilities. The EMS Agency Duty Officer will also make arrangements for the transportation of patients/residents in the event that the facility is unable to do so.

3.2.2.3 Movement of Patients/Residents to a Alternate Care Site

The San Joaquin County Public Health Officer has the authority to order patients/residents to be moved to a facility other than another licensed Long Term Care Facility or an acute care hospital. The decision to move patients/residents to an Alternate Care Site will be communicated to the Incident Commander/Unified Command.

In this case, staff from the evacuating facility will accompany and stay with patients/residents in the Alternate Care Site.

3.2.3 **Medical Control** (Single Facility/Planned)

The patient's or resident's physician will continue to render care to their patient. The receiving facility will notify physicians of the temporary transfer of patients to the new facility.

The evacuating facility is responsible for ensuring that all patients are moved with the following items physically with them:

1) Pertinent Personal and Medical information (e.g. Face Sheet, Patient ID Sheet, Med Sheet, Treatment Sheets, Physician Orders, Advance Directives, etc.)
2) Name of patient's or resident's physician and telephone number
3) Resident Identification (Arm Band or Disaster Tag)
4) Medications for a minimum of seventy-two hours (if possible)
5) Change of clothes

3.3 **Shelter-In-Place** (Single Facility)

Patients/residents remain indoors and are moved to a safe refuge within the facility. Windows and doors are closed and the ventilation system closed to outside air. (See Appendix H)

Example: A train derailment occurs two miles upwind from the facility. One of the railcars, containing 180,000 pound of chlorine (a toxic gas), is leaking. Emergency personnel on scene estimate that the toxic gas will travel approximately five miles downwind, and advises the Incident Commander to issue a shelter-in-place order for all downwind residents and businesses within five miles of the release.

3.3.1 **Notification Requirements**

Same as 3.1.1

3.3.2 **Patient/Resident Movement**

There is no movement of the patients/residents outside the facility.

4. EVACUATION PROCEDURES – MULTIPLE FACILITIES

These procedures apply to movement of patients/residents from multiple facilities only. Such evacuations are classified as "emergent" and "planned". Emergency situations may also warrant the use of a "shelter-in-place" protective action.

In the event that more than one facility must be evacuated due to threatening conditions affecting a large geographic area, these procedures will become the guide for response and evacuation operations. The procedures of the single facility evacuation will only remain operative to the extent that they conform to these procedures.

Examples: The most likely events that could require the nearly simultaneous evacuation of multiple facilities are as follows:

1) A flood or threatened flood within a geographic area of the county.
2) Extended loss of critical utilities over a large area that presents a health risk to patients/residents in more than one facility.
3) A major earthquake that creates the extended loss of critical utilities as discussed in item 2 above, and/or renders multiple facilities unsafe for occupancy due to structural damage.

4.1 Emergent Evacuation

An emergent evacuation is defined as unplanned spontaneous movement of patients/residents out of the facility due to an immediate threat that renders the facility unsafe for occupancy. Because an emergency evacuation is caused by an unforeseen event, other emergency response agencies should be immediately activated to assist.

4.1.1. Notification Requirements

The notification requirements are the same as 3.1.1. In addition the EMS Duty Officer will send out a CAHAN Alert to all Long Term Care Facilities in the county notifying them of the emergent evacuation and requesting information on how many patients/residents they are able to receive.

4.1.2 Patient/Resident Movement

In addition to the patient/resident movement procedures found in 3.1.2, the City of Stockton's Metropolitan Medical Response System (MMRS) Plan may be activated in order to obtain additional transit buses and/or vans.

4.2 Planned Evacuation (Multiple Facilities)

A planned evacuation is defined as a situation where the threat to the facility is not immediate and time is available to conduct orderly patient/resident movement. Patients/residents can remain within the facility without danger to their well being for a

limited amount of time while relocation arrangements are made.

Example: A nearby river has been at flood stage and is now forecasted to reach danger stage within twenty-four hours, creating a significant risk of a levee failure and widespread flooding. Government officials have issued an evacuation order for the area of greatest risk. The evacuation area includes a mixture of residential and commercial property, as well as five Long Term Care Facilities.

4.2.1. Notification Requirements

Same as 4.1.1

4.2.2 Patient/Resident Movement

Same as 4.1.2

4.3 Shelter-In-Place

Same as 3.3

4.4 Evacuation Management Procedures and Responsibilities

4.4.1 Activation

The San Joaquin County Office of Emergency Services will work with appropriate city officials and the Emergency Medical Services Administrator and the Public Health Officer (or their designees) to determine that the situation requires the activation of this plan. This determination will be communicated to the Operational Area EOC, city EOCs and affected Incident Commanders in the field.

The Long Term Care Facilities will be notified of the evacuation by a CAHAN Alert issued by the EMS Agency Duty Officer. The notified Long Term Care Facilities located outside of the evacuation area will be asked to reply to the CAHAN Alert with information on the number(s) of like facility patients/residents they can receive.

The community will be notified of the evacuation order and extent of evacuation through the Emergency Alert System (EAS).

In the event of an extended loss of a critical utility, or facility structural damage, the San Joaquin County Environmental Health Department, working with on-site Incident Commanders (and appropriate building officials if necessary), will make the final determination that the facility must be evacuated. If it is determined that more than one site must be evacuated then this plan will become operational.

4.4.2 **Command and Control** (Multiple Facilities)

Upon activation of this plan, the Emergency Medical Services Administrator and the Public Health Officer (or their designees) will establish the Medical/Health Branch at the Operational Area Emergency Operations Center (EOC), or in close communications with the Operational Area EOC, to perform functions identified in this plan. The Medical/Health Branch will work with elements of the community medical system as well as city, regional, and State officials to coordinate and control operations affecting community medical and Long Term Care Facilities.

4.4.3 **Facility Contact and Evacuation Capability Assessment**

Affected jurisdictions will identify which Evacuation Zones are affected by the evacuation order and will make appropriate modifications to Evacuation Zone Maps to further define the area to be evacuated. The field level Incident Commander(s) will manage the evacuation within their jurisdiction(s).

Evacuation Maps have been prepared for each Evacuation Zone and contain lists of known critical facilities, including Long Term Care Facilities. The Incident Commander will use these lists to ensure that contact is made with each Long Term Care Facility listed for the following purposes:

1) Ensure that the facility has received the evacuation order.

2) Assess the facility's ability to carry out the evacuation order. This assessment will place the facility in one of four Evacuation Status Categories (A to D).

   A. STATUS A: The facility has a destination identified for its patients/residents and can evacuate/transport without assistance from outside agencies.

   B. STATUS B: The facility does not have a destination identified for its patients/residents but can evacuate/transport its residents without assistance from outside agencies if provided a destination.

   C. STATUS C: The facility has a destination identified for its patients/residents and only requires evacuation/transportation assistance from outside agencies.

   D. STATUS D: The facility does not have a destination identified for its patients/residents and requires evacuation/transportation assistance from outside agencies.

See Appendix B (Form LTC 402) to document the contact and assessment.

The Incident Commander will ensure that the time the facility was contacted and the facility's Evacuation Status (A to D) is recorded on the appropriate Evacuation Zone Map.

This information will also be relayed to the Operational Area Medical/Health Branch as soon as has been collected.

4.4.4 **Prioritization of Facility Evacuation** (Multiple Facilities)

The Operational Area Medical/Health Branch will perform the following functions based on reports received from the Incident Commander(s) and/or city EOCs, and other relevant sources of information:

1) Evaluate, in conjunction with the Operational Area Planning/Intelligence Section, the relative risk for each facility including the time of arrival of threat, size of facility, and degree of threat (e.g. potential depths of flooding at facility site).

2) Determine one of two strategies for movement of facilities without an identified destination (Evacuation Status B and D).

    A. Strategy #1: Transport patients/residents directly to a final destination. This is the preferred strategy in most cases in order to minimize patient/resident transfer trauma.

    B. Strategy #2: Transport patients/residents to a temporary facility with movement to a final destination made at a later time.

3) Determine the priority for each facility in Evacuation Status C or D for receipt of transportation assistance.

4.4.5 **Implementation of Facility Evacuation**

Based on the strategy decided upon for the movement of facilities without a destination, the Operational Area Medical/Health Branch will work with the Medical Health Operational Area Coordinator (MHOAC) to find destinations for each facility. If the MHOAC is unable to find a destination for each facility within the Operational Area (County), the OES Region IV Regional Disaster Medical Health Specialist (RDMHS) will be contacted for assistance.

The Operational Area Medical/Health Branch will notify the appropriate city EOCs and/or Incident Commanders of evacuation priorities and destinations. In addition, the Medical/Health Branch will coordinate the deployment of transportation resources (ambulances, buses, vans and cars) with city EOCs and/or Incident Commanders for facilities in Evacuation Status B, C, and D.

Incident Commanders will oversee the on-site assistance to facilities awaiting evacuation to help protect patients/residents in-place until such time as the evacuation can be initiated and completed.

4.4.6 **Communications**

Communications between the Operational Area EOC, city EOCs, and field level response personnel will follow the chain of command identified in the Standardized Emergency Management System (SEMS) and National Incident Management System NIMS).

The Operational Area EOC working with appropriate city officials will provide ongoing instructions and information on the evacuation to facilities through the Emergency Advisory Radio System (EARS). Instructions on monitoring this information will be provided through the Emergency Alert System (EAS).

Appendix A

FACILITY NAME:_________________________________ **DATE:** __________

COMPLETED BY: _________________________________ **TIME:** __________

EMERGENCY EVACUATION DESTINATION CATEGORIES *for* LONG TERM CARE FACILITY PATIENTS / RESIDENTS			
LEVEL OF CARE	**FACILITY TYPE**	**TRANSPORT TYPE**	**NUMBER OF PATIENTS/ RESIDENTS**
LEVEL I ***Description:*** *Patients/residents are usually transferred from inpatient medical treatment facilities and require a level of care only available in hospital or Skilled Nursing or Sub-Acute Care Facilities.* ***Examples***: • Bedridden, totally dependent, difficulty swallowing • Requires dialysis • Ventilator-dependent • Requires electrical equipment to sustain life • Critical medications requiring daily lab monitoring • Requires continuous IV therapy • Terminally ill	Like Facility SNF or Sub-Acute Acute Care Hospital	ALS	
LEVEL II ***Description:*** *Patients/residents have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in home setting or public shelters.* ***Examples***: • Bedridden, stable, able to swallow • Wheelchair-bound requiring complete assistance • Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject • Requires assistance with tube feedings • Draining wounds requiring frequent sterile dressing changes • Oxygen dependent; requires respiratory therapy or assistance with oxygen • Incontinent; requires regular catheterization or bowel care	Like Facility Temporary Medical Care Shelter	BLS Wheelchair Van Car/Van/Bus	
LEVEL III ***Description:*** *Patients/residents are able to meet own needs or has reliable caretakers to assist with personal and/or medical care.* ***Examples***: • Independent; self-ambulating or with walker • Wheelchair dependent; has own caretaker if needed • Medically stable requiring minimal monitoring (i.e., blood pressure monitoring) • Oxygen dependent; has own supplies • Medical conditions controlled by self-administered medications • Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment	Like Facility Home Setting Temporary Medical Care Shelter	Car/Van/Bus	

(FORM LTC 401) INSTRUCTIONS: Document the number(s) of facility patients/resident in each category. Provide a copy of this form to the Incident Commander during evacuations.

Appendix B

FACILITY NAME: ______________________________________ **DATE:** _________

RESPRESENTATIVE NAME: _____________________________ **TIME:** ___________

CONTACT MADE BY: ____
(Name and Agency)

EVACUATION STATUS CATEGORIES *for* LONG TERM CARE FACILITIES	
EVACUATION STATUS DESCRIPTIONS	STATUS
STATUS A The facility **has a destination** identified for its patients/residents and **can evacuate/transport** without assistance from outside agencies.	
STATUS B The facility **does not have a destination** identified for its patients/residents but **can evacuate/transport** its residents without assistance from outside agencies if provided a destination.	
STATUS C The facility **has a destination** identified for its patients/residents and only **requires evacuation/transportation assistance** from outside agencies.	
STATUS D The facility **does not have a destination** identified for its patients/residents and **requires evacuation/transportation assistance** from outside agencies.	
COMMENTS	

(FORM LTC 402) INSTRUCTIONS: During planned multiple facility evacuations, field level response personnel will make contact with each Long Term Care Facility in the evacuation zone. Each facility will be evaluated on their ability to evacuate and placed into one of four Evacuation Status Categories. Use this form to document your contact and assessment. Communicate your findings up the chain of command immediately.

Appendix C

Disaster Control Facility/Acute Care Hospital Skilled Nursing Facility Evacuation Procedures

Upon notification of an emergency evacuation of a single Skilled Nursing Facility, the San Joaquin Disaster Control Facility will contact all acute care hospitals in San Joaquin County.

1) Each hospital Emergency Department will be notified by the Disaster Control Facility of the evacuation by EMSystem® and MCI “Blast Phone”.

2) Each acute care hospital will contact their assigned Skilled Nursing Facilities and obtain the number of patients/residents each can accept. (See Appendix D).

3) The acute care hospitals will report back to the Disaster Control Facility, on the MCI “Blast Phone”, the number(s) of patients/residents each of their assigned Skilled Nursing Facilities can accept.

4) The Disaster Control Facility will instruct the Medical Group Supervisor, or Patient Transportation Group Supervisor if assigned, where to take each patient/resident.

5) The Disaster Control Facility will track the number of patients/residents transported to each destination.

6) The Patient Transportation Group Supervisor and facility personnel share the responsibility for tracking the name(s) and destination(s) of each patient/resident. The Patient/Resident Transportation Summary Worksheet, Form LTC 403, will be used to document patient tracking (See Appendix E).

Appendix D

Assignment of Skilled Nursing Facilities to Acute Care Hospitals

Dameron Hospital	**461-3166**
Delta Valley SNF	466-5341
Plymouth Square SNF	466-4341
Windsor Hampton Care Center	466-0456
Wagner Heights Nursing / Rehab.	477-5252
Whispering Hope Care Center	473-3004
Doctor's Hospital Manteca	**239-8301**
Palm Haven SNF	823-1788
Lodi Memorial Hospital	**339-7576**
Arbor Convalescent Hospital	333-1222
Crescent Court Nursing Home	367-7400
Delta Rehab. Center	334-3825
Fairmont Rehabilitation	368-0693
Wine Country Care Center	334-3760
Lodi Memorial Hospital TCU	333-3042
Vienna Nursing / Rehab. Center	368-7141
Kaiser Hospital Manteca	**825-3555**
Bethany Home	599-4221
Kaiser DP/SNF	825-3625
Manteca Care and Rehab Center	239-1222
Saint Joseph's Medical Center	**476-6400**
Golden Living Center - Hypana	477-0271
LaSalette Rehabilitation Center	466-2066
Meadow Wood	956-3444
St. Joseph Medical Center SNF	467-6394
Valley Gardens Health Care Center	957-4539
San Joaquin General Hospital	**468-6301**
Golden Living Center - Portside	466-3522
Golden Living Center - Chateau	477-2664
Crestwood Manor	478-2060
Windsor Elmhaven Care Center	477-4817
Good Samaritan SNF	948-8762
Creekside Care Center (Heritage)	478-6488
Sutter Tracy Community Hospital	**832-6018**
New Hope Care Center	832-2273
Tracy Convalescent	835-6034

Appendix E

PATIENT/RESIDENT TRANSPORTATION SUMMARY WORKSHEET				1. INCIDENT / FACILITY NAME:			2. DATE PREPARED	3. TIME PREPARED:	
PATIENT READY	PATIENT STATUS	INJURY TYPE (IE: HEAD)	MODE OF TRANSPORT	FACILITY DESTINATION	AMBULANCE CO. AND ID	PATIENT/RESIDENT NAME/ TAG NUMBER	OFF SCENE TIME	ETA	FACILITY ADVISED
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
	I D M								Y / N
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FORM LTC 403		4. PREPARED BY (PATIENT TRANSPORTATION GROUP SUPERVISOR and FACILITY REPRESENTATIVE)							

Appendix F

FACILITY EVACUATION CHECKLIST

EMERGENT EVACUATION

- ❑ **Implement Facility Emergency Evacuation Procedures**
  - Move patients/residents to safe area outside the facility
  - Recover pertinent personal and medical information, essential medications and medical equipment (if safe to do so).
- ❑ **Dial 9-1-1**
- ❑ **Establish Contact and Unified Command with First Responder agency**
  - Develop and Implement an Incident Action Plan
- ❑ **Determine the Emergency Evacuation Designation Categories for patients/residents**
  - Emergency Evacuation Destination Categories, Form LTC 401 (Appendix A)
  - Contact the families of Level III patients/residents for temporary transfer to a home setting
- ❑ **Document the names and destinations of each evacuated patient/resident**
  - Patient/Resident Transportation Summary Worksheet, Form LTC 403 (Appendix E)
- ❑ **Notify Applicable Licensing Agency**

PLANNED EVACUATION

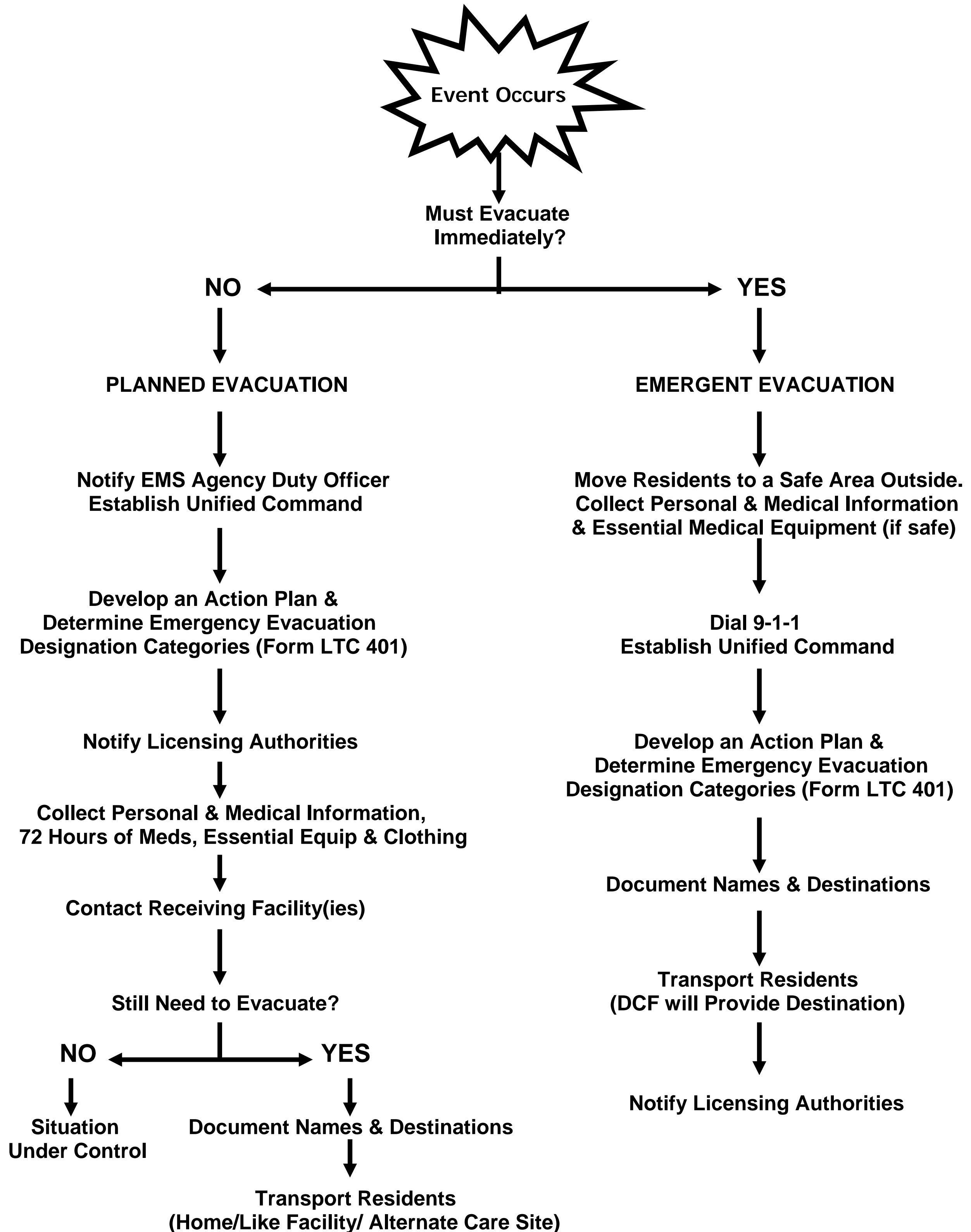
- ❑ **Notify the San Joaquin County EMS Agency Duty Officer**
  - (209) 234-5032 or (209) 236-8339
- ❑ **Establish Unified Command with EMS Agency Duty Officer**
  - Develop and Implement an Incident Action Plan
- ❑ **Determine the Emergency Evacuation Designation Categories for patients/residents**
  - Emergency Evacuation Destination Categories, Form LTC 401 (Appendix A)
  - Contact the families of Level III patients/residents for temporary transfer to a home setting
- ❑ **Notify Applicable Licensing Agency**
- ❑ **Collect pertinent personal and medical information, 72 hours of medications, essential medical equipment, and a change of clothing for each patient/resident**
- ❑ **Notify contracted receiving facilities**

Facility Name	24 Hour Telephone Number
1.	
2.	
3.	
4.	

- ❑ **Document the names and destinations of each evacuated patient/resident**
  - Patient/Resident Transportation Summary Worksheet, Form LTC 403 (Appendix E)

Appendix G

EVACUATION FLOWCHART



Appendix H

FACILITY SHELTER-IN-PLACE CHECKLIST

Implement this plan for a chemical release, if advised to Shelter-In-Place by emergency officials.

- ❑ Notify employees, visitors, patients/residents and vendors to Shelter-In-Place. (Sample message: "May I have your attention, please. San Joaquin County emergency authorities have advised us of a chemical emergency nearby. For your safety, everyone is requested to stay inside and Shelter-In-Place until we are notified that the emergency is over.")

- ❑ If you have a designated sheltering location with few windows and doors, ask people to move to that area. The area should have access to restrooms and drinking water.

- ❑ Close and lock windows. Secure doors – a better seal is achieved by locking doors. Post sign "Shelter-In-Place in Effect – Controlled Entry" at main door or window. Location where sign is kept: ___________________________________.

- ❑ Shut off heating, air conditioning or other ventilation system so outside air is not drawn indoors.

List locations where HVAC must be shut down and vents closed:
1.
2.
3.
4.

- ❑ Turn on AM radio and tune to KFBK 1530 to listen for further instructions.
  Location of radio at this facility: ____.

- ❑ Seal cracks around doors and windows (and any vents that do not close) with damp towels, duct tape, plastic sheeting, etc. Location where sealing supplies are kept: ____.

- ❑ Do not dial 9-1-1 unless you have an emergency that requires an immediate response. Keep lines free for emergency communication.

- ❑ After the emergency is over and county officials announce an "all clear" via the Emergency Alert System (EAS) and/or news media. Open doors and windows and air out the facility. Account for all employees, visitors, patients/residents and vendors. Turn heating, air conditioning and/or ventilation systems back on. Remove "Controlled Entry" sign. Replace/restock all emergency supplies, radio batteries, etc.

ACRONYMS

ACS	Alternate Care Site
ALS	Advanced Life Support
ADHC	Adult Day Health Care
ADCF	Adult Day Care Facility
ARF	Adult Residential Facility
BLS	Basic Life Support
CDHCS	California Department of Health Care Services
CDPH	California Department of Public Health
CAHAN	California Health Alert Network
CCRC	Continuing Care Retirement Community
DCF	Disaster Control Facility
EAS	Emergency Alert System
EARS	Emergency Advisory Radio System
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
HICS	Hospital Incident Command System
IC	Incident Commander
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
ICS	Incident Command System
MCI	Multi-Casualty Incident
MHOAC	Medical Health Operational Area Coordinator
NIMS	National Incident Management System
OES	Office of Emergency Services
RCFE	Residential Care Facility for the Elderly
RDMHC	Regional Disaster Medical/Health Coordinator
RDMHS	Regional Disaster Medical/Health Specialist
SEMS	Standardized Emergency Management System
SNF	Skilled Nursing Facility

Common Types of Long Term Care Facilities in California

The California Association of Health Facilities' membership is comprised of Skilled Nursing Facilities, Sub-Acute Care Facilities, Intermediate Care Facilities, Intermediate Care Facilities for the Developmentally Disabled, and Institutes for Mental Health. CAHF's Disaster Preparedness Program has a broader scope, and serves *all* residential long term care facilities in the state of California.

Long term care is a broad term and encompasses many different types of facilities. At this time, the Program does not specifically serve non-residential long term care facilities, although we welcome these providers to participate in our activities. Below are the most common types of long term care facilities in California and what they do.

- **Skilled Nursing Facilities (SNFs)** – Sometimes called "nursing homes" or "convalescent hospitals," these facilities provide comprehensive nursing care for chronically ill or short-term residents of all ages, along with rehabilitation and specialized medical programs.

- **Subacute-Care Facilities** – Specialized units often in a distinct part of a nursing facility, subacute-care facilities focus on intensive rehabilitation, complex wound care and post-surgical recovery for residents of all ages who no longer need the level of care found in a hospital.

- **Intermediate-Care Facilities (ICFs)** – In addition to room and board, these facilities provide regular medical, nursing, social and rehabilitative services for people not capable of full independent living.

- **Intermediate-Care Facilities for the Developmentally Disabled (ICF/DDs)** – Known at the federal level as ICFs/MR (mental retardation), these facilities provide services for people of all ages with developmental disabilities. ICF/DD-Hs (habilitative) and ICF/DD-Ns (nursing) have home-like settings with an average of six beds. ICF/DDs are larger homes with 16 or more beds.

- **Institutes for Mental Health (SNF/STPs)** – Designated in California as "special treatment programs," these facilities provide extended treatment periods for people of all ages with chronic mental-health problems; most of the clients are younger than 65. Specialized staff serve clients in a secured environment.

- **Residential Care Facility for the Elderly (RCFE)** – Also known as "Assisted Living Facilities", "retirement homes" or "board and care homes" these facilities provide care, supervision and assistance with activities of daily living, such as bathing and grooming. They may also provide incidental medical services under special care plans. Services are provided to persons 60 years of age and over and persons under 60 with compatible needs. The facilities can range in size from six beds or less to over 100 beds. The residents in these facilities require varying levels of personal care and protective supervision.

- **Continuing Care Retirement Communities (CCRCs)** – these facilities offer a long-term continuing care contract that provides for housing, residential services, and nursing care, usually in one location, and usually for a resident's lifetime. All providers offering continuing care contracts must first obtain a certificate of authority and a residential care facility for the elderly (RCFE) license. In addition, CCRCs that offer skilled nursing services must hold a Skilled Nursing Facility License issued by the Department of Health Services.

- **Adult Residential Facilities (ARFs)** – Facilities of any capacity that provide 24-hour non-medical care for adults ages 18 through 59, who are unable to provide for their own daily needs. Adults may be physically handicapped, developmentally disabled, and/or mentally disabled.

- **Residential Care Facilities for the Chronically Ill** – These facilities have a maximum licensed capacity of 25. Care and supervision is provided to adults who have Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus (HIV).

- **Social Rehabilitation Facilities** – Any facility that provides 24-hour-a-day non-medical care and supervision in a group setting to adults recovering from mental illnesses, who temporarily need assistance, guidance, or counseling.

Non-Residential Facilities

- **Adult Day Health Care (ADHC)** – "is an organized day program of therapeutic, social, and health activities and services provided pursuant to this chapter to elderly persons with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care. Provided on a short-term basis, adult day health care serves as a transition from a health facility or home health program to personal independence. Provided on a long-term basis, it serves as an option to institutionalization in long-term health care facilities, when 24-hour skilled nursing care is not medically necessary or viewed as desirable by the recipient or his or her family." [Health and Safety Code 1570.7]

  These programs provide individualized services in a group setting after developing an individual plan of care. ADHC is currently a Medi-Cal optional benefit. ADHC's are licensed by the Department of Health Services as health facilities.

- **Adult Day Care Facilities (ADCF)** – Also known as an Adult Day Program (ADP) these are facilities of any capacity that provide programs for frail elderly and developmentally disabled and/or mentally disabled adults in a day care setting. The State Department of Social Services licenses these programs as community care facilities. The majority of these licensed programs serve persons with developmental disabilities. A minority of programs serve older persons.