

2020 Nursing Home Emergency Preparedness Plan Survey

For Year: 2020

Facility Name (Print):

South Lafourche Nursing and Rehab

Name of Administrator (Print):

Bob Duet, NFA

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

Phone #: 985-693-1048

Cell Phone #: 985-856-8005

Administrator E-Mail: bobduet@southlanr.com

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

Name: Krystal Howard

Position: Assistant Administrator

Phone #: 985-693-1049

Cell Phone #: 985-414-4336

E-Mail: khoward@lahcc.com

Physical or Geographic address of Facility (Print):

146 E 28th St

Cut Off, LA 70345

Longitude: -90.582382986

Latitude: 29.714753778

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MAR 04 2020
HEALTH STANDARDS

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. 72 Hours before the arrival of the hurricane.

d) Who is responsible for making the decision to shelter in place?

TITLE/POSITION: Administrator

NAME: Bob J. Duet

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. 48 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. 72 Hours before the arrival of the hurricane.

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d) Who is responsible for making the decision to evacuate?

TITLE/POSITION: Bob J. Duet

NAME: Administrator

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

A. Facility Description:

1. What year was the facility built? 2017

2. How many floors does facility have? 1

3. Is building constructed to withstand hurricanes or high winds?

☒ 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. ☐ 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. ☐ 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. ☒ 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. ☐ 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 3.51 feet above sea level.

b) Air conditioner (HVAC) is 7.51 feet above sea level.

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- c) Generator(s) is 7.51 feet above sea level.
- d) Lowest electrical service box(s) is 3.51 feet above sea level.
- e) Fuel storage tank(s), if applicable, is 7.51 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 3.51 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

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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: 3.51

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

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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; 500 kw 2nd generator; 3rd generator;
 - c) Mark which primary **fuel** each generator(s) uses?

i. <input type="checkbox"/> natural gas;	2nd generator; <input type="checkbox"/> natural gas;	3rd generator; <input type="checkbox"/> natural gas
ii. <input type="checkbox"/> propane;	2nd generator; <input type="checkbox"/> propane;	3rd generator; <input type="checkbox"/> propane
iii. <input type="checkbox"/> gasoline;	2nd generator; <input type="checkbox"/> gasoline;	3rd generator; <input type="checkbox"/> gasoline
iv. <input checked="" type="checkbox"/> diesel;	2nd generator; <input type="checkbox"/> diesel;	3rd generator; <input type="checkbox"/> diesel
 - d) How many **total hours** would generator(s) run on the fuel supply always on hand? (enter NG if Natural Gas)
 1st 168 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

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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 #: 370001318351

b) Who supplies water to the facility? (supplier's name)

- i. Suppliers name: Lafourche Parish Water
- ii. Account #: 491-0820-01

c) Who supplies fuels (natural gas, propane, gasoline, diesel, etc) to the facility? If applicable.

- i. Suppliers name: Louisiana Propane
- ii. Account #: Cutoff

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 identify on floor plan and mark Yes.
- ii. Storage areas for supplies: ☒ Yes. If No- indicate on floor plan and mark Yes.

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- iii. Emergency power outlets: ☐ Yes. If No- identify on floor plan and mark Yes.
- iv. Emergency communication area: ☒ Yes. If No- identify on floor plan and mark Yes.
- v. The location of emergency plan: ☒ Yes. If No- identify on floor plan and mark Yes.
- vi. Emergency command post: ☒ Yes. If No - identify 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: 102

- 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: 12

- 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: 0

- 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: 0

- 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: 80

- 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.

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- 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?

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 _____ hours?
☐ No. There is no need for a specified time or timeline for contacting transportation.

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- 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.*
- The complete name of the transportation provider?
☒ Yes. If No - obtain and mark Yes.
 - The number of vehicles and type (van, bus, car) of vehicles contracted for?
☒ Yes. If No - obtain and mark Yes.
 - The capacity (number of people) of each vehicle?
☒ Yes. If No - obtain and mark yes.
 - Statement of if each vehicle is air conditioned?
☒ Yes. If No - obtain and mark Yes.
 - 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!)*
- 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.
 - Provide the following information:(list all sites, if multiple sites **list each** - see extra pages)
 - What is the name of each **primary** site(s)?
 Plaquemine Manor Nursing Home/Old River West Hospital
 - What is the physical address of each host site(s)?
 59355 River/West Dr
 Plaquemine, LA
 70821
 - What is the distance to each host site(s)?
 87.8
 - Is the host site(s) located outside of the parishes identified as hurricane risk areas?
 Yes
 - Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.

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- vi. Who is the contact person at **each primary** host site(s)?
Name: Angie Courville
Phone: 225-343-9152
Email: angiec@deancompanies.com
Fax: 225-343-9152, 225-912-8603
- vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
➤ Capacity that will be allowed at each site: 572
➤ Total Capacity of all primary sites: 572
➤ 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?

➤ What is host site currently being used for?

➤ 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)?

➤ 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?

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- 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? _____
☐ 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 Deville of Harvey
 - ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th st
Harvey, LA
 - iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.7 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: Dante Landry
 Phone: 504-362-9522
 Email: dlandry@devilleharvey.com
 Fax: 504-368-4118
 - 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:
75
☒ Total Capacity of all **alternate/secondary** sites:
572
☒ 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.

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- 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?

 - What is host site currently being used for?

 - 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)?

 - 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?

- 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? 24 hrs
☐ 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.

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- 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.

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- 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?
Satelite Phones and cell phones
 - ii. Is there back up or alternate equipment used to send/receive and what is it?
☒ Yes. Name equipment: Satelite Phone
☐ No

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- 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? Radio, TV, Internet, Phone

- ii. Is there back up or alternate equipment and what is it?

☒ Yes. Name equipment: Satellite Phone

☐ No

- iii. Is the equipment tested?

☒ Yes

☐ No

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- 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?
Satelite Phones and cell phones
- ii. Is there back up or alternate equipment used to send/receive and what is it?
☒ Yes. Name equipment: Satelite 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

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- 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

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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

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- 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

2020 Nursing Home Emergency Preparedness Plan Survey

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

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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: South Lafourche Nursing and Rehab

Position: Administrator

Emergency contact information:

Phone: 985-856-8005

Email: bobduet@southlanr.com

Fax: 985-693-1011

B. Who is the backup/second in line responsible for decision to sheltering in place/evacuating?

Provide Name: South Lafourche Nursing and Rehab

Position: Assistant Administrator

Emergency contact information:

Phone: 985-414-4336

Email: khoward@lahcc.com

Fax: 985-693-1011

C. Who will be in charge when sheltering in place?

Provide Name: Bob Duet, NFA

Position: Administrator

Emergency contact information:

Phone: 985-856-8005

Email: bobduet@southlanr.com

Fax: 985-693-1011

D. Who will be the backup/second in line when sheltering in place?

Provide Name: Krystal Howard

Position: Assistant Administrator

Emergency contact information:

Phone: 985-414-4336

Email: khoward@lahcc.com

Fax: 985-693-1011

E. Who will be in charge at each evacuation host site(s)?

Provide Name: Bob Duet, NFA

Position: Administrator

Emergency contact information:

Phone: 985-856-8005

Email: bobduet@southlanr.com

Fax: 985-693-1011

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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:
Social Services Director

 - 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:
Nursing Facility 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?
Ward Clerk/Medical Records

 - 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 Supervisor

 - 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

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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

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2020 Nursing Home Emergency Preparedness Plan Survey

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

AUTHENTICATION

Facility Name (Print):

South Lafourche Nursing & 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:

2/27/20

2020 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

South Laguerche Nursing - 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: 2/27/20

Facility Administrator Name (PRINT): Bob J. Duet

Facility Administrator Signature: 

Comments:

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:

Plaquemine Manor Nursing Home/Old River West Hospital

Contact Person: Angie Courville

Phone # of Contact Person: 225-343-9152

FAX#: 225-343-9154

E-Mail Address: acourville@deancompany.com

Physical Address of evacuation site:

24320 Ferdinand St

Plaquemine, LA 70769

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?

24 hrs

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

1 Hr and 24 Mins

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

2hrs

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: 120

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

Date of agreement/contract/verification: 01/01/2020

Date agreement/contract ends: Renews Annually



PLAQUEMINE PLAZA HOLDINGS, LLC
343 THIRD STREET, SUITE 600
BATON ROUGE, LA 70801

Year 2020 Hurricane Evacuation Plan

To: PLAQUEMINE MANOR NURSING HOME, INC. D/B/A/ INBERVILLE OAKS NURSING & REHAB, INC.

The letter serves as confirmation of our arrangement that in the event of an emergency evacuation. Depending on the acuity of your residents, we have three different sites in which we will deploy services and residents to. Evacuation sites are below:

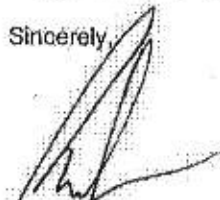
<u>Evacuation Site Address</u>	<u>Bed Availability</u>
1. 24320 Ferdinand Street Plaquemine, LA 70769	120 Beds
2. 129 Calhoun Street Independence, LA 70443	120 Beds

Also, should a disaster occur and you require additional beds for your residents, the following skilled nursing facility beds will be made available to you.

<u>Facility</u>	<u>Address</u>	<u>Phone</u>	<u>Bed Availability</u>
Maison De'Ville Nursing Home, Inc.	107 S Hollywood Rd Houma, LA 70360	985-876-3250	20 Beds
St. Elizabeth's Caring, LLC	1020 Manhattan Blvd. Harvey, LA 70058	504-362-9522	20 Beds
Maison De'Ville Nursing Home of Harvey	2233 8 th Street Harvey, LA 70058	504-362-9522	20 Beds
South Lafourche Nursing and Rehab	4302 Highway 1 Raceland, LA 70394	985-693-1065	20 Beds
Maison Orleans Healthcare of New Orleans	1420 General Taylor Street New Orleans, LA 70115	504-895-7755	20 Beds
River Palms Nursing Home	5301 Tullis Dr. New Orleans, LA 70131	504-394-5807	20 Beds

If you have any questions or need additional information, please do not hesitate to contact me at (225) 343-9152.

Sincerely,



Bob G. Dean
Man. Member

2020 Nursing Home Emergency Preparedness Plan Survey

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 Manor Nursing Home/Old River West Hospital
- ii. What is the physical address of each host site(s)?
59355 River West Dr
Plaquemine, LA 70769
- iii. What is the distance to each host site(s)?
87.8 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: Diedra Jones
Phone: 225-603-1558
Email: djones@ibervilleoaks.com
Fax: 225-687-6136
- vii. What is the capacity (number of residents allowed) of each **primary** host site(s)?
 - Capacity that will be allowed at each site:
120
 - 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?

 - What is host site currently being used for?
Nursing Home
 - 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)?
2015
 - Is host facility(s) air conditioned?
☒ Yes
☐ No

2020 Nursing Home Emergency Preparedness Plan Survey

➤ 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? _____

☒ No.



PLAQUEMINE PLAZA HOLDINGS, LLC
343 THIRD STREET, SUITE 600
BATON ROUGE, LA 70801

Year 2020 Hurricane Evacuation Plan Effective Date 1/1/2020

To:

- Maison Deville Nursing Home Inc.
- Maison Deville Nursing Home of Harvey LLC
- Raceland Manor Nursing Home Inc. DBA South Lafourche Nursing & Rehab
- St. Elizabeth's Caring LLC DBA West Jefferson Healthcare, LLC
- Plaquemine Manor Nursing Home, Inc. DBA Iberville Oaks Nursing & Rehab
- Uptown Healthcare Center, LLC DBA Maison Orleans Nursing & Rehab
- River Palms Nursing & Rehab LLC

The letter serves as confirmation of our arrangement that in the event of an emergency evacuation. Depending on the acuity of your residents, we have three different sites in which we will deploy services and residents to.

Evacuation sites are below:

	<u>Evacuation Site Address:</u>
1	24320 Ferdinand Street, Plaquemine, LA 70769
2	129 Calhoun Street Independence, LA 70443
3	59355 Riverwest Dr. Plaquemine, LA 70764

The nursing facilities listed above will pay Plaquemine Plaza Holdings, LLC \$20,000.00 a month for this service. This fee will be paid every month on the 5th. If you have any questions or need additional information, please do not hesitate to contact me at (225) 343-9152.

Sincerely,



Bob G Dean
Man. Member

2020 Nursing Home Emergency Preparedness Plan Survey

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 Orleans Healthcare
- ii. What is the physical address of each alternate/secondary host site(s)?
1420 General Taylor Blvd
New Orelans, LA 70115
- iii. What is the distance, in miles, to each alternate/secondary host site(s)?
65.8 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: Kim Russell
Phone: 504-895-7755
Email: krussell@maisonorleansnola.com
Fax: 504-355-4876
- 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:

➤ 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?
Nursing Home/ LTC
➤ What is host site currently being used for?
Nursing Home/ LTC

2020 Nursing Home Emergency Preparedness Plan Survey

- 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)?

- 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?

- 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? 24 Hrs
☐ 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.



Maison Orleans Healthcare

NURSING HOME & REHABILITATION

1420 GENERAL TAYLOR STREET
NEW ORLEANS, LA 70115

A tradition of caring

(504) 895-7755 PHONE
(504) 355-4876 FAX

January 27, 2020

Re: Emergency Evacuation for 2020

Iberville Oaks Nursing & Rehab
South Lafourche Nursing & Rehab
Maison DeVille of Harvey
Maison DeVille of Houma
West Jefferson Healthcare Center
River Palms Nursing & Rehab

To Whom It May Concern:

Maison Orleans Healthcare and Rehabilitation located at 1420 General Taylor St. New Orleans, LA. 70115 is at your disposal for use of any and all evacuation procedures. Space within the facility will be made available to you, your residents, and staff in case of an emergency. We will coordinate our open beds with the ESF-8 Portals.

Please access the following contact information as needed: Facility phone number: (504) 895-7755, 24- hour emergency number is (205) 7465550.

Sincerely,

Kim N Russell, RN, LNFA

"Family Owned and Operated"

2020 Nursing Home Emergency Preparedness Plan Survey

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 Deville of Harvey
- ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th st
Harvey, LA 70058
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.7 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: Anthony Jones
Phone: 504-362-9522
Email: ajones@devilleharvey.com
Fax: 504-263-5099
- 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:

➤ 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?
Nursing Home/ LTC
➤ What is host site currently being used for?
Nursing Home/ LTC

2020 Nursing Home Emergency Preparedness Plan Survey

- 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)?

- 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?

- 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? 24 Hrs
☐ 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.



Maison De'ville of Harvey

NURSING HOME & REHABILITATION

A tradition of caring

2233 8TH STREET
HARVEY, LA 70058

(504) 362-9522 PHONE
(504) 368-4118 FAX

Date: 02/13/2020

TO: Raceland Manor
Plaquemine Manor
Maison Deville of Houma
West Jefferson Healthcare Center
Uptown Care Center

From: Anthony Jones, NFA

RE: Emergency Evacuation Procedure

Maison De'ville of Harvey's facility and staff are available for your use if an evacuation event were to occur. Space and care will be made available to your residents and staff in case of any emergency. Please note our phone is 504-362-9522 and fax is 504-263-5099

Sincerely,

Anthony Jones, NFA
Administrator

"Family Owned and Operated"

2020 Nursing Home Emergency Preparedness Plan Survey

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 Deville of Houma
- ii. What is the physical address of each **alternate/secondary** host site(s)?
107 S. Hollywood Blvd
Houma, LA 70360
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
28.8 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: William Daigre
Phone: 985-876-3250
Email: wdaigre@devillhouma.com
Fax: 985-873-0046
- 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:

➤ 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?
Nursing Home/ LTC
➤ What is host site currently being used for?
Nursing Home/ LTC

2020 Nursing Home Emergency Preparedness Plan Survey

- 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)?

- 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?

- 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? 24 Hrs
☐ 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.

Maison De'Ville Nursing Home
107 S. Hollywood Rd.
Houma, LA 70360
(985) 876-3250

February 19, 2020

Re: Emergency Evacuation for 2020

To Whom It May Concern:

Maison De'Ville Nursing Home of Houma is at your disposal for use of any and all evacuation procedures. Space within this facility will be made available to you, your residents and staff in case of an emergency. We will coordinate our open bed with the ESF-8 Portal.

Sincerely,

A handwritten signature in black ink, appearing to read 'William Daigre', with a stylized flourish extending to the right.

William Daigre
NFA

2020 Nursing Home Emergency Preparedness Plan Survey

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)?
West Jefferson Healthcare
- ii. What is the physical address of each **alternate/secondary** host site(s)?
1020 Manhattan Blvd
Harvey, LA 70058
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.3 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: Lindsey Dukes
Phone: 504-669-2904
Email: ldukes@westjeffcaring.com
Fax: 504-336-2147
- 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:

➤ 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?
Nursing Home/ LTC
➤ What is host site currently being used for?
Nursing Home/ LTC

2020 Nursing Home Emergency Preparedness Plan Survey

- 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)?

- 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?

- 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? 24 Hrs
☐ 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.

West Jefferson Healthcare Center



A tradition of caring

1020 Manhattan Blvd

Harvey, LA 70058

Phone: 504-362-2020

Fax: 504-362-9620

February 21, 2020

Re: Emergency Evacuation 2020

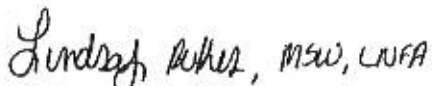
River Palms Nursing & Rehab
Maison DeVile of Houma
Maison DeVile of Harvey
Maison Orleans Healthcare & Rehab
South Lafourche Nursing & Rehab
Iberville Oaks Nursing & Rehab

To Whom It May Concern:

West Jefferson Healthcare Center located at 1020 Manhattan Blvd, Harvey, LA, 70058 is at your disposal for use and all evacuation procedures. Space within the facility will be made to you, your residents, and staff in case of an emergency. We will coordinate our open beds with the ESF-8 portals.

Please access the following contact information as needed: Facility phone number: (504) 362-2020. In the event there is an emergency please contact (504) 421-0145.

Sincerely,


Lindsay Dukes, MSW, LNFA

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):

Nichols Limousine and Shuttle Services

Contact Person: Mike Nichols

Phone # of Contact Person: 504-454-7722, 800-788-9944

Physical Address of transportation provider:

4302 Williams Blvd Kenner, La 70065

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?

24 hrs

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

2hrs

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

3hrs

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

Bus

Total number of transport vehicles to be provided: 2

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

380

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

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

Date agreement/ contract ends: Renews Annually

**TRANSPORTATION AGREEMENT
FOR
LA HEALTH CARE CONSULTANTS, LLC**

This agreement is by and between Nicoll's Limousine and Shuttle Service, hereinafter called PROVIDER, and all nursing homes owned and/or operated by LA Health Care Consultants, LLC (LHCC) hereinafter called CUSTOMER, as follows:

NAME: Maison Deville of Harvey
2233 Eighth Street
Harvey, LA 70058
(504) 363-9522

NAME: West Jefferson Health Care
1020 Manhattan Blvd.
Harvey, LA 70058
(504) 362-2020

NAME: Maison Deville of Houma
107 South Hollywood Blvd.
Houma, LA 70360
(985) 876-3250

NAME: South Lafourche Nursing
146 East 28th Street
Cut Off, LA 70345
(985) 537-3569

NAME: Maison Orleans Health Care Center
1420 General Taylor Street
New Orleans, LA 70115
(504) 895-7755

NAME: Iberville Oaks Nursing
59355 River West Drive
Plaquemine, LA 70764
(225) 385-4332

NAME: River Palms Nursing & Rehab
5301 Tullis Drive
New Orleans, LA 70131
(504) 394-5807

PURPOSE

To evacuate nursing home residents, as directed by each nursing home administrator, in the event of an approaching hurricane or other disaster which requires evacuation and to return residents as instructed.

To transport all required medical equipment and supplies, mattresses, wheelchairs, etc. as needed.

MISCELLANEOUS

Customer shall furnish a minimum of one (1) nurse aide per bus for each trip.

Provider shall furnish one (1) 26 ft. box truck per nursing home to transport all equipment and supplies. As space is available, provider will transport, on the buses, mattresses, wheelchairs, medical supplies, etc. as needed.

It is the intent of the provider to furnish safe, comfortable and expedient transportation to and from your designated locations.

This agreement shall commence on March 1, 2020, and end on February 28, 2021, unless extended by mutual written agreement by the parties hereto.

Signed this 11th day of February 2020.

Nicoll's Limousine and Shuttle Service

By: M. H. Nicoll

Mike Nicoll

LA Health Care Consultants, LLC (LHCC)

By: [Signature]

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):

Nichols Limousine and Shuttle Services

Contact Person: Acadian Ambulance

Phone # of Contact Person: Sue Szush

Physical Address of transportation provider:

PO Box 98000 Lafayette, LA 70509-8000

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 hrs

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

20 Mins

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

20 Mins

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

Ambulance

Total number of transport vehicles to be provided: 4

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

Stretcher

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: Jan 2, 2020

Date agreement/ contract ends: Renews Annually

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: Water

Name of Supplier:

Rouses

Contact Person: Bradley Gaudet

Phone # of Contact Person: 985-693-4858

FAX#: n/a

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?

48 hrs

How long will it take to receive the delivery?

upon contact

Date of agreement/contract/verification: 01/01/2020

Date agreement/contract ends: Renews Annually

Rouses Supermarkets #18

13980 West Main Street

Larose, La 70373

In the event of an emergency we will supply South Lafourche Nursing and Rehab with 1260 gallons of water to supply their needs for 7 days. We would need no more than 2 days notice before the water would be picked up at store level.

Bradley Gaudet

A handwritten signature in black ink, appearing to read 'Bradley Gaudet', written over the printed name.

Store Director

Rouses #18

985-693-4858

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: Pharmacy

Name of Supplier:

Peoples Pharmacy

Contact Person: Susan Brunet

Phone # of Contact Person: 985-873-8526

FAX#: 985-873-8541

E-Mail Address: jacesjaces@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?

4 Hrs

How long will it take to receive the delivery?

2 hrs

Date of agreement/contract/verification: 01/16/2020

Date agreement/contract ends: Renews Annually

***Peoples* DRUG STORE, INC.**

Emergency Medications Agreement

This agreement is entered into between South Lafourche Nursing and Peoples Drug Store. During emergency situations, Peoples Drug Store will provide medications to the facility to ensure that a 7-day supply of medications for each resident is on-hand at the facility. This agreement will remain in effect for a period of one year.



South Lafourche Nursing

148 East 28th Street

Cutoff, LA 70345

Dated: 1-10-20



Peoples Drug Store

7869 Main Street

Houma, LA 70360

Dated: 01/10/2020

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: Food, Water, Linen

Name of Supplier:

Reinhardt/ DBA Reyes

Contact Person: Adrienne Huffman

Phone # of Contact Person: 225-715-8227

FAX#: 504-734-5270

E-Mail Address: addmonique@rfsdeliver.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 Hrs

How long will it take to receive the delivery?

72 hrs

Date of agreement/contract/verification: 01/01/2020

Date agreement/contract ends: Renews Annually



Reinhart Foodservice Louisiana, L.L.C.
918 Edwards Ave
Harahan, LA 70123
January 30, 2020

Bd-South Lafourche Nurs
Atten: Administrator
146 East 28th Street
Cut Off, LA 70345

Valued Customer:

This letter shall serve as documentation of the policy of Reinhart Foodservice Louisiana, L.L.C. ("Reinhart") regarding delivery of goods during a disaster or emergency. Reinhart is committed to working with you to ensure that emergency supplies are available to your facility in the event of an emergency situation.

Should Reinhart be affected by a disaster or emergency the following actions will take place:

- Affected customers will be notified of delays by phone as soon as possible.
- Proper food safety and sanitation procedures will be maintained throughout the event.
- Customers will not receive any food that has been affected by damage sustained from the disaster or emergency.
- Deliveries will resume as soon as possible from either the affected facility or alternate distribution center(s).

If your facility is involved in a disaster or emergency the following items may be supplied upon availability and upon request:

- Freezer/refrigerated trailer (requires signed Food Trailer Usage Agreement)
- Emergency seven-day food supply with a 72-hour notice (we reserve the right to make alternative product substitutions)

Refer to your state's Department of Health and Human Services guidelines for food and water supply for emergencies. Reinhart will provide to you, upon request, a Disaster Planning Kit which gives information on recommended perishable and non-perishable food and water to keep on hand in case an emergency arises, and a Three Day Emergency/Disaster Menu.

Should your facility undergo a disaster or emergency it is your responsibility to notify Reinhart as to stoppage of delivery or delivery to an alternate site. Should you have any questions regarding this policy, please contact your healthcare specialist at 1-800-488-3988.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to be 'P. D. ...', is written over a horizontal line.

Louisiana Market President

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: Diesel/ Fuel

Name of Supplier:

Gaubert Oil

Contact Person: Wade Hebert

Phone # of Contact Person: 985-447-3811

FAX#: 985-447-1614

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?

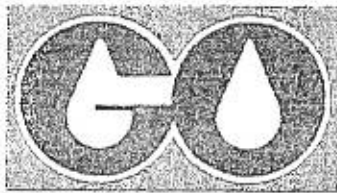
3-5 days prior to threat

How long will it take to receive the delivery?

48 hrs

Date of agreement/contract/verification: 01/01/2020

Date agreement/contract ends: Renews Annually



GAUBERT OIL

COMPANY INCORPORATED

ESTABLISHED 1926

1201 St. Patrick Hwy
P.O. Box 310
Thibodaux, LA 70301
(985) 447-3811 (985) 447-1614 fax

June 5, 2018

Raceland Manor
South Lafourche Nursing and Rehab Inc.
146 E 28th St
Cut Off, La 70345

Dear Mr. Dean,

This letter is a follow-up as to how Gaubert Oil Company, Inc. Can be of assistance in your Emergency Preparedness Planning at Raceland Manor South Lafourche Nursing and Rehab. Inc..

Gaubert Oil Co. Will provide diesel fuel at market value of that time. Although Gaubert Oil Company has multiple supply points to work from and large storage tanks, We also have many obstacles in emergency situations, such as downed refineries, employee evacuations and fuel allocations. It is strongly advised that you top off your tanks three to five days prior to any threatening emergency.

If you have any questions, please contact me at 985-447-3811.

Sincerely,

Wade Hebert
Supply & Distribution Manager
Gaubert Oil Company, Inc.

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: Linen

Name of Supplier:

West Port Linen

Contact Person: Eddie Lafeaux

Phone # of Contact Person: 225-268-3393

FAX#: 225-218-8885

E-Mail Address: elefeaux@westportlinen.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?

24 Hrs

How long will it take to receive the delivery?

24 hrs

Date of agreement/contract/verification: 01/22/2020

Date agreement/contract ends: Renews Annually

WESTPORT LINEN SERVICES
EMERGENCY LINEN ADDENDUM

(Effective January 22, 2019 – February 28, 2021)

These are the latest changes made to the Emergency Linen Service Agreement for Plaza Holdings LLC, ("Facility") and Westport Linen Services, LLC, ("Westport").

The following locations will be covered under the agreement for emergency linen processing:

South Lafourche Nursing and Rehab – previously Raceland Manor
146 E 28th St
Cut Off, LA 70345

Iberville Oaks Nursing and Rehab- previously Plaquemine Manor Nursing Home
59355 River West Dr Plaquemine, LA 70764

Maison Deville Nursing Home
107 S. Hollywood RD
Houma, LA

West Jefferson Healthcare Center
1020 Manhattan Blvd
Harvey, LA 70058

Maison Deville of Harvey
2233 8th St
Harvey, LA 70058

Maison Orleans previously Uptown Healthcare
1420 General Taylor
New Orleans, LA 70115

If activated the Evacuation site addresses are as follows:

59355 River West Dr
Plaquemine, LA 70764

24320 Ferdinand St
Plaquemine LA 70769

129 Calhoun St
Independence, LA 70764

Prices are \$.60 per pound received by Westport.

If transported by a Westport Delivery truck, delivery fee is \$1.55 per mile driven.

If Westport carts are used during the service, carts will be rented at \$5.00 per day.

Carts are to be returned to Westport, if not carts will be billed at \$350 each.

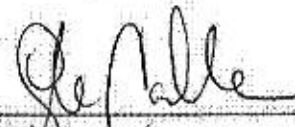
Invoice Billing is weekly and to be paid with a Credit Card submitted to Westport on first day of service.


Signature

Westport Linen Services, LLC.

CEO
Title

1/21/19
Date

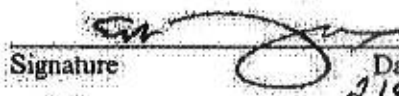

Signature

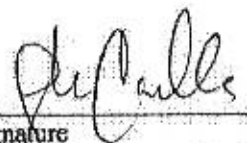
Plaza Holdings LLC.

CEO
Title

2-18-2020
Date

Renewal 2020:


Signature Date
CEO 2.18.20
Title


Signature Date
CEO 2-18-2020
Title

Renewal 2021:

Signature Date

Title

Signature Date

Title