

The following minimum criteria are to be used when developing Comprehensive Emergency Management Plans (CEMP) for all Nursing Homes. The criteria serve as the required plan format for the CEMP, and will also serve as the compliance review document for county emergency management agencies upon submission for review and approval pursuant to Chapter 252, Florida Statutes (F.S.). These minimum criteria satisfy the basic emergency management requirements of 400, Part II, Florida Statutes, but are not designed to provide specific emergency medical planning guidance. Although such planning is required under 400, Part II, Florida Statutes, and this rule and may be included in this plan, those items will not be subject to review or approval by county emergency management agencies.

These criteria are also not intended to limit nor exclude additional materials facilities may decide to include to satisfy other relevant rules, requirements, or any special issues facility administrators deem appropriate for inclusion. As before, such voluntary inclusions will not be subject to the specific review by county emergency management personnel, but only those items identified in these criteria.

**This form must be attached to your facility's comprehensive emergency management plan upon submission for approval to the county emergency management agency. Use it as a cross reference to your plan, by listing the page number and paragraph where the criteria are located in your plan on the line to the left of each item.** This will ensure accurate review of your facility's plan by the county emergency management agency.

Criteria and upload portal is available on the Emergency Management website:  
<http://www.seminolecountyfl.gov/health>

**\*\*\*\*\*IMPORTANT SUBMITTAL INFORMATION\*\*\*\*\***

1. All plans **must** be submitted on-line through the Healthcare Upload Portal;
2. It must be in PDF, doc, or docx format;
3. It cannot be password protected;
4. Criteria showing page numbers, Contact Sheet and Review Acknowledgement must be included before the basic plan.
5. Plans must be submitted as one document with all supporting documentation inserted after the basic plan. Use identifiers (blank page with title of next section) between each section to separate the annexes/appendixes/MA Agreements/Floor plans etc;
6. All pages must be numbered; annexes / appendixes should be numbered separately.
7. The **fire plan** must be a separate appendix, and include the approval letter from the fire marshal is included.



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*\* ITALIZED ITEMS ARE BEING REQUESTED BY THE OFFICE OF EMERGENCY MANAGMEMENT\**

***CEMP TABLE OF CONTENTS (Example)***

- I. Introduction
- II. Authorities and References
- III. Hazards Analysis
- IV. Concept of Operations
  - A. Direction and Control
  - B. Notification
  - C. Evacuation
  - D. Re-entry
  - E. Sheltering
- V. Information, Training and Exercise
  - A. Training and Exercises Schedule
    - 1. Calendar / schedule showing drills and exercises for 12 months
- Appendix
  - A. Roster of Employees and Companies with Key Disaster Roles
    - 1. List of company
    - 2. List of emergency service provider
  - B. Agreements and Understandings
    - 1. Transportation, Host Facility, Pharmacy, Water, Food
  - C. Evacuation Route Maps
    - 1. Map of evacuation routes and description to receiving facility
  - D. Support Materials
    - 1. Any additional material to support the plan: (SOP, supply list, menu, floor plans)
    - 2. Facility Approved Fire Safety Plan
- EM Requirements
  - 1. Contact Information Form
  - 2. Facility Acknowledgement Plan Review Form
  - 3. Location map of facility

**I – INTRODUCTION**

A. Provide basic information concerning the facility, to include:

- \_\_\_\_\_ 1. Name of facility,  
address,  
telephone number,  
emergency contact telephone number,  
fax number.  
*email address (if applicable)*
  
- \_\_\_\_\_ 2. Owner of facility,  
address,  
telephone number.
  
- \_\_\_\_\_ 3. Year facility was built.
  
- \_\_\_\_\_ 4. Name of administrator,  
address,  
work/ home telephone number.  
*Cell and email address*
  
- \_\_\_\_\_ 5. Name of person implementing the provisions of this plan (if different from administrator),  
address,  
work and home telephone number,
  
- \_\_\_\_\_ 6. Name of person(s) who developed this plan.  
Work and home telephone number,
  
- \_\_\_\_\_ 7. Provide an organizational chart with key emergency positions identified.
  
- \_\_\_\_\_ Identify the Safety Liaison Officer (per 2011 Florida Statute 408.821)  
*Cell and email address*
  
- \_\_\_\_\_ Identify, by title, of the person responsible for registering and updating the DOH-EMResource  
(per Section 408.821(4), Florida Statutes).
  
- \_\_\_\_\_ B. Provide an introduction to the Plan which describes its **purpose, time of implementation,** and the **desired outcome** that will be achieved through the planning process.  
\_\_\_\_\_ Also provide any other information concerning the facility that has bearing on the implementation of this plan.

**II - AUTHORITIES & REFERENCES**

- \_\_\_\_\_ A. Identify the legal basis for the plan development and implementation of local ordinances and apply 400.23, Florida Statutes, and 59 A-4.126, F.A.C.
- \_\_\_\_\_ B. Identify reference materials used in the development of the Plan.
- \_\_\_\_\_ C. Identify the hierarchy of authority in place during emergencies. Provide an organizational chart, if different from the previous chart required.

**III – HAZARDS ANALYSIS**

- \_\_\_\_\_ A. Describe the potential hazards that the hospital is vulnerable to, such as hurricanes, tornadoes, flooding, fires, hazardous materials incidents from fixed facilities or transportation accidents, proximity to a nuclear power plant, power outages during severe cold or hot weather, etc.
  - \_\_\_ Indicate past history and lessons learned.
- \_\_\_\_\_ B. Provide site-specific information concerning the hospital to include:
  - \_\_\_\_\_ 1. Number of facility beds,
    - \_\_\_ Maximum number of clients on site,
    - \_\_\_ Average number of clients on site.
  - \_\_\_\_\_ 2. Type of patients served by the facility, including but not limited to:
    - \_\_\_ a. Patients with Alzheimer’s Disease,
    - \_\_\_ b. Patients requiring special equipment or other special care, such as oxygen or dialysis,
    - \_\_\_ c. Number of patients who are self-sufficient.
  - \_\_\_\_\_ 3. Identification of hurricane evacuation zone facility is in.
  - \_\_\_\_\_ 4. Identification of which flood zone facility is in as identified on a Flood Insurance Rate Map.  $\tau_0$
  - \_\_\_\_\_ 5. Proximity of the hospital to a railroad **or**
    - \_\_\_ major transportation artery (per hazardous materials incidents).
  - \_\_\_\_\_ 6. Identify if facility is located within 10 mile or 50 mile emergency planning zone of a nuclear power plant.

**IV - CONCEPT OF OPERATION:**

This section of the plan defines the policies, procedures, responsibilities and actions that the facility will take before, during and after any emergency situation. At a minimum, the facility plan needs to address direction and control, notification, evacuation and sheltering.

**A. Direction and Control**

Define the management function for emergency operations. Direction and control provides a basis for decision-making and identifies who has the authority to make decisions for the facility.

- \_\_\_\_\_ 1. Identify, by name and title, who is in charge during an emergency **and** \_\_\_\_\_ one alternate, should that person be unable to serve in that capacity.
- \_\_\_\_\_ 2. Identify the chain of command to ensure continuous leadership and authority in key positions.
- \_\_\_\_\_ 3. State procedures to ensure timely **activation** and staffing of the facility in emergency functions.  
\_\_\_\_\_ Are there provisions for emergency workers' families?
- \_\_\_\_\_ 4. State the operational and support roles for all facility staff. (This will be accomplished through the development of Standard Operating Procedures, which must be attached to this Plan).
5. State the procedures to ensure the following needs are supplied:
  - \_\_\_\_\_ a. Food, \_\_\_\_\_ water, and \_\_\_\_\_ sleeping arrangements.
  - \_\_\_\_\_ b. Emergency power, natural gas or diesel. If natural gas, identify alternate means should loss of power occur which would affect the natural gas system.  
\_\_\_\_\_ What is the capacity of the emergency fuel system?
  - \_\_\_\_\_ c. Transportation (may be covered in the evacuation section)
  - \_\_\_\_\_ d. 72 hour supply of all essential supplies
- \_\_\_\_\_ 6. Provisions for 24-hour staffing on a continuous basis until the emergency has abated.

## B. Notification

Procedures must be in place for the facility to receive timely information on impending threats and the alerting of facility decision makers, staff and residents of potential emergency conditions.

- \_\_\_\_\_ 1. Define how the facility will receive warnings, to include off hours and weekends/holidays.
- \_\_\_\_\_ 2. Identify the facility 24-hour contact number, if different than number listed in introduction.
- \_\_\_\_\_ 3. Define how key staff will be alerted.
- \_\_\_\_\_ 4. Define the procedures and policy for reporting to work for key workers.
- \_\_\_\_\_ 5. Define how residents/patients will be alerted and the precautionary measures that will be taken.
- \_\_\_\_\_ 6. Identify alternative means of notification should the primary system fail.
- \_\_\_\_\_ 7. Identify procedures for notifying those facilities to which facility residents will be evacuated.
- \_\_\_\_\_ 8. Identify procedures for notifying those families of residents that facility is being evacuated.

## C. Evacuation

Describe the policies, role responsibilities, and procedures for the evacuation of residents from the facility.

- \_\_\_\_\_ 1. Identify the individual responsible for implementing the facility evacuation procedures.
- \_\_\_\_\_ 2. Identify transportation arrangements made through mutual aid agreements or understandings that will be used to evacuate residents (copies of the agreements must be attached as annexes).
- \_\_\_\_\_ 3. Describe transportation arrangements for logistical support to include moving records, medications, food, water, and other necessities.
- \_\_\_\_\_ 4. Identify the pre-determined locations where residents will be evacuated.
- \_\_\_\_\_ 5. Provide a copy of the mutual aid agreement that has been entered into with a facility to receive residents/patients.
- \_\_\_\_\_ 6. Identify evacuation routes that will be used and secondary routes should the primary route be impassable.
- \_\_\_\_\_ 7. Specify the amount of time it will take to successfully evacuate all patients/residents to the receiving facility. Keep in mind that in hurricane evacuations, all movement should be completed before the arrival of tropical storm winds (40 mph winds).
- \_\_\_\_\_ 8. Specify the procedures that ensure facility staff will accompany evacuating residents/patients.

- \_\_\_\_\_ 9. Identify procedures that will be used to keep track residents once they have been evacuated to include a log system.
- \_\_\_\_\_ 10. Determine **what and how much** should each resident take. Provide for a minimum of 72 -hour stay, with provisions to extend this period of time if the disaster is of catastrophic magnitude.
- \_\_\_\_\_ 11. Establish procedures for responding to family inquiries about residents who have been evacuated.
- \_\_\_\_\_ 12. Establish procedures for ensuring all residents are accounted for and are out of the facility.
- \_\_\_\_\_ 13. Determine at what point to begin pre-positioning of necessary medical supplies and provisions.
- \_\_\_\_\_ 14. Specify at what point the mutual aid agreements for transportation and the notification of alternate facilities will begin.

#### D. Re-Entry

Once a facility has been evacuated, procedures need to be in place for allowing residents or patients to re-enter the facility.

- \_\_\_\_\_ 1. Identify who is the responsible person(s) for authorizing re-entry to occur.
- \_\_\_\_\_ 2. Identify procedures for inspecting the facility to ensure it is structurally sound.
- \_\_\_\_\_ 3. Identify how residents will be transported from the host facility back to their home facility **and** identify how you will receive accurate and timely data on re-entry operations.

#### E. Sheltering

If the facility is to be used as a shelter for an evacuating facility, the plan must describe the sheltering/hosting procedures that will be used once the evacuating facility residents arrive.

- \_\_\_\_\_ 1. Describe the receiving procedures for arriving residents/patients from evacuating facility.
- \_\_\_\_\_ 2. Identify where additional residents will be housed.
  - \_\_\_\_\_ Provide a floor plan, which identifies the space allocated for additional residents or patients.
- \_\_\_\_\_ 3. Identify provisions of additional food, water, medical needs of those residents/patients being hosted at receiving facility for a minimum of 72 hours
- \_\_\_\_\_ 4. Describe the procedures for ensuring 24-hour operations.
- \_\_\_\_\_ 5. Describe procedures for providing sheltering for family members of critical workers.

- \_\_\_\_\_ 6. Identify when the facility will seek a waiver from Agency for Health Care Administration to allow for the sheltering of evacuees if this creates a situation, which exceeds the operating capacity of the host facility. (Call 904-487-2515)
- \_\_\_\_\_ 7. Describe procedures for tracking additional residents or patients sheltered within the facility.

**V. INFORMATION, TRAINING AND EXERCISES**

This section shall identify the procedures for increasing employee and patient/residents awareness of possible emergency situations and provide training on their emergency roles before, during and after a disaster.

- \_\_\_\_\_ A. Identify how key workers will be instructed in their emergency roles during non-emergency times.
- \_\_\_\_\_ B. Identify training schedule for all employees and identify the provider of the training.
- \_\_\_\_\_ C. Identify the provisions for training new employees regarding their disaster related role(s).
- \_\_\_\_\_ D. Identify a schedule for exercising all or portions of the disaster plan on an annual basis.
- \_\_\_\_\_ E. Establish procedures for correcting deficiencies noted during training exercises.



**APPENDIX**

The following information is required, yet placement in an appendix is optional, if the material is included in the body of the plan.

**A. Roster of employees and companies with key disaster related roles.**

- \_\_\_\_\_ 1. List the names, addresses, and telephone numbers of all staff with disaster related roles.
- \_\_\_\_\_ 2. List the name of the company, contact person, telephone number and address of emergency service providers such as transportation, emergency power, fuel, food, water, police, fire, Red Cross, etc.

**B. Agreements & Understandings**

- \_\_\_\_\_ 1. Provide copies of any **mutual aid agreement** entered into pursuant to the fulfillment of this plan. This is to include reciprocal host facility agreements, transportation agreements, current vendor agreements or any agreement needed to ensure the operational integrity of this plan.

**C. Evacuation Route Map**

- \_\_\_\_\_ 1. A map of evacuation routes and description of how to get to a receiving facility for drivers.

**D. Support Material**

- \_\_\_\_\_ 1. Any additional material needed to support the information provided in the plan.
- \_\_\_\_\_ 2. Copy of the facility's fire safety plan that is approved by the local fire department.

## *FACILITY CONTACT INFORMATION*

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Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility Type: \_\_\_\_\_

Location Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Facility Phone: \_\_\_\_\_ Emerg. Phone Number: \_\_\_\_\_

Facility Email: \_\_\_\_\_

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**Administrator/Owner Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

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**Alternate Administrator Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

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**Safety Liaison Officer Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

***All information is required***

## *FACILITY CONTACT INFORMATION*

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

FACILITY TYPE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ Zip: \_\_\_\_\_

I certify the facility's Comprehensive Emergency Management Plan (CEMP) and the facility's fire plan have been updated and all employees have been trained on their roles and responsibilities during an emergency and given the opportunity to review the CEMP.

This CEMP is exercised on an annual basis with all employees who have a disaster role and any deficiencies found during an exercise have been corrected and the plan updated with all emergency personnel made aware of any new procedures or changes.

Please **initial** by each one:

\_\_\_\_\_ DOH EMSsystems: The information in the DOH EMSsystem has been updated

\_\_\_\_\_ Weather Radio: The facility has a NOAA weather radio monitored at all times

\_\_\_\_\_ Alert Seminole: The facility is signed up for Alert Seminole to receive emergency information

\_\_\_\_\_  
Signature of Administrator / Director / Owner **AND/OR**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Assistant Administrator/Manager **AND/OR**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Safety Liaison

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

*At least one signature is required*