

**NURSING HOME**  
**EMERGENCY ENVIRONMENTAL CONTROL PLAN**  
**RULE 59A-4.1265, FLORIDA ADMINISTRATIVE CODE (F.A.C.)**  
**AHCA Sample Format for Plan Submission**

*The AHCA sample format is designed as a tool for facilities to use as they develop their Emergency Power Plan to meet the provisions of the rule. Local Emergency Management Agencies may have specific checklists to assess the plans and assist with plan development and review, which should be used before this format is considered. Please visit <https://www.floridadisaster.org/counties/> to contact your local county emergency management agency to determine whether a specific local checklist is available.*

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**1. Facility Information:**

Facility Name:

Street Address:

City, County, Zip:

Administrator Name:

Contact Number(s):

License Number: \_\_\_\_\_ Number of Licensed Beds: \_\_\_\_\_

- Is the facility:  Located on a campus with other facilities under common ownership  
 Located in a multistory building  
 Stand-alone single story building  
 Located in a mandatory evacuation zone (If so, provide details below).

Details:

**2. Alternate Power Source:**

Description of onsite alternate power source:

- Portable generator       Fixed generator       Other: \_\_\_\_\_

Provide: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Size: \_\_\_\_\_

Make: \_\_\_\_\_ Model: \_\_\_\_\_ Size: \_\_\_\_\_

Make: \_\_\_\_\_ Model: \_\_\_\_\_ Size: \_\_\_\_\_

The alternate power source is capable of powering the following equipment:

- Entire Facility       Lights       Refrigeration       Life Safety Systems  
 Air Conditioning       Heating Systems       Other \_\_\_\_\_

Provide the date implementation of the alternate power source will be complete:

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

**3. Fuel Information:**

Type of Fuel:  Diesel       Propane       Piped Gas       Gasoline

Hours of runtime with onsite fuel: \_\_\_\_\_ hours

Fuel Distributor:

Are there local restrictions on the amount of fuel stored onsite?  Yes       No

If yes, list regulation and limitation:

Describe how your fuel will be stored onsite?

Describe how your facility will refuel before, during, and after an emergency.

**4. Cooling Method:**

What kind of equipment will be used to cool the facility?

- Air Conditioner(s)       Spot Cooler(s)       Chiller       Fan(s)  
 Other: \_\_\_\_\_

**5. Cooled Area:**

What area(s) of the facility do you plan to keep at or below 81 degrees?

- Entire Facility       Living Room       Dining Room       Resident Room(s)  
 Common Area(s)       Hallways       Other Area(s) \_\_\_\_\_

What is the net square footage of the area to be cooled? \_\_\_\_\_

How many people (residents and staff) do you plan to locate in this cooled space/area? (Please keep in mind the required square footage requirements per person for your facility type.) \_\_\_\_\_

Will there be beds available in the cooled area? Yes       No

If yes, are these beds currently onsite? Yes       No

Describe how you will ensure the facility does not exceed the required temperature and how the facility and residents will be monitored.

**6. Policies and Procedures**

Provide a training procedure to ensure staff are aware of how to operate the emergency power to the facility. Describe:

Provide a maintenance and testing schedule for both the alternate power source and cooling system. Describe:

**7. Supporting Documentation**

Submit the following documentation with the plan:

- Facility floor plan. Area(s) intended to be used as the “cooled area” identified in Section 5 should be outlined/highlighted on the facility floor plan.
- Documentation verifying approval of the planned project from the Agency for Health Care Administration’s Office of Plans and Construction
- Fuel agreement

Once the plan is implemented (completed), submit documentation that the alternate power source is installed and operable.

**ATTESTATION**

**I attest that the facility is in compliance with all of the requirements and standards that are contained in Rule 59A-4.1265, F.A.C. (Emergency Environmental Control for Nursing Homes)**

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Signature of Licensee or Authorized Representative

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Title

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Date

**NOTE:**

- The plan must be submitted to your Local Emergency Management Agency for review and approval.
- If there are deficiencies with the plan, the plan must be resubmitted to the Local Emergency Management Agency within 10 business days.
- Within 2 business days of the approval of your plan, written proof must be submitted to the Agency for Health Care Administration.
- Once approved by your local emergency management office, your facility is responsible for providing a consumer friendly summary of your emergency power plan to the Agency for Health Care Administration.
- A copy of your plan must be maintained and readily available at the facility's physical location.