River Palms
NURSING & REHAB

River Palms Nursing & Rehab
5301 Tullis Dr. New Orleans, LA 70131

Phone #: (504) 394-5807
Fax #: (504) 394-5980

February 27, 2020

To: Malcolm Tietje
From: Tamara White, Administrator
Re: Nursing Home Emergency Preparedness Survey

Please see the enclosed 2020 Emergency Preparedness Survey for River Palms Nursing & Rehab, LLC. The Emergency Operations Plan was submitted to Orleans Parish Office of Homeland Security on Thursday, February 27, 2020.

Feel to contact me at (504)394-5807 or twhite@riverpalmsnr.com with any questions regarding this survey.

Thanks,

Tamara White, LNFA, MBA, RN

Administrator

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NURSING & REHAB

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5301 Tullis Dr. New Orleans, LA 70131

Phone #: (504) 394-5807
Fax #: (504) 394-5980

To: New Orleans Office of Homeland Security & Emergency Preparedness
From: Tamara White, Administrator
Re: 2020 Emergency Plan

Please find the enclosed copy of the 2020 Emergency Preparedness Plan for River Palms Nursing & Rehab delivered in person to:

New Orleans Office of Homeland Security & Emergency Preparedness
1300 Perdido Street
Suite 8E18
New Orleans, LA 70112

Delivered by: _____ 2/27/2020
Tamara White, RN, MBA, LNFA — Date
Administrator

Received by: _____ 2/27/20
Dept. of Emergency Management — Date
Representative

Feel free to direct any questions regarding this plan to River Palms Nursing & Rehab, Administration at (504)394-5807.

RECEIVED
MAR 04 2020
HEALTH STANDARDS

2020 Nursing Home Emergency Preparedness Plan Survey

For Year: **2020**

ALL Information in the Plan should match information in the ESF-8 Portal.

Facility Name (Print):

River Palms Nursing and Rehab

Name of Administrator (Print):

Tamara White

Administrator's Emergency Contact Information **(should be reflected in MSTAT/ESF8)**:

Phone #: 504-394-5807

Cell Phone #: 504-669-2904

Administrator E-Mail: twhite@riverpalmsnr.com

Alternative (not administrator) Emergency Contact Information **(should be reflected in MSTAT/ESF8)**:

Name: Torrel Bridges

Position: Assistance Administrator

Phone #: 504-394-5807

Cell Phone #: 504-570-8418

E-Mail: tbridges@riverpalmsnr.com

Physical or Geographic address of Facility (Print):

5301 Tullis Drive

New Orleans, LA 70131

Longitude: -90.0001

Latitude: 29.9003

2020 Nursing Home Emergency Preparedness Plan Survey

2020 Nursing Home Emergency Preparedness Plan Survey

VERIFICATION of OHSEP SUBMITTAL for Year: **2020**

Nursing Facility's Name: River Palms Nursing and Rehab

The **EMERGENCY PREPAREDNESS PLAN** or a **SUMMARY of UDATES** to a previously submitted plan was submitted to the local parish **OFFICE OF HOMELAND SECURITY AND EMERGENCY PREPAREDNESS.**

Orleans Parish
(Name of the Local/Parish Office of Homeland Security and Emergency Preparedness)
Date submitted: 2/27/2020

MARK the appropriate answer:

☐ **YES** ☒ **NO** -Did the local parish Office of Homeland Security and Emergency Preparedness give any recommendations?

☐ – I have included recommendations, or correspondence from OHSEP and facility's response with this review.

☒- There was **NO response** from the local/parish Office of Homeland Security and Emergency Preparedness; **include verification of delivery such as a mail receipt, a signed delivery receipt, or other proof that it was sent or delivered to their office for the current year.** Be sure to include the date plan was sent or delivered.

2020 Nursing Home Emergency Preparedness Plan Survey

I. **PURPOSE** – Complete the survey using information from the facility's current emergency plan.

A. Are the facility's goals, in regards to emergency planning, documented in plan?
☒ YES
➢ NO, if goals are NOT in plan add the facility's goals and indicate completion by marking YES.

B. Does the facility's plan enable the achievement of those goals?
☒ YES
➢ NO, if plan does NOT provide for the achievement of goals, correct the plan and indicate completion by marking YES.

C. Determinations, **by the facility,** for sheltering in place or evacuation due to Hurricanes.
1. Utilizing all current, available, and relevant information answer the following:
a) MARK the **strongest** category of hurricane the facility can safely shelter in place for?
i. ☐ Category 1- winds 74 to 95 mph
ii. ☒ Category 2- winds 96 to 110 mph
iii. ☐ Category 3- winds 111 to 130 mph
iv. ☐ Category 4- winds 131 to 155 mph
v. ☐ Category 5- winds 156 mph and greater

b) At what time, **in hours** before the hurricane's arrival, will the decision to shelter in place have to be made by facility?
i. 72 **Hours** before the arrival of the hurricane.

c) What is the **latest time, in hours** before the hurricanes arrival, which preparations will need to start in order to safely shelter in place?
i. 60 **Hours** before the arrival of the hurricane.

d) Who is responsible for making the decision to shelter in place?
TITLE/POSITION: Owner
NAME: Bob Dean

2. Utilizing all current, available, and relevant information answer the following:
a) MARK the **weakest** category of hurricane the facility will have to evacuate for?
i. ☐ Category 1- winds 74 to 95 mph
ii. ☐ Category 2- winds 96 to 110 mph
iii. ☒ Category 3- winds 111 to 130 mph
iv. ☐ Category 4- winds 131 to 155 mph
v. ☐ Category 5- winds 156 mph and greater

b) At what time, **in hours** before the hurricanes arrival, will the decision to evacuate have to be made by facility?
i. 72 Hours before the arrival of the hurricane.

c) What is the **latest time, in hours** before the hurricane's arrival, which preparations will need to start in order to safely evacuate?
i. 60 Hours before the arrival of the hurricane.

d) Who is responsible for making the decision to evacuate?
TITLE/POSITION: Owner
NAME: Bob Dean

II. SITUATION - Complete the survey using information from the facility's current emergency plan.

A. Facility Description:

1. What year was the facility built? 1986

2. How many floors does facility have? 1

3. Is building constructed to withstand hurricanes or high winds?
- [x] Yes, answer 3.a, b, c, d
- [ ] No/Unknown, answer 3.e

a) MARK the **highest category** of hurricane or wind speed that building can withstand?
- i. [ ] Category 1- winds 74 to 95 mph
- ii. [x] Category 2- winds 96 to 110 mph
- iii. [ ] Category 3- winds 111 to 130 mph
- iv. [ ] Category 4- winds 131 to 155 mph
- v. [ ] Category 5- winds 156 mph and greater
- vi. [ ] Unable to determine : see A.3.e

b) MARK the **highest category** of hurricane or wind speed that facility roof can withstand?
- i. [ ] Category 1- winds 74 to 95 mph
- ii. [x] Category 2- winds 96 to 110 mph
- iii. [ ] Category 3- winds 111 to 130 mph
- iv. [ ] Category 4- winds 131 to 155 mph
- v. [ ] Category 5- winds 156 mph and greater
- vi. [ ] Unable to determine : see A.3.e

c) MARK the source of information provided in a) and b) above? **(DO NOT give names or wind speeds of historical storms/hurricanes that facility withstood.)**
- i. [ ] Based on professional/expert report,
- ii. [ ] Based on building plans or records,
- iii. [x] Based on building codes from the year building was constructed
- iv. [ ] Other non-subjective based source. Name and describe source.

_____

d) MARK if the windows are resistant to or are protected from wind and windblown debris?
- i. [ ] Yes
- ii. [x] No

e) If plan does not have information on the facility's wind speed ratings (wind loads) explain why. _____

4. What are the elevations **(in feet above sea level, use NAVD 88 if available)** of the following:

a) Building's lowest living space is 16 feet above sea level.

b) Air conditioner (HVAC) is 16 feet above sea level.

c) Generator(s) is 16 feet above sea level.

d) Lowest electrical service box(s) is 16 feet above sea level.

e) Fuel storage tank(s), if applicable, is N/A feet above sea level.

f) Private water well, if applicable, is N/A feet above sea level.

g) Private sewer system and motor, if applicable, is N/A feet above sea level.

5. Does plan contain a copy of the facility's Sea Lake Overland Surge from Hurricanes (SLOSH) model?

☒ Yes. Use SLOSH to answer A.5.a. and b.

➢ If No. Obtain SLOSH, incorporate into planning, and then indicate that this has been done by marking yes.

a) Is the building or any of its essential systems susceptible to flooding from storm surge as predicted by the SLOSH model?

i. ☒ Yes- answer A.5.b
ii. ☐ No, go to A. 6.

b) If yes, what is the **weakest** SLOSH predicted category of hurricane that will cause flooding?

i. ☐ Category 1- winds 74 to 95 mph
ii. ☒ Category 2- winds 96 to 110 mph
iii. ☐ Category 3- winds 111 to 130 mph
iv. ☐ Category 4- winds 131 to 155 mph
v. ☐ Category 5- winds 156 mph and greater

6. Mark the FEMA Flood Zone the building is located in?

a) ☒ **B and X** – Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. B Zones are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile. **Moderate to Low Risk Area**

b) ☐ **C and X** – Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level. Zone C may have ponding and local drainage problems that don't warrant a detailed study or designation as base floodplain. Zone X is the area determined to be outside the 500-year flood and protected by levee from 100-year flood. **Moderate to Low Risk Area**

c) ☐ **A** – Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones. **High Risk Area**

d) ☐ **AE** – The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30 Zones. **High Risk Area**

e) ☐ **A1-30** – These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format). **High Risk Area**

f) ☐ **AH** – Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of

flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones. **High Risk Area**

g) ☐ **AO** – River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones. **High Risk Area**

h) ☐ **AR** – Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations. **High Risk Area**

i) ☐ **A99** – Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones. **High Risk Area**

j) ☐ **V** – Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones. **High Risk – Coastal Areas**

k) ☐ **VE, V1 – 30** – Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones. **High Risk – Coastal Areas**

l) ☐ **D** – Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk. **Undetermined Risk Area**

7. What is the area's Base Flood Elevation (BFE) if given in flood mapping?
   - ❖ See the **A** zones. Note: **AE** zones are now used on new format FIRMs instead of A1-A30 Zones. The BFE is a computed elevation to which floodwater is anticipated to rise. Base Flood Elevations (BFEs) are shown on Flood Insurance Rate Maps (FIRMs) and flood profiles.
   - ❖ The facility's Base Flood Elevation(BFE) is: -4 FEET

8. Does the facility flood during or after heavy rains?
   a) ☐ Yes
   b) ☒ No

9. Does the facility flood when the water levels rise in nearby lakes, ponds, rivers, streams, bayous, canals, drains, or similar?
   a) ☐ Yes
   b) ☒ No

10. Is facility protected from flooding by a levee or flood control or mitigation system (levee, canal, pump, etc)?
   a) ☒ Yes
   b) ☐ No

11. Have the areas of the building that are to be used for safe zones/sheltering been identified?
    a) ☒Yes
    b) No. Identify these areas then indicate that this has been completed by marking Yes.

12. Have the facility's internal and external environments been evaluated to identify potential chemical or biological hazards?
    a) ☒Yes
    b) No. Evaluate and identify areas then indicate that this has been done by marking Yes.

13. Has the facility's external environment been evaluated to identify potential hazards that may fall or be blown onto or into the facility?
    a) ☒Yes
    b) No. Evaluate and identify areas then indicate that this has been done by answering Yes.

14. Emergency Generator - **generator information should match MSTAT!**
    a) Is the generator(s) intended to be used to shelter in place during hurricanes (extended duration)?
        i. ☒Yes. The generator(s) will be used for Sheltering in place for Hurricanes.
        ii. ☐No. The generator(s) will **NOT** be used for Sheltering In Place for Hurricanes.

    b) What is the **wattage(s)** of the generator(s)? Give answer in **kilowatts (kW).**
        1st; 250kW 2nd generator; _____ 3rd generator; _____

    c) Mark which primary fuel each generator(s) uses?

i.	☐natural gas;	2nd generator;	☐natural gas;	3rd generator;	☐natural gas
ii.	☐propane;	2nd generator;	☐propane;	3rd generator;	☐propane
iii.	☐gasoline;	2nd generator;	☐gasoline;	3rd generator;	☐gasoline
iv.	☒diesel;	2nd generator;	☐diesel;	3rd generator;	☐diesel

    d) How many **total hours** would generator(s) run on the fuel supply always on hand? (enter NG if Natural Gas)
        1st140 Hours 2nd_____ Hours 3rd_____ Hours

    e) If generator will be used for sheltering in place for a hurricane (extended duration), are there provisions for a seven day supply of fuel?
        i. ☐Not applicable. The facility will not use the generator for sheltering in place during hurricanes.
        ii. ☒Yes. Facility has a seven day supply on hand at all times or natural gas.
        iii. ☐Yes. Facility has signed current contract/agreement for getting a seven day fuel supply before hurricane.
        iv. No supply or contract. Obtain either a contract or an onsite supply of fuel, OR make decision to not use generator for sheltering in place, then mark answer.

    f) Will life sustaining devices, that are dependent on electricity, be supplied by these generator(s) during outages?
        i. ☒Yes
        ii. ☐No

g) Does generator provide for air conditioning?

i. ☒**Yes**. Mark closest percentage of the building that is cooled?
- ☐100 % of the building cooled
- ☐76% or more of the building is cooled
- ☐51 to 75% of the building is cooled
- ☐26 to 50% of the building is cooled
- ☐Less than 25% of the building is cooled

☐**No**. The generator does not provide for any air conditioning.

ii. If air conditioning fails, for any reason, does the facility have procedures (specific actions) in place to prevent heat related medical conditions?
- ☒Yes
- ☐No

h) Does facility have in the plan, a current list of what equipment is supplied by each generator?

☒Yes

If No - Evaluate, identify then indicate that this has been done by answering Yes.

15. Utility information – answer all that apply **(should match what is in MSTAT!)**

a) Who supplies electricity to the facility?
- i. Suppliers name: Entergy
- ii. Account #: 98841943

b) Who supplies water to the facility? (supplier's name)
- i. Suppliers name: New Orleans Sewerage and Water Board
- ii. Account #: 731117

c) Who supplies fuels (natural gas, propane, gasoline, diesel, etc) to the facility? If applicable.
- i. Suppliers name: Entergy
- ii. Account #: 98853591

d) Does plan contain the emergency contact information for the utility providers? (Contact names, 24 hour emergency phone numbers)?
- i. ☒Yes
- ii. No. Please obtain contact information for your utility providers.

16. Floor Plans

a) Does plan have current legible floor plans of the facility?
- i. ☒Yes
- ii. No. Please obtain, then indicate that this has been done by answering Yes

b) Indicate if the following locations are marked, indicated or described on floor plan:
- i. Safe areas for sheltering: ☒Yes. If No- Please indentify on floor plan and mark Yes.
- ii. Storage areas for supplies: ☒Yes. If No- indicate on floor plan and mark Yes.

iii. Emergency power outlets: ☒Yes. If No- indentify on floor plan and mark Yes.

iv. Emergency communication area: ☒Yes. If No- indentify on floor plan and mark Yes.

v. The location of emergency plan: ☒Yes. If No- indentify on floor plan and mark Yes.

vi. Emergency command post: ☒Yes. If No - indentify on floor plan and mark Yes.

B. Operational Considerations - Complete using information from facility's current emergency plan.

1. Residents information

a) What is the facility's total number of state licensed beds?
Total Licensed Beds: 186

b) If the facility had to be evacuated today to the host facility(s) - answer the following using current resident census and their transportation requirements:

i. How many high risk patients (RED) will need to be transported by **advanced life support ambulance** due to dependency on mechanical or electrical life sustaining devices or very critical medical condition? Give the total number of residents that meet these criteria the facility would need its named ambulance provider to transport.
RED: 5

ii. How many residents (YELLOW) will need to be transported by a **basic ambulance** who are not dependent on mechanical or electrical life sustaining devices, but who cannot be transported using normal means (buses, vans, cars). For example, this category might include patients that cannot sit up, are medically unstable, or that may not fit into regular transportation? Give the total number of residents that meet these criteria the facility would need its named ambulance provider to transport.
YELLOW: 26

iii. How many residents (GREEN) can only travel using **wheelchair accessible transportation**? Give the total number of residents that meet these criteria the facility would need its named transportation provider to transport.
GREEN WHEEL CHAIR: 81

iv. How many residents (GREEN) need no specialized transportation could go **by car, van, or bus**? Give the total number of residents that meet these criteria the facility would need its named transportation provider to transport.
GREEN: 46

c) Is the following provided in the list(s) or roster(s) of current residents that is kept in or used for the facility emergency preparedness plan: **do not send in this list or roster.**

i. Each resident's current and active diagnosis?
☒Yes. If No - Obtain and mark Yes.

ii. Each resident's current list of medications including dosages and times?
☒Yes. If No - Obtain and mark Yes.

iii. Each resident's allergies, if any?
☒Yes. If No - Obtain and mark Yes.

iv. Each resident's current dietary needs or restrictions?
☒Yes. If No - Obtain and mark Yes.

v. Each resident's next of kin or responsible party and their contact information?
☒Yes. If No - Obtain and mark Yes.

vi. Each resident's current transportation requirements? (advanced life support ambulance, basic ambulance, wheel chair accessible vehicle, car-van-bus)
☒Yes. If No - Obtain and mark Yes.

2. Staff

a) Is each of the following provided in the list(s) or roster(s) of all current staff that is kept in or used with the facility emergency preparedness plan: **do not send in this list or roster.**

i. Emergency contact information for all current staff?
☒Yes. If No - Obtain and mark Yes.

ii. Acknowledgement of if they will work during emergency events like hurricanes or not?
☒Yes. If No - Obtain and mark Yes.

b) What is **total number** of planned **staff** and other **non residents** that will require facility transportation for an evacuation or need to be sheltered?
35

3. Transportation - **should match what is in MSTAT!**

a) Does facility have transportation, or have current or currently verified contracts or agreements for emergency evacuation transportation?
☒Yes. If No - Obtain transportation and mark Yes.

i. Is the capacity of planned emergency transportation adequate for the transport of all residents, planned staff and supplies to the evacuation host site(s)?
☒Yes. If No - Obtain adequate transport and mark Yes.

ii. Is all transportation air conditioned?
☒Yes. go to B. 3. a) iv.
☐No, go to B. 3. a) iii.

iii. If not air conditioned are there provisions (specific actions and supplies) in plan to prevent and treat heat related medical conditions?
☒Yes. If No - make plans (specific actions and supplies) and mark Yes.

iv. Is there a specified time or timeline (H-Hour) that transportation supplier will need to be notified by?
☒Yes. What is that time 72 hours?
☐No. There is no need for a specified time or timeline for contacting transportation.

b) Does each contract or agreement for-***NON-AMBULANCE***- transportation contain the following information? **NOTE:** *Vehicles that **are not owned by but at the disposal** of the facility **shall have written usage agreements** (with all required information) that are **signed and dated. Vehicles that are owned by the facility will need to verify ownership.***

i. The complete name of the transportation provider?
☒Yes. If No - obtain and mark Yes.

ii. The number of vehicles and type (van, bus, car) of vehicles contracted for?
☒Yes. If No - obtain and mark Yes.

iii. The capacity (number of people) of each vehicle?
☒Yes. If No - obtain and mark yes.

iv. Statement of if each vehicle is air conditioned?
☒Yes. If No - obtain and mark Yes.

v. Verification of facility ownership, if applicable; copy of vehicle's title or registration?
☒Yes. If No - obtain and mark Yes.

c) Have copies of each **signed and dated contract/agreement** been included for submitting?
☒Yes. If no, obtain and mark Yes.

d) Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
☒Yes. If No - complete and mark Yes.

4. Host Site(s)-***extra pages for multiple sites have been included with forms near end of survey.*** **(should match what is in MSTAT!)**

a) Does the facility have current contracts or verified agreements for a **primary** evacuation host site(s) outside of the primary area of risk?
☒Yes. If No - obtain and mark Yes.

b) Provide the following information:(list all sites, if multiple sites **list each - see extra pages**)

i. What is the name of each **primary** site(s)?
Plaquemine Plaza Holding, LLC

ii. What is the physical address of each host site(s)?
129 Calhoun Street
Independence, LA
70769

iii. What is the distance to each host site(s)?
74.3

iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
YES

2020 Nursing Home Emergency Preparedness Plan Survey

v. Does plan include map of route to be taken and written directions to host site?
☒Yes. If No - obtain and mark Yes.

vi. Who is the contact person at **each primary** host site(s)?
Name: See Attached
Phone:_____
Email: _____
Fax: _____

vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
- Capacity that will be allowed at each site:
  104
- Total Capacity of all primary sites:
- 350
- Is this adequate for all evacuating residents?
  ☒Yes. If No - obtain and mark Yes.

viii. Is the **primary** site a currently licensed nursing home(s)?
☐Yes, go to- B.4.b) x.
☒No, go to- B.4.b) ix.

ix. If **primary** host site is **not a licensed nursing home** provide a description of host site(s) including;
- What type of facility it is?
  WAREHOUSE CONVERTED INTO EVAC SHELTER
- What is host site currently being used for?
  EVACUATION SITE FOR NURSING FACILITIES
- Is the square footage of the space to be used adequate for the residents?
  ☒Yes
  ☐No
- What is the age of the host facility(s)?
  UNKNOWN
- Is host facility(s) air conditioned?
  ☒Yes
  ☐No
- What is the current physical condition of facility?
  ☒Good
  ☐Fair
  ☐Poor
- Are there adequate provisions for food preparation and service?
  ☒Yes
  ☐No
- Are there adequate provisions for bathing and toilet accommodations?
  ☒Yes
  ☐No
- Are any other facilities contracted to use this site?
  ☒Yes
  ☐No

x. Is the capacity of primary host site(s) adequate for staff?
☒Yes
☐No. If No - where will staff be housed?
_____

xi. Is there a specified time or timeline (H-Hour) that **primary** host site will need to be notified by?
☒Yes. If Yes - what is that time? 48 HOURS
☐No.

c) Does the facility have current contracts or verified agreements for an **alternate or secondary** host site(s)?
☒Yes. If No - obtain and mark Yes.

d) Provide the following information:(list all sites, if multiple sites **list each - see extra pages**)

i. What is the name of each **alternate/secondary** site(s)?
MAISON DE'VILLE HARVEY; MASION DE'VILLE HOUMA; SOUTH LAFOURCHE; IBERVILLE OAKS; WEST JEFFERSON; MAISON ORLEANS

ii. What is the physical address of each **alternate/secondary** host site(s)?
MAISON DE'VILLE HARVEY - 2233 8TH STREET, HARVEY, LA 70058
MAISON DE'VILLE HOUMA - 107 S. HOLLYWOOD ROAD, HOUMA, LA 70360
SOUTH LAFOURCHE - 146 E. 28TH STREET, CUT OFF, LA 70345
MAISON ORLEANS HEALTHCARE - 1020 MANHATTAN BLVD., HARVEY, LA 70058
IBERVILLE OAKS NURSING AND REHAB - 59355 RIVER WEST DR., PLAQUEMINE, LA 70764

iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
MAISON DE'VILLE OF HARVEY - 6 MILES
MAISON DE'VILLE OF HOUMA - 58 MILES
SOUTH LAFOURCHE - 64 MILES
MAISON ORLEANS HEALTHCARE - 8 MILES
WEST JEFFERSON HEALTHCARE - 6 MILES
IBERVILLE OAKS NURSING AND REHAB - 93 MILES

iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
☒Yes
☐No

v. Does plan include map of route to be taken and written directions to host site?
☒Yes. If No - obtain and mark Yes.

vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: See Attached
Phone:_____
Email: _____
Fax: _____

vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?

- Capacity that will be allowed at each **alternate/secondary** site:
  20
- Total Capacity of all **alternate/secondary** sites:
  120
- Is this adequate for all evacuating residents?
  ☒ Yes. If No - obtain and mark Yes.

viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?

☒ Yes, go to - B.4.d) x.
☐ No, go to - B.4.d) ix.

ix. If **alternate/secondary** host site is **not a licensed nursing home** provide a description of host site(s) including;

- What type of facility it is?
  N/A
- What is host site currently being used for?
  N/A
- Is the square footage of the space to be used adequate for the residents?
  ☒ Yes
  ☐ No
- What is the age of the host facility(s)?
  N/A
- Is host facility(s) air conditioned?
  ☒ Yes
  ☐ No
- What is the current physical condition of facility?
  ☒ Good
  ☐ Fair
  ☐ Poor
- Are there provisions for food preparation and service?
  ☒ Yes
  ☐ No
- What are the provisions for bathing and toilet accommodations?
  ☒ Yes
  ☐ No
- Are any other facilities contracted to use this site?
  ☒ Yes
  ☐ No

x. Is the capacity of **alternate/secondary** host site(s) adequate for staff?

☐ Yes
☒ No. If No - where will staff be housed?
HOTEL IN CLOSE PROXIMITY

xi. Is there a specified time or timeline (H-Hour) that **alternate/secondary** host site will need to be notified by?

☒Yes. If yes what is that time? 48 HOURS
☐No.

e) Have copies of each **signed and dated contract/agreement** been included for submitting?
☒Yes. If No - obtain and mark Yes.

f) Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
☒Yes. If No - complete and mark Yes.

2020 Nursing Home Emergency Preparedness Plan Survey

5. **Non-perishable food or nourishment** – for sheltering in place or for host site(s)
   a) For Sheltering In Place, does facility have – **on site** - a seven day supply of non-perishable food/nourishment that meets all resident's needs?
   ☒Yes. If yes go to - B. 5. c)
   ☐No. If no go to - B. 5. b)

   b) Provide the following if no onsite supply:
      i. Does facility have a current or currently verified contract to have a seven day supply of non-perishable food that meets all resident's needs delivered prior to a foreseeable emergency event?
      ☒Yes, go to - B. 5.b). ii, iii, iv
      If No - obtain supply or contract then mark appropriate answer.

      ii. Does each contract contain all of the following?
      – name of supplier?
      – specified time or timeline (H-Hour) that supplier will need to be notified
      – contact information of supplier
      ☒Yes. If No - obtain information then mark Yes.

      iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
      ☒Yes. If No - obtain and mark Yes.

      iv. Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
      ☒Yes. If No - complete and mark Yes.

   c) For evacuations, does facility have provisions for **food/nourishment supplies at host site**(s)?
   ☒Yes. If No - make necessary arrangements then mark Yes.

   d) Is there a means to prepare and serve food/nourishment at host site(s)?
   ☒Yes. If No - make necessary arrangements then mark Yes.

6. **Drinking Water or fluids – for sheltering in place – one gallon per day per resident.**
   a) Does facility have – **on site** - a seven day supply of **drinking water or fluids** for all resident's needs?
   ☒Yes. Go to B. 6. c)
   ☐No. If No See B. 6.b)

   b) If no, provide the following:
      i. Does facility have a current contract for a seven day supply of drinking water or fluids to be delivered prior to a foreseeable emergency event?
      ☒Yes, see B. 6.b). ii, iii, iv,
      If No - please obtain supply or contract.

ii. Does each contract for **Drinking Water or fluids** contain all of the following?
- name of supplier?
- specified time or timeline (H-Hour) that supplier will need to be notified
- contact information of supplier

☒Yes. If No - obtain information then mark Yes.

iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
☒Yes. If no - obtain and mark Yes

iv. Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
☒Yes. If no - complete and mark Yes

c) Does facility have a supply of water for needs other than drinking?
☒Yes
If No - make necessary provisions for water for non drinking needs then mark Yes.

d) **For evacuations**, does host site(s) have an adequate supply of water for all needs?
☒Yes
If No - make necessary provisions for water for non drinking needs then mark Yes

7. **Medications**- for sheltering in place or for host site(s)

a) Does facility have – **on site** - a seven day supply of **medications for all resident's needs**?
☒Yes. go to - B. 7. **c)**
☐No. go to - B. 7.**b) i,ii,iii,iv**

b) If no, provide the following:
i. Does facility have a current or currently verified contract to have a seven day supply of **medications** delivered prior to a foreseeable emergency event?
☒Yes, see B. 7.**b). ii, iii, iv**
If No - please obtain supply or contract then mark Yes.

ii. Does contract for **medications** contain the following?
- Name of supplier?
- Specified time or timeline (H-Hour) that supplier will need to be notified
- Contact information of supplier

☒Yes. If No - obtain information then mark Yes.

iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
☒Yes. If no - obtain and mark Yes.

iv. Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
☒Yes. If no - complete and mark Yes.

c) For **evacuation**, does facility have provisions for **medications at host site**(s)?
☒Yes
If No - make necessary provisions for medications then mark Yes.

8. **Medical, Personal Hygiene, and Sanitary Supplies** – for sheltering in place or for host site(s)
   a) Does facility have –**on site**- medical, personal hygiene, and sanitary supplies to last seven days for all resident's needs?
   ☒Yes. go to - B. 8. **c)**
   ☐No. go to - B. 8. **b) i,ii,iii,iv**

   b) If no, provide the following:
      i. Does facility have a current or currently verified contract to have a seven day supply of medical, personal hygiene, and sanitary goods delivered prior to a foreseeable emergency event?
      ☒Yes, see B. 7.**b). ii, iii, iv**
      If No - please obtain supply or contract then mark Yes.

      ii. Does contract for medical, hygiene, and sanitary goods contain the following?
      – Name of supplier?
      – Specified time or timeline (H-Hour) that supplier will need to be notified
      – Contact information of supplier
      ☒Yes. If No, obtain information then mark Yes.

      iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
      ☒Yes. If no, obtain and mark Yes.

      iv. Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
      ☒Yes. If no, complete and mark Yes

   c) For evacuation, does facility have provisions for medical, personal hygiene, and sanitary supplies at host site(s)?
   ☒Yes
   If No - make necessary provisions for medications then mark Yes

9. Communications/Monitoring - all hazards
   a) **Monitoring Alerts**. Provide the following:
      i. What equipment/system does facility use to **monitor** emergency broadcasts or alerts? TV, SMART PHONES, COMPUTER WITH INTERNET

      ii. Is there back up or alternate equipment and what is it?
      ☒Yes. Name equipment: WEATHER ALERT CRANK RADIO
      ☐No

      iii. Is the equipment tested?
      ☒Yes
      ☐No

iv. Is the **monitoring** equipment powered and operable during utility outages?
☒Yes.
☐No.

v. Are there provisions/plans for facility to **monitor** emergency broadcasts and alerts **at evacuation site**?
☒Yes
☐No

b) **Communicating- send and receive-** with emergency services and authorities. Provide the following:

i. What equipment does facility have to **communicate** during emergencies?
CELLULAR DEVICES

ii. Is there back up or alternate equipment used to send/receive and what is it?
☒Yes. Name equipment: SATELLITE PHONE
☐No

iii. Is the equipment tested?
☒Yes
☐No

iv. Is the **communication** equipment powered and operable during utility outages?
☒Yes.
☐No

v. Are there provisions/plans for facility to send and receive **communications** at evacuation site?
☒Yes
☐No

C. All Hazard Analysis

1. Has the facility identified potential emergencies and disasters that facility may be affected by, such as fire, severe weather, missing residents, utility (water/electrical) outages, flooding, and chemical or biological releases?
☒Yes
If No - identify, and then mark **Yes** to signify that this has been completed.

2020 Nursing Home Emergency Preparedness Plan Survey

III. **CONCEPT OF OPERATIONS** – Answer the following or Provide the requested information. Any areas of planning that have not been provided for in the facility's emergency preparedness plan will need to be addressed.

A. Plans for **sheltering in place**

1. Does facility have written viable plans for sheltering in place during emergencies?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes.

   a) Does the plan for sheltering in place take into account all known limitations of the facility to withstand flooding and wind? (This includes if limits were undetermined as well)
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   b) Does the plan for sheltering in place take into account all requirements (if any) by the local Office of Homeland Security and Emergency Preparedness?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

2. Does facility have written viable plans for adequate staffing when sheltering in place?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes.

3. Does facility have written viable plans for sufficient supplies to be on site prior to an emergency event which will enable it to be totally self-sufficient for seven days? (potable and non-potable water, food, fuel, medications, medical, personal hygiene, sanitary, repair, etc)
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

4. Does facility have communication plans for sheltering in place?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   a) Does facility have written viable plans for contacting staff pre event?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   b) Does facility have written viable plans for notifying resident's responsible party before emergency event?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   c) Does facility have written viable plans for monitoring emergency alerts and broadcasts before, during, and after event?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

d) Does facility have written viable plans for receiving information from emergency services and authorities before, during, and after event?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

e) Does facility have written viable plans for contacting emergency services and authorities before, during, and after event?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

5. Does facility have written viable plans for providing emergency medical care if needed while sheltering in place?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

6. Does facility have written viable plans for the preparation and service of meals while sheltering?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

7. Does facility have written viable plans for repairing damages to the facility incurred during the emergency?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

B. Plans for Evacuation

1. Does facility have written viable plans for adequate transportation for transporting all residents to the evacuation host site(s)?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

a) Does facility have written viable plans for adequate staffing for the loading of residents and supplies for travel to evacuation host site(s)?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

b) Does facility have written viable plans for adequate staffing to ensure that all residents have access to licensed nursing staff and appropriate nursing services during all phases of the evacuation?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

c) Does facility have written viable plans for adequate staffing for the unloading of residents and supplies at evacuation host site(s)?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

2. Does facility have written viable plans for adequate transportation for the return of all residents to the facility?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   a) Does facility have written viable plans for staffing to load residents and supplies at the shelter site for the return to facility?
      ☒Yes
      If No - Planning is needed for compliance. Complete then mark Yes

   b) Does facility have written viable plans for staffing to ensure that all residents have access to licensed nursing staff and appropriate nursing services provided during the return to facility?
      ☒Yes
      If No - Planning is needed for compliance. Complete then mark Yes

   c) Does facility have written viable plans for staffing for the unloading of residents and supplies after return to facility?
      ☒Yes
      If No - Planning is needed for compliance. Complete then mark Yes

3. Does facility have written viable plans for the management of staff, including provisions for adequate qualified staffing and the distribution and assignment of responsibilities and functions at the evacuation host site(s)?
   ☐Yes
   If No - Planning is needed for compliance. Complete then mark Yes

4. Does facility have written viable plans to have sufficient supplies – to be totally self sufficient - at or delivered to the evacuation host site(s) prior to or to coincide with arrival of residents? (potable and non-potable water, food, fuel, medications, medical goods, personal hygiene, sanitary, clothes, bedding, linens, etc)
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

5. Does facility have written viable plans for communication during evacuation?
   ☒Yes
   If No - Planning is needed for compliance. Complete then mark Yes

   a) Does facility have written viable plans for contacting host site prior to evacuation?
      ☒Yes
      If No - Planning is needed for compliance. Complete then mark Yes

   b) Does facility have written viable plans for contacting staff before an emergency event?
      ☒Yes
      If No - Planning is needed for compliance. Complete then mark Yes

c) Does facility have written viable plans for notifying resident's responsible party - pre event- of intentions to evacuate?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

d) Does facility have written viable plans for monitoring emergency alerts and broadcasts - while at host site- before, during, and after event?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

e) Does facility have written viable plans for receiving information from and contacting emergency services and authorities –while at host site- before, during and after event?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

f) Does facility have written viable plans for the need to remain at an unlicensed evacuation shelter site for more than five days, if evacuating to an unlicensed site?

☒Yes ☐ Evacuating to a licensed site

If No - Planning is needed for compliance. Complete then mark Yes

6. Does facility have written viable plans to provide emergency medical care if needed while at evacuation site(s)?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

C. Does facility have written viable plans for all identified potential hazards?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

D. Does facility have written viable plans for communicating during all emergencies?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

1. Does facility have written viable plans for immediately providing **written** notification by hand delivery, facsimile, email or other acceptable method of the nursing home's decision to either shelter in place or evacuate due to any emergency to the Health Standards Section of the Department of Health and Hospitals?

☒Yes

If No - Planning is needed for compliance. Complete then mark Yes

2. Does plan include providing the following information to Health Standards Section of the Department of Health and Hospitals?
   a) Is it a full facility evacuation, partial facility evacuation or shelter in place?
   b) The date(s) and approximate time(s) of full or partial evacuation?
   c) The names and locations of all host site(s)?
   d) The emergency contact information for the person in charge of evacuated residents at each host site(s)?
   e) The names of all residents being evacuated and the location each resident is going to?

f) A plan to notify Health Standards Section within 48 hours of any deviations or changes from original notification?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

3. Does facility have written viable plans for receiving and sending emergency information during emergencies?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

4. Does facility have written viable plans for monitoring emergency alerts and broadcasts at all times?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

5. Does facility have written viable plans for notifying authorities of decision to shelter in place or evacuate?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

6. Does facility have written viable plans for notifying authorities and responsible parties of the locations of all residents and any changes of those locations?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

E. Does facility have written viable plans for entering all required information into the Health Standards Section's (HSS) emergency preparedness webpage?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

F. Does facility have written viable plans for triaging residents according to their transportation needs?
☒Yes
If No - Planning is needed for compliance. Complete then mark Yes

IV. ORGANIZATION AND RESPONSIBILITIES - The following should be determined and kept current in the facility's plan:

A. Who is responsible for the **decision** to **shelter in place or evacuate**?
Provide Name: BOB DEAN, JR
Position: OWNER
Emergency contact information:
Phone: (225)342-9154
Email: 1@DEANCOMPANIES.COM
Fax: (225)343-9154

B. Who is the backup/second in line responsible for **decision** to **sheltering in place/evacuating**?
Provide Name: Tamara White
Position: LNFA

Emergency contact information:
Phone: (504)669-2904
Email: TWHITE@RIVERPALMSNR.COM
Fax: (866) 816-9744

C. Who will be **in charge when sheltering in place**?
Provide Name: TAMARA WHITE
Position: LNFA
Emergency contact information:
Phone: (504)669-2904
Email: TWHITE@RIVERPALMSNR.COM
Fax: (866) 816-9744

D. Who will be the backup/second in line **when sheltering in place**?
Provide Name: TORREL BRIIDGES
Position: ASSISTANT ADMINISTRATOR
Emergency contact information:
Phone: (504) 570-8418
Email: TBRIDGES@RIVERPALMSNR.COM
Fax: (866) 816-9744

E. Who will be **in charge at** each evacuation **host site**(s)?
Provide Name: TAMARA WHITE
Position: LNFA
Emergency contact information:
Phone: (504) 669-2904
Email: TWHITE@RIVERPALMSNR.COM
Fax: (866) 816-9744

F. Who has been (**by position or title**) designated or assigned in the facility's plan to the following required duties?

1. Title or position of person(s) assigned to notify the responsible party of each resident of the following information within 24 hours of the decision:
   DIRECTOR OF SOCIAL SERVICES
   a) If facility is going to shelter in place or evacuate.
   b) The date and approximate time that the facility is evacuating.
   c) The name, address, and all contact information of the evacuation site.
   d) An emergency telephone number for responsible party to call for information.

2. Title or position of person(s) assigned to notify the Department of Health and Hospitals- Health Standards Section and the local Office of Homeland Security and Emergency Preparedness of the facility's decision to shelter in place or evacuate:
   ADMINISTRATOR

3. Title or position of person(s) assigned to securely attach the following information to each resident during an emergency so that it remains with the resident at all times?
   DIRECTOR OF NURSING / ASSISTANT DIRECTORS OF NURSING

a) Resident's identification.
b) Resident's current or active diagnoses.
c) Resident's medications, including dosage and times administered.
d) Resident's allergies.
e) Resident's special dietary needs or restrictions.
f) Resident's next of kin, including contact information.

4. Title or position of person(s) assigned to ensure that an adequate supply of the following items accompany residents on buses or other transportation during all phases of evacuation?
DIETARY MANAGER / DIRECTOR OF NURSING
a) Water
b) Food
c) Nutritional supplies and supplements
d) All other necessary supplies for the resident.

5. Title(s) or position(s) of person(s) assigned for contacting emergency services and monitoring emergency broadcasts and alerts?
ADMINISTRATOR AND DIRECTOR OF NURSING

V. Administration & Logistics

Annexes or tabbed sections that contain only current information pertinent to planning and the plan but are too cumbersome for the body of the plan; maps, forms, agreements or contracts, rosters, lists, floor plans, contact information, etc. These items can be placed here.

These blank forms are provided for your use and are to be completed:

- Page 1 - the Cover page of this document complete prior to submitting
- Page 2 - OHSEP Verification complete prior to submitting
- Transportation contract or agreement cover page, to be attached to each
- Evacuation host site contract or agreement cover page, to be attached to each
- Supply Cover sheets are to be used for each:
  - Non-perishable food/nourishment contract or agreement cover page, to be attached to each
  - Drinking water contract or agreement cover page, to be attached to each
  - Medication contract or agreement cover page, to be attached to each
  - Miscellaneous contract or agreement for supplies or resources that do not have a specific cover page, to be attached to each
- Multiple Host Site pages
- Authentication page, last page of document to be complete prior to submitting

VI. Plan Development and Maintenance

A. Has the plan been developed in cooperation with the local Office of Homeland Security and Emergency Preparedness?
☒ Yes
☐ No

B. If not, was there an attempt by facility to work with the local Office of Homeland Security and Emergency Preparedness?
☒ Yes

☐No

C. During the review of the facility's emergency preparedness plan were the following steps taken?

1. Were all out dated or non essential information and material removed?
   ☒Yes
   No - Complete this step then mark Yes

2. Were all contracts or agreements updated, renewed or verified?
   ☒Yes
   No - Complete this step then mark Yes

3. Was all emergency contact information for suppliers, services, and resources updated?
   ☒Yes
   No - Complete this step then mark Yes

4. Was all missing information obtained added to plan and the planning revised to reflect new information?
   ☒Yes
   No - Complete this step then mark Yes

5. Were all updates, amendments, modifications or changes to the nursing facility's emergency preparedness plan submitted to the Health Standards Section along with this survey?
   ☒Yes
   No - Complete this step then mark Yes

VII. Authentication

The plan should be signed and dated by the responsible party(s) each year or as changes, modifications, or updates are made. A copy of that **Authentication page** shall be signed, dated and included with this survey. ***(Blank form provided near end of document)***

If there is a change of responsible party(s) (administrator, etc) plan needs to be updated to reflect this change page resigned/dated and copy submitted to Health Standards Section.

2020 Nursing Home Emergency Preparedness Plan Survey

TRANSPORTATION COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each transportation resource agreement, transportation contract, or verification of facility's ownership of transportation.

Example: If there are 5 transportation providers there should be 5 coversheets, one attached to the front of each signed and dated agreement, verification or contract.

If transportation is facility-owned, state that it is facility owned and provide verification of ownership and all applicable information. A photocopy of a vehicle's title or registration will be sufficient for verification of ownership. Ongoing contracts will need to be verified annually and signed by all parties.

Name of transportation resource provider (print):

NICHOLL'S TRANSPORTATION SERVICES

Contact Person: Mike Nicholl

Phone # of Contact Person: (504) 210-8340

Physical Address of transportation provider:

717 S. CLAIBORNE AVE.
NEW ORLEANS, LA
70113

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that transportation resource can be contacted according to agreement?

48 HOURS

How long will it take the transportation to reach the facility after being contacted?

1-2 HOURS

How long will the facility need to load residents and supplies onto the transportation?

2-3 HOURS

Type (bus, van, car, ambulance, wheelchair) transport vehicle to be provided:

BUS

Total number of transport vehicles to be provided: 1 MINIMUM; BASED ON CENSUS

Total number and type (wheelchair, stretcher, seated) of passengers each vehicle will accommodate:

47 PASENGERS / EA

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: 3/1/2020

Date agreement/ contract ends: 2/28/2021

2020 Nursing Home Emergency Preparedness Plan Survey

TRANSPORTATION COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each transportation resource agreement, transportation contract, or verification of facility's ownership of transportation.

Example: If there are 5 transportation providers there should be 5 coversheets, one attached to the front of each signed and dated agreement, verification or contract.

If transportation is facility-owned, state that it is facility owned and provide verification of ownership and all applicable information. A photocopy of a vehicle's title or registration will be sufficient for verification of ownership. Ongoing contracts will need to be verified annually and signed by all parties.

Name of transportation resource provider (print):

ACADIAN AMBULANCE SERVICES

Contact Person: Kevin Spansel

Phone # of Contact Person: (504) 451-2610

Physical Address of transportation provider:

200 WRIGHT AVENUE
GRETNA, LA
70056

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that transportation resource can be contacted according to agreement?

48 HOURS

How long will it take the transportation to reach the facility after being contacted?

1-2 HOURS

How long will the facility need to load residents and supplies onto the transportation?

2-3 HOURS

Type (bus, van, car, ambulance, wheelchair) transport vehicle to be provided:

AMBULANCE; WHEELCHAIR VAN

Total number of transport vehicles to be provided: 1 MINIMUM; BASED ON CENSUS

Total number and type (wheelchair, stretcher, seated) of passengers each vehicle will accommodate:

BASED ON CENSUS

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: 3/1/2020

Date agreement/ contract ends: 2/28/2021

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each evacuation host site agreement, evacuation host site contract, or verification of evacuation host site. Complete this cover page for each facility named in the document.

Example: If there are 5 evacuation host site(s) contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 evacuation host sites named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

PLACUEMINE PLAZA HOLDINGS, LLC

Contact Person: TAMARA WHITE

Phone # of Contact Person: (504) 669-2904
FAX#: (866) 816-9744
E-Mail Address: TWHITE@RIVERPALMSNR.COM

Physical Address of evacuation site:
129 CALHOUN STREET
INDEPENDENCE, LA
70443

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

1 HOUR AND 15 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☒**PRIMARY** or ☐**ALTERNATE** site?

Is it a ☐**LICENSED Nursing Home** or ☒**NON-LICENSED FACILITY**?

Total number of residents and staff that facility is willing to host: 104

Is the evacuation host site air conditioned? ☒Yes, air conditioned ☐Not air conditioned

Date of agreement/contract/verification: 3/1/2020

Date agreement/contract ends: 2/28/2021

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each evacuation host site agreement, evacuation host site contract, or verification of evacuation host site. Complete this cover page for each facility named in the document.

Example: If there are 5 evacuation host site(s) contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 evacuation host sites named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

MAISON ORLEANS HEALTHCARE

Contact Person: KIM RUSSELL

Phone # of Contact Person: (504) 895-7755
FAX#: (504) 355-4876
E-Mail Address: KRUSSELL@MAISONORLEANSNOLA.COM

Physical Address of evacuation site:
1420 GENERAL TAYLOR
NEW ORLEANS, LA
70115

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

16 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY**?

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each evacuation host site agreement, evacuation host site contract, or verification of evacuation host site. Complete this cover page for each facility named in the document.

Example: If there are 5 evacuation host site(s) contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 evacuation host sites named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

IBERVILLE OAKS NURSING AND REHAB

Contact Person: DEIDRA JONES

Phone # of Contact Person: (225) 385-4332
FAX#: (225) 687-4778
E-Mail Address: DJONES@IBERVILLEOAKS.COM

Physical Address of evacuation site:
59355 RIVER WEST DRIVE
PLAQUEMINE, LA
70764

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

1 HOUR AND 56 (MINUTES)

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY**?

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each evacuation host site agreement, evacuation host site contract, or verification of evacuation host site. Complete this cover page for each facility named in the document.

Example: If there are 5 evacuation host site(s) contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 evacuation host sites named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

WEST JEFFERSON HEALTHCARE CENTER

Contact Person: LINSEY DUKES

Phone # of Contact Person: (504) 362-2020
FAX#: (504) 355-4876
E-Mail Address: LDUKES@WESTJEFFCARING.COM

Physical Address of evacuation site:
1020 MANHATTAN
HARVEY, LA
70058

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

14 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY**?

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

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Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

MAISON DE'VILLE OF HARVEY

Contact Person: DANTE LANDRY

Phone # of Contact Person: (504) 362-9522
FAX#: (504) 368-4118
E-Mail Address: DLANDRY@DEVILLEHARVEY.COM

Physical Address of evacuation site:
2233 8TH STREET
HARVEY, LA
70058

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

15 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY?**

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

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Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

MAISON DE'VILLE OF HOUMA

Contact Person: WILLIAM DAIGRE

Phone # of Contact Person: (985) 876-3250
FAX#: (985) 873-0046
E-Mail Address: WDAIGRE@DEVILLEHOUMA.COM

Physical Address of evacuation site:
107 S. HOLLYWOOD ROAD
HOUMA, LA
70360

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

1 HOUR AND 20 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY?**

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

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Ongoing evacuation host site contracts will need to be verified annually and signed by all parties.

Name of EVACUATION HOST SITE:

SOUTH LAFOURCHE NURSING AND REHAB

Contact Person: BOB DUET

Phone # of Contact Person: (985) 693-8677
FAX#: (985) 693-8126
E-Mail Address: BOBDUET@SOUTHLANR.COM

Physical Address of evacuation site:
146 E. 28TH STREET
CUTOFF, LA
70345

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that evacuation host site can be contacted according to agreement?

48 HOURS

How long will it take to reach the evacuation host site facility?

1 HOUR AND 27 MINUTES

How long will it take to unload residents and supplies from the transportation?

2 HOURS

Type of evacuation host site:
Is it the ☐ **PRIMARY** or ☒ **ALTERNATE** site?

Is it a ☒ **LICENSED Nursing Home** or ☐ **NON-LICENSED FACILITY**?

Total number of residents and staff that facility is willing to host: BASED ON CENSUS AND BED AVAILABILITY

Is the evacuation host site air conditioned? ☒ Yes, air conditioned ☐ Not air conditioned

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

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SUPPLY CONTRACTS COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each type of supply agreement or of supply contract. Complete this cover page for each supplier named in the facility plan.

Example: If there are 5 supply contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 suppliers named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing supply contracts will need to be verified annually and signed by all parties.

Type of Supply: FOOD SERVICE

Name of Supplier:

REINHART FOOD SERVICE

Contact Person: Candace Faler
Phone # of Contact Person: (985) 778-8449
FAX#: (800) 488-3988
E-Mail Address: CJFALER@RFSDELIVERS.COM

Indicate where the supplies are to be delivered to;

- ☐ **Evacuation host site**
- ☐ **Nursing home's licensed facility**
- ☒ **determined upon decision of sheltering or evacuating**

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that supplier can be contacted according to agreement?
72 HOURS

How long will it take to receive the delivery?

24-48 HOURS DEPENDING ON DECISION OF SHELTERING OR EVACUATING

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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Ongoing supply contracts will need to be verified annually and signed by all parties.

Type of Supply: NURSING; LINEN; FORMULA; WOUND CARE

Name of Supplier:

MEDLINE

Contact Person: TODD ROMIG
Phone # of Contact Person: (504) 256-1798
FAX#: (866) 914-2730
E-Mail Address: TROMIG@MEDLINE.COM

Indicate where the supplies are to be delivered to;

- ☐ **Evacuation host site**
- ☐ **Nursing home's licensed facility**
- ☒ **determined upon decision of sheltering or evacuating**

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that supplier can be contacted according to agreement?
72 HOURS

How long will it take to receive the delivery?

24-48 HOURS DEPENDING ON DECISION OF SHELTERING OR EVACUATING

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each type of supply agreement or of supply contract. Complete this cover page for each supplier named in the facility plan.

Example: If there are 5 supply contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 suppliers named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing supply contracts will need to be verified annually and signed by all parties.

Type of Supply: DELIVERING AND CLEANING LINENS

Name of Supplier:

WESTPORT LINEN SERVICES

Contact Person: WESTPORT LINEN SERVICES
Phone # of Contact Person: (225) 218-8878
FAX#: _____
E-Mail Address: _____

Indicate where the supplies are to be delivered to;

- ☐ **Evacuation host site**
- ☐ **Nursing home's licensed facility**
- ☒ **determined upon decision of sheltering or evacuating**

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that supplier can be contacted according to agreement?
72 HR

How long will it take to receive the delivery?

24-48 HOURS DEPENDING ON DECISION OF SHELTERING OR EVACUATING

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

2020 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each type of supply agreement or of supply contract. Complete this cover page for each supplier named in the facility plan.

Example: If there are 5 supply contracts there should be 5 coversheets, one attached to the front of each signed and dated contract. If there are 5 suppliers named in one agreement there should be 5 coversheets attached to that agreement.

Ongoing supply contracts will need to be verified annually and signed by all parties.

Type of Supply: PRESCRIPTIONS

Name of Supplier:

PEOPLES'S DRUGS

Contact Person: SUSAN BRUNET
Phone # of Contact Person: (985) 873-8526
FAX#: (985) 873-8541
E-Mail Address: JACEJACES@BELLSOUTH.NET

Indicate where the supplies are to be delivered to;

- ☐ **Evacuation host site**
- ☐ **Nursing home's licensed facility**
- ☒ **determined upon decision of sheltering or evacuating**

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that supplier can be contacted according to agreement?
72 HR

How long will it take to receive the delivery?

24-48 HOURS DEPENDING ON DECISION OF SHELTERING OR EVACUATING

Date of agreement/contract/verification: 1/1/2020

Date agreement/contract ends: 12/31/2020

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Multiple **Primary** Host Site(s) - print then complete the following two pages for each additional site.

I. Provide the following information:(list **primary** sites in this area, if multiple sites **list each**)

i. What is the name of each **primary** site(s)?
PLAQUEMINE PLAZA HOLDINGS, LLC

ii. What is the physical address of each host site(s)?
129 CALHOUN STREET
INDEPENDENCE, LA
70443

iii. What is the distance to each host site(s)?
74 MILES

iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
YES

v. Does plan include map of route to be taken and written directions to host site?
☒Yes. If No - obtain and mark Yes.

vi. Who is the contact person at **each primary** host site(s)?
Name: TAMARA WHITE
Phone: (504) 669-2904
Email: TWHITE@RIVERPALMSNR.COM
Fax: (866) 816-9744

vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
- Capacity that will be allowed at each site:
  104
- Is this adequate for all evacuating residents?
  ☒Yes. If No - obtain and mark Yes.

viii. Is the **primary** site a currently licensed nursing home(s)?
☐Yes, go to- B.4.b) x.
☒No, go to- B.4.b) ix.

ix. If **primary** host site is **not a licensed nursing home** provide a description of host site(s) including;
- What type of facility it is?
  WAREHOUSE CONVERTED INTO EVAC SITE
- What is host site currently being used for?
  EVACUATION SITE FOR NURSING FACILITIES
- Is the square footage/area of the space to be used adequate for the residents?
  ☒Yes
  ☐No
- What is the age of the host facility(s)?
  UNKNOWN
- Is host facility(s) air conditioned?
  ☒Yes

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☐ No

- What is the current physical condition of facility?
  - ☒ Good
  - ☐ Fair
  - ☐ Poor
- Are there adequate provisions for food preparation and service?
  - ☒ Yes
  - ☐ No
- Are there adequate provisions for bathing and toilet accommodations?
  - ☒ Yes
  - ☐ No
- Are any other facilities contracted to use this site?
  - ☒ Yes
  - ☐ No

x. Is the capacity of primary host site(s) adequate for staff?
☒ Yes
☐ No. If No - where will staff be housed?

_____

xi. Is there a specified time or timeline (H-Hour) that **primary** host site will need to be notified by?
☒ Yes. If Yes - what is that time? 48 HOURS
☐ No.

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Multiple **Alternate/Secondary** Host Site(s) – print then complete the following two pages for each additional site.

A. Provide the following information:(list each **alternate or secondary site**)

i. What is the name of each **alternate/secondary** site(s)?
MAISON DE'VILLE OF HARVEY,
MAISON DE'VILLE OF HOUMA,
WEST JEFFERSON HEALTHCARE,
SOUTH LAFOURCHE,
IBERVILLE OAKS,
MAISON ORLEANS HEALTHCARE

ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8TH STREET, HARVEY, LA 70058
107 S. HOLLYWOOD RD., HOUMA, LA 70360
1020 MANHATTAN, HARVEY, LA 70058
146 E. 28TH STREET, CUT OFF, LA 70345
59355 RIVERWEST DRIVE, PLAQUEMINE, LA 70764
1420 GENERAL TAYLOR ST., NEW ORLEANS, LA 70115

iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
6.2 MILES;
58 MILES;
5.9 MILES;
64.2 MILES;
93.3 MILES;
8.4 MILES

iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
☐ Yes
☒ No

v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.

vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: SEE ATTACHED
Phone: _____
Email: _____
Fax: _____

vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
- Capacity that will be allowed at each **alternate/secondary** site:
  VARIEES BASED ON CENSUS AND BED AVAILABILITY
- Is this adequate for all evacuating residents?
  ☒ Yes. If No - obtain and mark Yes.

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viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?
☒ Yes go to - B.4.d) x.
☐ No, go to - B.4.d) ix.

ix. If **alternate/secondary** host site is **not a licensed nursing home** provide a description of host site(s) including;

- What type of facility it is?
  N/A
- What is host site currently being used for?
  N/A

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- Is the square footage/area of the space to be used adequate for the residents?
  ☒ Yes
  ☐ No
- What is the age of the host facility(s)?
  VARIES BY LOCATION
- Is host facility(s) air conditioned?
  ☒ Yes
  ☐ No
- What is the current physical condition of facility?
  ☒ Good
  ☐ Fair
  ☐ Poor
- Are there provisions for food preparation and service?
  ☒ Yes
  ☐ No
- What are the provisions for bathing and toilet accommodations?
  ☒ Yes
  ☐ No
- Are any other facilities contracted to use this site?
  ☒ Yes
  ☐ No

x. Is the capacity of **alternate/secondary** host site(s) adequate for staff?
☐ Yes
☒ No. If No - where will staff be housed?
HOTEL IN PROXIMITY

xi. Is there a specified time or timeline (H-Hour) that **alternate/secondary** host site will need to be notified by?
☒ Yes. If yes what is that time? 48 HOURS
☐ No.

g) Have copies of each **signed and dated contract/agreement** been included for submitting?
☒ Yes. If No - obtain and mark Yes.

h) Has a cover page been completed and attached for each contract/agreement. ***(blank form provided)***
☒ Yes. If No - complete and mark Yes.

2020 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

RIVER PALMS NURSING AND REHAB

The Emergency Preparedness Plan for the above named facility provides the emergency operational plans and procedures that this facility will follow during emergency events. The current plan supersedes any previous emergency preparedness plans promulgated by this facility for this purpose. This plan was developed to provide for the health, safety, and wellbeing of all residents. I (current/acting administrator) have read and agree that the information used and included in the facility's emergency preparedness plan is current, valid, and reliable.

Date: 2/25/2020

Facility Administrator Name (PRINT): **TAMARA WHITE, LFA, MBA, RN**

Facility Administrator Signature: _____ admin

Comments:

N/A