

# San Joaquin County Long Term Care Facility Evacuation Plan



July 20, 2007  
FINAL DRAFT

**San Joaquin County Emergency Medical Services Agency**  
500 West Hospital Road, Benton Hall, French Camp, California 95231

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**TABLE OF CONTENTS**

<b>Purpose and Authority</b> .....	<b>4</b>
<b>Objective and Related Policies</b> .....	<b>4</b>
Incident Command System	4
Control of Patient Dispersal	4
Mutual Aid	5
Emergency Evacuation Designation Categories	5
Evacuation Status Categories	6
<b>Evacuation Procedures – Single Facility</b> .....	<b>7</b>
Emergent Evacuation	7
Notifications Requirements	7
Patient/Resident Movement	8
Planned Evacuation	9
Notifications Requirements	9
Patient/Resident Movement	10
Movement to a Home Setting	10
Movement to a Like Facility	10
Movement to a Temporary Medical Care Shelter	11
Medical Control	11
Shelter-In-Place	11
Notifications Requirements	11
Patient/Resident Movement	11
<b>Evacuation Procedures – Multiple Facilities</b> .....	<b>12</b>
Emergent Evacuation	12
Notifications Requirements	12
Patient/Resident Movement	12
Planned Evacuation	12
Shelter-In-Place	13
Evacuation Management Procedures and Responsibilities	13
Activation	13
Command and Control	14
Facility Contact and Evacuation Capability Assessment	14
Prioritization of Facility Evacuation	15
Implementation of Facility Evacuation	15
Communications	16
<b>Appendix</b> .....	<b>17</b>
A – Emergency Evacuation Destination Categories Form (LTC 401)	17
B – Evacuation Status Categories Form (LTC 402)	18
C – DCF/Acute Care Hospital SNF Evacuation Procedures	19
D – Assignment of SNF to Acute Care Hospitals	20
E – Patient/Resident Transportation Summary Worksheet (LTC 403)	21
F – Facility Evacuation Checklist	22
G – Evacuation Flowchart	23
H – Facility Shelter-In-Place Checklist	24
<b>Acronyms</b> .....	<b>25</b>
<b>Common Types of Long Term Care Facilities in California</b> .....	<b>26</b>

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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).

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

### **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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**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) 341-6845
• 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

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

- 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.



**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**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) 341-6845
  - 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

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

- 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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**3.2.2.3 Movement of Patients/Residents to a Temporary Medical Care Shelter**

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 a temporary medical care shelter 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 temporary medical care shelter.**

**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 G)

**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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

#### 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

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

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).

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**San Joaquin County  
Long Term Care Facility Evacuation Plan**

**Appendix A**

**FACILITY NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**COMPLETED BY:** \_\_\_\_\_

**TIME:** \_\_\_\_\_

<b>EMERGENCY EVACUATION DESTINATION CATEGORIES for LONG TERM CARE FACILITY PATIENTS / RESIDENTS</b>			
<b>LEVEL OF CARE</b>	<b>FACILITY TYPE</b>	<b>TRANSPORT TYPE</b>	<b>NUMBER OF PATIENTS/ RESIDENTS</b>
<p align="center"><b>LEVEL I</b></p> <p><b>Description:</b> 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.</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Bedridden, totally dependent, difficulty swallowing</li> <li>• Requires dialysis</li> <li>• Ventilator-dependent</li> <li>• Requires electrical equipment to sustain life</li> <li>• Critical medications requiring daily lab monitoring</li> <li>• Requires continuous IV therapy</li> <li>• Terminally ill</li> </ul>	<p>Like Facility</p> <p>SNF or Sub-Acute</p> <p>Acute Care Hospital</p>	<p>ALS</p>	
<p align="center"><b>LEVEL II</b></p> <p><b>Description:</b> 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.</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Bedridden, stable, able to swallow</li> <li>• Wheelchair-bound requiring complete assistance</li> <li>• Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject</li> <li>• Requires assistance with tube feedings</li> <li>• Draining wounds requiring frequent sterile dressing changes</li> <li>• Oxygen dependent; requires respiratory therapy or assistance with oxygen</li> <li>• Incontinent; requires regular catheterization or bowel care</li> </ul>	<p>Like Facility</p> <p>Temporary Medical Care Shelter</p>	<p>BLS</p> <p>Wheelchair Van</p> <p>Car/Van/Bus</p>	
<p align="center"><b>LEVEL III</b></p> <p><b>Description:</b> Patients/residents are able to meet own needs or has reliable caretakers to assist with personal and/or medical care.</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Independent; self-ambulating or with walker</li> <li>• Wheelchair dependent; has own caretaker if needed</li> <li>• Medically stable requiring minimal monitoring (i.e., blood pressure monitoring)</li> <li>• Oxygen dependent; has own supplies</li> <li>• Medical conditions controlled by self-administered medications</li> <li>• Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment</li> </ul>	<p>Like Facility</p> <p>Home Setting</p> <p>Temporary Medical Care Shelter</p>	<p>Car/Van/Bus</p>	

**(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.

**San Joaquin County  
Long Term Care Facility Evacuation Plan**

**Appendix B**

**FACILITY NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RESPRESENTATIVE NAME:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**CONTACT MADE BY:** \_\_\_\_\_  
(Name and Agency)

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

**(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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**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 EMSsystem<sup>®</sup> 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).

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**Appendix D**

**Assignment of Skilled Nursing Facilities to Acute Care Hospitals**

**Dameron Hospital** **461-3166**  
Delta Valley Convalescent 466-5341  
Plymouth Square Convalescent 466-4341  
Sunbridge Hampton Care Center 466-0456  
Wagner Heights 477-5252  
Whispering Hope Convalescent 473-3004

**Doctor's Hospital Manteca** **239-8301**  
Palm Haven Convalescent 823-1788

**Lodi Memorial Hospital** **339-7576**  
Arbor Convalescent Hospital 333-1222  
Crescent Court Nursing Home 367-7400  
Delta Convalescent 334-3825  
Fairmont Rehabilitation 368-0693  
Wine Country Convalescent 334-3760  
Lodi Memorial Hospital TCU 333-3042  
Vienna Convalescent 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**  
Beverly Health Care Center 477-0271  
La Salette Convalescent 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**  
Beverly Manor of Stockton 466-3522  
Chateau Convalescent 477-2664  
Crestwood Manor Convalescent 478-2060  
Sunbridge Elmhaven Convalescent 477-4817  
Good Samaritan 948-8762  
Sunbridge Heritage of Stockton 478-6488

**Sutter Tracy Community Hospital** **832-6018**  
New Hope Care Center 832-2273  
Tracy Convalescent 835-6034



**San Joaquin County  
Long Term Care Facility Evacuation Plan**

**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**

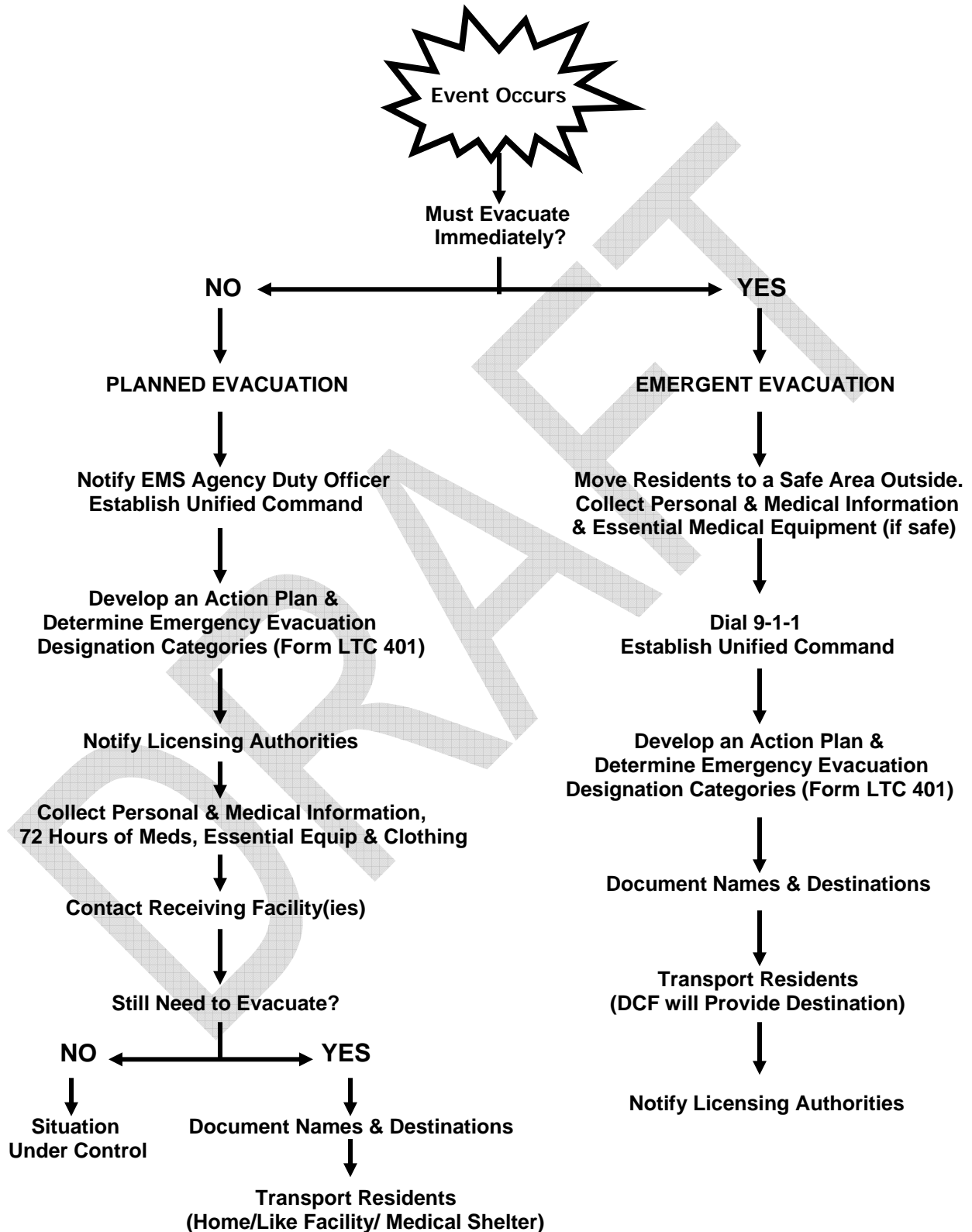
Facility Name	24 Hour Telephone Number
1.	
2.	
3.	
4.	

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

San Joaquin County  
Long Term Care Facility Evacuation Plan

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.



**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**ACRONYMS**

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

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

**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.

**San Joaquin County**  
**Long Term Care Facility Evacuation Plan**

- **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 III** – 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.