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.

Steven Lerner, Sr. Planner
Seminole County Emergency Management
150 Bush Blvd.
Sanford FL 32773
Phone: (407)-665-5121
Fax: (407)-665-5036
slerner@seminolecountyfl.gov
www.prepareseminole.org

*ITALIZED ITEMS ARE BEING REQUESTED BY THE OFFICE OF EMERGENCY MANAGEMENT*
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. To

_____ 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? Type 1 or 2 ESS (level 1, type 10, class 48 generator) required per NFPA 99: 420.3.26, if life support is needed for residents if not, battery backup for 1.5 hrs required for emergency lights and alarm panels.
   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.

_____ 3. 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.
Date:  ________________________

Facility Name: ______________________________________ Facility Type:_______________________________
Location Address:  _______________________________________________________________________________
City:   _____________________________________________  Zip: ____________________
Mailing Address (if different):______________________________________________________________________
City: ______________________________________________   Zip: ____________________
Facility Phone: ______________________________________  Emerg. Phone Number:_______________________
Facility Email: ______________________________________

Administrator/Owner Contact:  New Contact _____  Contact Update _____
First Name: _________________________________________  Last Name: ______________________________
Office Phone: _______________________ X _____________  Cell Phone:______________________________
Office E-Mail: _______________________________________________________________________________
Alt. E-Mail (optional): _________________________________________________________________________

Alternate Administrator Contact:  New Contact _____  Contact Update _____
First Name: ________________________________________  Last Name: _____________________________
Office Phone: _________________________ X ___________  Cell Phone:  _____________________________
Office E-Mail: _______________________________________________________________________________
Alt. E-Mail (optional): _________________________________________________________________________

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 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 EMSys: The information in the DOH EMSystem 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