Vermilion HC 3/2/2021

2021 Nursing Home Emergency Preparedness Plan Survey

For Year: **2021**

Facility Name (Print):
Vermilion Health Care Center

Name of Administrator (Print):
Gary Green

Administrator's Emergency Contact Information **(should be reflected in MSTAT/ESF8)**:
Phone #: 337-643-1949
Cell Phone #: 337-652-4906
Administrator E-Mail: gng5412@gmail.com

Alternative (not administrator) Emergency Contact Information **(should be reflected in MSTAT/ESF8)**:
Name: Kim Istre
Position: Office manager
Phone #: 337-643-1949
Cell Phone #: 337-652-2744
E-Mail: Kimharrington@kaplantel.net

Physical or Geographic address of Facility (Print):
14008 Cheneau Rd.
Kaplan, La 70548
Longitude: 92°229° W
Latitude: 29.991 N

Vermilion HC

VERMILION
HEALTHCARE CENTER

Bus Transportation

Bus Transportation agree to furnish Vermilion Healthcare Center, located in Kaplan, Louisiana, three (3) air-conditioned school busses with drivers in the event of an evacuation order. Destination to Winnfield, Louisiana.

Mike Richard

Mike Richard 337-278-5579

3/2/21
Date

NFA

Gary Green, Administrator

3/2/21
Date

2021 Nursing Home Emergency Preparedness Plan Survey

VERIFICATION of OHSEP SUBMITTAL for Year: **2021**

Nursing Facility's Name: Vermilion Health Care Center

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.**

Vermilion Parish office of Emergency preparedness
(Name of the Local/Parish Office of Homeland Security and Emergency Preparedness)

Date submitted: _____

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.

2021 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. 48 **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. 36 **Hours** before the arrival of the hurricane.

   d) Who is responsible for making the decision to shelter in place?
      TITLE/POSITION: Administrator
      NAME: Gary Green

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. 48 Hours before the arrival of the hurricane.

d) Who is responsible for making the decision to evacuate?
TITLE/POSITION: Gary Green
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? 1983

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. [ ] Category 2- winds 96 to 110 mph
- iii. [x] 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. [x] 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. [x] 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 10'2 feet above sea level.

b) Air conditioner (HVAC) is 17 feet above sea level.

c) Generator(s) is 20 feet above sea level.

d) Lowest electrical service box(s) is 20 feet above sea level.

e) Fuel storage tank(s), if applicable, is 18 feet above sea level.

f) Private water well, if applicable, is 17 feet above sea level.

g) Private sewer system and motor, if applicable, is 20 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: _____

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

2021 Nursing Home Emergency Preparedness Plan Survey

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; 60KW 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)
    1st 168 Hours 2nd_____ Hours 3rd_____ Hours 7 days

    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: Slemco
- ii. Account #: 3224028300

b) Who supplies water to the facility? (supplier's name)
- i. Suppliers name: Water District #1
- ii. Account #: 10881-0000089400

c) Who supplies fuels (natural gas, propane, gasoline, diesel, etc) to the facility? If applicable.
- i. Suppliers name: Cajun Propane
- ii. Account #: 177201

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: 120

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: 0

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: 48

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: 44

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: 13

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?
40

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 48 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)?
LaSalle Nursing Home / First Assembly of God Church

ii. What is the physical address of each host site(s)?
139 Ninth St. Jena La 71342
5693 Hwy 167 North Winnfield. La 71483

iii. What is the distance to each host site(s)?
160.32 miles
165.34 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: _____
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: _____
- Total Capacity of all primary sites: _____
- 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?
_____

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)?
_____

ii. What is the physical address of each **alternate/secondary** host site(s)?
_____
_____
_____

iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
_____

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: _____
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:
_____
- Total Capacity of all **alternate/secondary** sites:
_____
- 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?
  Church
- What is host site currently being used for?
  religious service
- Is the square footage of the space to be used adequate for the residents?
  - [x] Yes
  - [ ] No
- What is the age of the host facility(s)?
  _____
- Is host facility(s) air conditioned?
  - [x] Yes
  - [ ] No
- What is the current physical condition of facility?
  - [x] Good
  - [ ] Fair
  - [ ] Poor
- Are there provisions for food preparation and service?
  - [x] Yes
  - [ ] No
- What are the provisions for bathing and toilet accommodations?
  - [x] Yes
  - [ ] No
- Are any other facilities contracted to use this site?
  - [ ] Yes
  - [x] No

x. Is the capacity of **alternate/secondary** host site(s) adequate for staff?
- [x] 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? _____
- [x] No.

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

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

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? Radio

      ii. Is there back up or alternate equipment and what is it?
      ☑ Yes. Name equipment: Cellphone
      ☐ 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?
Cellphones / Two-way radios

ii. Is there back up or alternate equipment used to send/receive and what is it?
☑ Yes. Name equipment: other cellphones
☐ 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.

2021 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

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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

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

2021 Nursing Home Emergency Preparedness Plan Survey

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: Gary Green
Position: Administrator
Emergency contact information:
Phone: 337-652-4906
Email: gng5612@gmail.com
Fax: 337-643-3456

B. Who is the backup/second in line responsible for **decision** to **sheltering in place/evacuating**?
Provide Name: Kim Istre
Position: Business Office manager
Emergency contact information:
Phone: 337-643-1949
Email: Kimharrington@kaplantel.net
Fax: 337-643-3456

C. Who will be **in charge when sheltering in place**?
Provide Name: Gary Green
Position: Administrator
Emergency contact information:
Phone: 337-652-4906
Email: gng5612@gmail.com
Fax: 337-643-3456

D. Who will be the backup/second in line **when sheltering in place**?
Provide Name: Kim Istre
Position: Business Office manager
Emergency contact information:
Phone: 337-643-1949
Email: Kimharrington@kaplantel.net
Fax: 337-643-3456

E. Who will be **in charge at** each evacuation **host site**(s)?
Provide Name: Gary Green
Position: Administrator
Emergency contact information:
Phone: 337-652-4906
Email: gng5612@gmail.com
Fax: 337-643-3456

2021 Nursing Home Emergency Preparedness Plan Survey

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:
   Margaret
   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:
   Gary Green (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?
   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?
   Gary Green Sr. (Maintenance)
   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?
   Gary Green Jr. (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

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.

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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 Servie

Contact Person: Mel Guidry

Phone # of Contact Person: 337-291-2201 / 337-349-1020

Physical Address of transportation provider:

300 Hopkin St.
Lafayette, LA 70501

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?

12 Hours

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

1 Hour

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

Total number of transport vehicles to be provided: 4-5

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

4 Stretchers

Is the transportation air conditioned? ☑ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: _____

Date agreement/ contract ends: _____

2021 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):

MAB Bus Transportation

Contact Person: Mike Richard

Phone # of Contact Person: 337-278-5579

Physical Address of transportation provider:

314 S. Fieldspan Rd.
Scott, La 70583

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 Hours

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

1 Hour

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

2 Hours

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

Air conditioned School Bus

Total number of transport vehicles to be provided: 3

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

45 Seated and wheelchair

Is the transportation air conditioned? ☑ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: _____

Date agreement/ contract ends: _____

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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: Lasalle Nursing Home

Contact Person: phyllis Bryan

Phone # of Contact Person: 318-992-6627

FAX#: (318) 992-9288

E-Mail Address:

Physical Address of evacuation site:
139 Ninth St.
Jena, La 71342

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 Hours

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

3 Hours, 4 minutes

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

2-3 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:

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

Date of agreement/contract/verification:

Date agreement/contract ends:

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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:
First Assembly of God Church

Contact Person: Sue Kelly

Phone # of Contact Person: 318-628-5200

FAX#: 318-628-5220

E-Mail Address:

Physical Address of evacuation site:
5693 HWY 167 North
Winnfield, LA 71483

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 Hours

How long will it take to reach the evacuation host site facility?
3 Hours 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: 110

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

Date of agreement/contract/verification:

Date agreement/contract ends:

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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: Medical Supplies

Name of Supplier;

Medline

Contact Person: Rocky Guidry
Phone # of Contact Person: 337-258-3965
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?

24 Hours

How long will it take to receive the delivery?

3 Hours

Date of agreement/contract/verification:

Date agreement/contract ends:

2021 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

Name of Supplier:
Reinhart Food Service

Contact Person: Dawn Arceneaux
Phone # of Contact Person: _____
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?
24 Hours

How long will it take to receive the delivery?
3 Hours

Date of agreement/contract/verification: _____

Date agreement/contract ends: _____

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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)?
LaSalle Nursing Home

ii. What is the physical address of each host site(s)?
139 Ninth St.
Jena, La 71342

iii. What is the distance to each host site(s)?
3 Hours 9 minutes

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: Phyllis Bryan, Administrator
Phone: 318-992-4627
Email:
Fax: 318-992-9288

vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
- Capacity that will be allowed at each site:
- 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/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

2021 Nursing Home Emergency Preparedness Plan Survey

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

x. Is the capacity of primary host site(s) adequate for staff?
- [x] 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? _____
- [x] No.

2021 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)?
First Assembly of God Church

ii. What is the physical address of each **alternate/secondary** host site(s)?
5693 Hwy 167 North
Winnfield, La 71483

iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
16534 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: Gary Green
Phone: 337-652-4906
Email: gng5126@gmail.com
Fax: 337-643-3056

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?
  Church
- What is host site currently being used for?
  Religious service

2021 Nursing Home Emergency Preparedness Plan Survey

- Is the square footage/area of the space to be used adequate for the residents?
  - [x] Yes
  - [ ] No
- What is the age of the host facility(s)?

  _____
- Is host facility(s) air conditioned?
  - [x] Yes
  - [ ] No
- What is the current physical condition of facility?
  - [x] Good
  - [ ] Fair
  - [ ] Poor
- Are there provisions for food preparation and service?
  - [x] Yes
  - [ ] No
- What are the provisions for bathing and toilet accommodations?
  - [x] Yes
  - [ ] No
- Are any other facilities contracted to use this site?
  - [ ] Yes
  - [x] No

x. Is the capacity of **alternate/secondary** host site(s) adequate for staff?
- [x] 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?
- [x] Yes. If yes what is that time? 24 Hours
- [ ] No.

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

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

2021 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

Vermilion Healthcare Center

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: 8/25/21

Facility Administrator Name (PRINT): Gary Green

Facility Administrator Signature:

Comments:

Disaster-related Medical and Other Supplies and Equipment Agreement

Carmichael's Cashway Pharmacy, Inc.
1002 North Parkerson Avenue • Crowley, Louisiana 70526
(337) 783-7200 • (337) 783-8996 (FAX) • (800) 570-7263

This Disaster-related Medical and Other Supplies and Equipment Agreement (the "Agreement") is made and entered into this 1st day of January, 2021 (the "Effective Date") by and between Carmichael's Cashway Pharmacy, Inc. ("Carmichael's") and Vermilion Health Care ("Facility").

Subject to availability and utilizing reasonably practicable best efforts, Carmichael's agrees to procure, in as timely a manner as reasonably possible, and supply disaster-related medical and other supplies and equipment ("Relief Products") to Facility on an as-requested basis. As quickly as conditions are determined to be safe for delivery drivers to be dispatched, solely in the opinion and at the discretion of the management of Carmichael's, Carmichael's agrees to deliver the requested Relief Products to Facility at the following evacuation site, as specified by Facility:

Winnfield First Assembly of God
Lasalle Nursing Home

As compensation for the delivery of the Relief Products by Carmichael's, Facility agrees to pay Carmichael's an amount equal to the sum of a) the total of Carmichael's acquisition cost for the Relief Products delivered to Facility in conjunction with this Agreement and b) thirty per cent (30%) of such acquisition cost, which additional amount is to compensate Carmichael's for the cost of delivery drivers, fuel and other related overhead costs. Facility agrees to make payment to Carmichael's for such delivered Relief Products within thirty (30) days of receipt of the related invoice from Carmichael's.

The term of this Agreement shall be for a period of one year, commencing on the Effective Date, and shall automatically renew for successive one-year terms on an annual basis, unless earlier terminated for any reason by either party providing at least thirty (30) days prior written notice to the other party.

Please specify the Facility evacuation site above, sign and complete below and return this Agreement to Carmichael's at your earliest convenience.

FACILITY

Gary Green
Signature

Gary Green
Print Name

Administrator
Title

CARMICHAEL'S

Henry J. Helo III
Signature

Henry J. Helo III
Print Name

General Manager
Title

LaSalle
Nursing Home

February 25, 2021

Phyllis Bryan
LaSalle Nursing Home
139 Ninth Street
Jena, La 71342

Dear Vermillion Healthcare Center Administrator,

Vermillion Healthcare agrees that during any "EMERGENCY" at LaSalle Nursing Home requiring the evacuation of the home, we stand ready to accept as many residents as may safely be housed in our facility.

We understand that Vermillion Healthcare, will not be liable for any incidents which may occur in connection with this. We agree to let Lasalle Nursing Home personnel use our facility to feed, house, and care for the residents until such a time as a permanent facility may be obtained.

We understand that Lasalle Nursing Home will be fully liable for the residents' care and feeding during the time in which they are housed in our facility.

This agreement will be deemed reciprocal in the case of the above listed receiving facility experiencing an emergency situation requiring evacuation of its residents.
This agreement will remain in effect until terminated by mutual agreement by the Administrators of both facilities.

Administrator
LaSalle Nursing Home
139 9th Street
Jena, La 71342

Administrator
Vermillion Healthcare Center
14008 Cheneau Rd
Kaplan, La 70548

Please return this form fax #318-992-9288 as soon as possible.

PERFORMANCE
FOODSERVICE

Reinhart Foodservice Louisiana, LLC d/b/a
Performance Foodservice - New Orleans
918 Edwards Ave.
Harahan, LA 70123

February 16, 2021

Valued Customer:

Reinhart Foodservice Louisiana, LLC, doing business as Performance Foodservice–New Orleans ("Performance Foodservice"), is committed to working with you through our disaster planning service to ensure that emergency supplies are provided to your facility prior to and in the event of a disaster or emergency. This letter shall serve as documentation of Performance Foodservice's policy regarding delivery of goods during a disaster or emergency.

Should Performance Foodservice be affected by a disaster or emergency, it will take the following actions:

- 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 Performance Foodservice facility or one or more alternate facilities.

If your facility is involved in a disaster or emergency, Performance Foodservice may supply the following items upon request and depending upon availability:

- Coordinated delivery schedule adjustments prior to or after the emergency has passed.
- Disaster/Emergency order consultation and order placement assistance.
- Delivery of emergency rations and supplies as available from the Performance Foodservice OPCO's inventory supplies and delivered on a first come/first serve basis prior to the event, and/or as service is available in the affected area.

Refer to your state's Department of Health and Human Services guidelines for food and water supply for emergencies. Performance Foodservice 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 Performance Foodservice regarding stoppage of delivery or delivery to an alternate site. Alternate shelter site deliveries will be made as available on normal routes and days in the area. You should take as many supplies as possible to the shelter site from your current inventory. This recommendation is to ensure your existing inventory is not destroyed during the event and/or product is available for meals should our ability to ship supplies to the alternate site be delayed because of excessive demands prior to and following the event. Should you have any questions regarding this policy, please contact your Performance Foodservice Healthcare Account Manager or Customer Service at 1-800-488-3988.

Sincerely,

Steve Wood
Area President New Orleans and Shreveport Opcos

Acadian
AMBULANCE SERVICE

NATIONALLY ACCREDITED

P.O. Box 98000 • Lafayette, LA • 70509-9800

AMBULANCE DISPATCH
911
800-259-1111

ADMINISTRATION
337-291-3333
800-259-3333

BILLING
800-259-2222

January 12 , 2021

To whom it may concern:

In response to a request for verification from Vermilion Healthcare (hereinafter "Facility"), please allow this to serve as confirmation that Facility currently has in place an agreement for the evacuation of resident/patients in the case of a disaster, as required by the Louisiana Department of Health and Hospitals and in accordance with the terms and conditions of such Agreement. The Agreement auto-renews annually unless otherwise terminated by either party. As of this Date, no notice of termination has been received and therefore such Agreement remains in full force and effect for the 2021 calendar year.

Sincerely,

Mel Guidry
Community Relations Supervisor
Acadian Ambulance Service, Inc.

MEDICAL TRANSPORTATION AGREEMENT

THIS AGREEMENT is made and entered into on the January 1, 2021, by and between Acadian Ambulance Service, Inc ("SUPPLIER"), and Vermilion Healthcare ("FACILITY"), effective 1/1/2021 (the "Effective Date").

Recitals

WHEREAS, SUPPLIER is established and experienced in providing quality medical transportation services to health care providers;

WHEREAS, FACILITY desires and has requested that SUPPLIER provide medical transportation services to patients that require such transportation services ; and

WHEREAS, SUPPLIER is willing to provide ground transportation services under the terms and conditions stated herein;

NOW THEREFORE, in consideration of the foregoing recitals, mutual covenants and promises hereinafter set forth, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1. Covered Persons. Individuals whose transport(s) fall within the purview of this Agreement.

1.2. Covered Services. Medical Necessity ambulance services (and related supplies) provided by SUPPLIER to a Covered Person or to a facility where the Covered Person may receive appropriate care.

1.3. Indigent. Any person who has no third party insurance or source of payment.

1.4. Medical Necessity. The services, procedures, drugs, supplies, or medical equipment provided by SUPPLIER in accordance with established medical protocols in connection with the diagnosis or treatment of the Covered Person. For the purposes of this definition, emergency medical transportation shall be deemed a Medical Necessity if established medical protocols are followed and non-emergency medical transportation shall be deemed a Medical Necessity if a patient is transported to or from a state licensed facility, or if the transport is pre-approved by the responsible party and the patient's ailment contraindicates transportation by any other means.

1.5. Payors. FACILITY, certain employers, plan sponsors or other entities obligated to make payments for health care services.

1.6. Usual Charge. The fee regularly charged by SUPPLIER.

ARTICLE II
OBLIGATIONS/REPRESENTATIONS OF FACILITY AND/OR PAYORS

2.1 Information. FACILITY agrees to provide SUPPLIER with any/all information necessary to obtain payment from Medicare, Medicaid or private insurance carriers. Such information shall include, but is not limited to all applicable billing information, history or physical, and any other information required to obtain payment for services set forth in this Agreement.

2.2 SUPPLIER/Patient Relationship. This Agreement shall not have the purpose or effect of infringing upon SUPPLIER'S provider/patient relationship with any Covered Person. FACILITY shall remain solely and ultimately responsible for the quality of health care services provided by FACILITY and shall render such services according to generally accepted medical and surgical practices and professional standards.

ARTICLE III
OBLIGATIONS / REPRESENTATIONS APPLICABLE TO SUPPLIER

3.1 Scope of Service. Upon request and acceptance, SUPPLIER will provide twenty-four (24) hour access to emergency (in locations not prohibited by City Ordinances), urgent, and non-emergency ambulance service with a unit qualified at an appropriate level of service for the request to FACILITY'S private, public, and contract customers that qualify for ambulance service needs.

Bariatric services may be provided, based upon availability of bariatric unit, patient necessity, for a patient whose weight is in excess of 500 pounds or request from FACILITY.

Additional services may be requested based upon availability and FACILITY will be charged and agrees to pay SUPPLIER's customary rates for requested services unless otherwise mutually agreed upon.

It will be mutually agreed upon by all parties to provide the appropriate mode and level of service determined based upon medical necessity and standards of care in accordance with all local, state and federal regulations.

3.2 Nondiscrimination. SUPPLIER shall not discriminate against any COVERED Person because of race, physical handicap, color, religion, sex or national origin. SUPPLIER shall not be required to provide medical care if a Covered Person refuses to cooperate with the medical advice and treatment or if there is other good cause for refusing to

provide medical services. SUPPLIER agrees to comply with the provisions of 41 C.F.R. § 60-1.4.

3.3 Utilization Management. SUPPLIER shall cooperate with any utilization management program provided by FACILITY or its designee for review of utilization of health care s services.

3.4 Business and Health Records. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of the duly authorized representatives, SUPPLIER will make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If SUPPLIER carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a twelve (12) month period with a related individual or organization, SUPPLIER agrees to include this requirement in any subcontract. This Section is included pursuant to and is governed by the requirement of public law 96-499, Section 952 (Section 1861 (v) (I) of the Social Security Act) and the regulations promulgated hereunder. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by FACILITY or SUPPLIER by virtue of this Agreement.

3.5 Credentialing. SUPPLIER and all its employees and representatives providing services hereunder will be duly licensed or certified and in good standing as required by the appropriate governing regulatory agency. SUPPLIER shall provide to FACILITY evidence thereof upon request. SUPPLIER shall continuously satisfy FACILITY'S reasonable credentialing criteria and shall provide services and supplies according to generally accepted medical practices and professional standards, and within the scope of the employee's or representative's applicable license. SUPPLIER and its employees and representatives shall comply with all applicable federal, state and municipal laws, orders and regulations, and shall promptly notify FACILITY upon becoming the subject of any regulatory or professional disciplinary action, which may materially affect the Covered Services. SUPPLIER shall use its best efforts to assure that all duties are provided in and through the FACILITY as may be required by any standard, ruling or regulation of The Joint Commission ("TJC"); the State Department of Health, State Board (IF APPLICABLE); or any other federal, state, or local government agency, corporate entity or individual exercising authority with respect to, affecting FACILITY in such a manner as to confirm to all requirements of the federal and state Constitutions and all applicable federal and state statutes and regulations. Further, Supplier's director (IF APPLICABLE) shall ensure that its director shall have thorough knowledge of the TJC standards, including, but not limited to, the director's role in this process from daily operations to performance improvement.

3.6 Continuous Performance Improvement. SUPPLIER, as part of FACILITY'S Performance Improvement Program will ensure the quality and appropriateness of patient care services provided are monitored and evaluated, and identified problems are resolved.

3.6 a. SUPPLIER will have a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of services provided to FACILITY patients. This system shall be coordinated with the FACILITY'S Performance Improvement Program and Contractor shall report results on a quarterly basis when requested.

3.6 b. Upon reasonable request, SUPPLIER will provide a written document outlining the aforementioned plan.

3.6 c. SUPPLIER will maintain written standards of care/practice. Said standards shall be available to the FACILITY, upon reasonable request for review.

ARTICLE IV PAYMENT

4.1 Compensation. For Services provided under this Agreement, FACILITY agrees to pay SUPPLIER as set forth on Schedule A.

4.1.1 The rates set forth herein are the contractually negotiated rates between FACILITY and SUPPLIER, and shall supersede any rates set by local ordinance or the laws of any other governmental entity, unless the superseding of such local ordinance or governmental rates by these contractually negotiated rates is specifically prohibited by law. If any changes to these contractually negotiated rates are required by law, the parties agree to meet and discuss the changes and to amend this Agreement so that it complies with all legal requirements.

4.2 Rates. Unless indicated otherwise by specific rates in Exhibit A, the rates that SUPPLIER shall charge FACILITY when FACILITY pays SUPPLIER for ground ambulance transports shall be subject to the Medicare Allowable rates for the geographic area in which services are provided. For ground ambulance roundtrip transports of inpatients in which the patient is a Beneficiary of Medicaid or a Medicaid managed care plan where the FACILITY is responsible for ground ambulance transportation, FACILITY shall be subject to the Medicaid allowable rates.

4.3 Claim Processing. All invoices for services provided are due net thirty days from receipt. All invoices not paid in full within 61 days from date of invoice will be considered past due. Once an invoice becomes past due, SUPPLIER may mail to FACILITY a Past Due Notice consisting of the invoice number(s) and amount(s) due on said invoice(s). Failure of FACILITY to pay the past due invoice(s) in full within thirty (30) days of SUPPLIER's mailing of the Past Due Notice shall obligate FACILITY to pay finance charges of 1% per month, retroactive to the respective invoice date(s), on the unpaid balance of the respective invoice(s).

4.4 Delinquent Status of FACILITY. All invoices not paid in full within 91 days from date of invoice will be considered delinquent. Once an invoice becomes delinquent, FACILITY shall no longer be entitled to the discount to which it would otherwise be

entitled under the terms of this contract. Except for invoiced payments that FACILITY has successfully disputed, all delinquent invoices shall bear interest at the lesser of the rate of 1% per month and compounded monthly. FACILITY shall also reimburse SUPPLIER for all reasonable costs incurred in collecting any delinquent invoices, including, without limitation, attorneys' fees, court costs and all other amounts to which it is legally entitled. In addition to all other remedies available under this Agreement or at law (which SUPPLIER does not waive by the exercise of any rights hereunder), SUPPLIER shall have the option to either terminate this Agreement or suspend the provision of any Services if FACILITY fails to pay any amounts when due hereunder and such failure continues for 30 days following written notice thereof.

4.5 Charge Verification. Upon request, SUPPLIER shall furnish FACILITY or their duly authorized representative with such documents or reports as may be reasonably necessary to verify the accuracy of charges as reflected on SUPPLIER Service's bills.

4.6 Coordination of Benefits. SUPPLIER shall make all reasonable efforts to assist in coordinating benefits with other health care plans, which may provide coverage to patients covered under a Health Plan. Other plans shall include, but are not limited to group insurance plans, Blue Cross and Blue Shield Plans, government-sponsored plans (including Medicare and Medicaid), multiple-employer trust plans and prepaid health maintenance organization plans.

4.7 Waiver of Charges. SUPPLIER shall collect full deductibles, co-payments or coinsurance amounts applicable under a Health Plan except as determined to be uncollectible pursuant to reasonable and prudent professional collection practices.

4.8 Separate Agreements. SUPPLIER is free to enter into a separate agreement with a payor under such terms and condition as they may agree upon.

4.9 Payment Guarantor. FACILITY's parent company or affiliate hereby agrees that should facility become delinquent on payment of any outstanding amounts owed hereunder, then such Parent or Affiliate company shall make payment on FACILITY's behalf. For purposes of this Agreement "affiliate" shall be defined as any person or entity owning a majority share of Facility or which through a contractual arrangement or otherwise has the ability to control the operations or activities or financial outcomes of FACILITY.

ARTICLE V
TERM and TERMINATION

5.1 Term of Agreement. This Agreement shall be in effect for one (1) year from the Effective Date, and shall thereafter automatically renew for additional one (1) year terms until terminated by either party giving notice to termination of the other party.

5.2 Termination. All notices of termination must in writing. Refer to Section 8.9 of this Agreement.

5.2.1 Either party shall be free to terminate this Agreement by providing thirty (30) days written notice to the other party.

5.2.2 Material breach of this Agreement upon thirty (30) days' prior written notice to terminate to the breaching Party for a breach of any material term or condition; provided the breaching Party shall not have cured such breach within the thirty (30) day period.

5.2.3 SUPPLIER may terminate this Agreement in whole or in part with respect to a particular FACILITY should an entity acquire all or substantially all of the business or assets of FACILITY or any FACILITY to which this Agreement pertains, whether by merger, reorganization, acquisition, sale or otherwise.

5.2.4 Repeated failure by FACILITY to pay timely shall be grounds for termination of this Agreement at the option of SUPPLIER without further notice.

5.2.5 This Agreement shall automatically terminate for any of the following reasons:

5.2.5.1 Cessation of business or insolvency of SUPPLIER or FACILITY.

5.2.5.2 If legislation is enacted or a court of competent jurisdiction interprets a law so as to prohibit the continuance of this Agreement; or

5.2.5.3 If SUPPLIER: (1) suffers revocation, termination or suspension of any license required; (2) is found guilty of any felony criminal offense or a misdemeanor in the scope of SUPPLIER'S services; (3) is found guilty of gross misconduct in providing supplies or services; or (4) fails to meet the liability insurance requirements of Article III.

ARTICLE VI
INDEMNIFICATION

6.1 Liability of FACILITY. FACILITY shall indemnify, defend and hold harmless SUPPLIER, Covered Person and Payors from any claims, losses, damages, liabilities, costs, expenses or obligations, including but not limited to attorneys' fees, court costs and punitive or similar damages, arising out of or resulting from the negligent, fraudulent, dishonest or other acts or omissions, of FACILITY, or its agents, officers, directors or employees.

6.2 Liability of SUPPLIER. SUPPLIER shall indemnify, defend and hold harmless FACILITY Covered Person and Payors from any claims, losses, damages, liabilities, costs, expenses or obligations, including but not limited to attorneys' fees, court costs and punitive or similar damages, arising out of or resulting from the negligent, fraudulent,

dishonest or other acts or omissions, of SUPPLIER, or its agents, officers, directors or employees.

6.3 Non-assumption of Liability. FACILITY and Payors do not assume any liability for the neglect, fraudulent, dishonest or other acts or omissions of SUPPLIER. SUPPLIER does not assume any liability for the neglect, fraudulent, dishonest or other acts or omissions of FACILITY or Payor.

ARTICLE VII
INSURANCE

7.1 Liability Insurance. SUPPLIER shall maintain, at its own expense, professional liability insurance in amounts equal to at least $1,000,000 for each claim and $3,000,000 annual in the aggregate. SUPPLIER shall maintain, at its own expense, comprehensive general liability insurance in amounts equal to at least $1,000,000 for each claim and $3,000,000 annual in the aggregate. SUPPLIER agrees to furnish FACILITY with satisfactory evidence of such insurance upon request. SUPPLIER shall immediately advise FACILITY of any termination of such insurance or any reduction in the amount of such insurance. The parties agree that any insurance policies maintained by them shall contain provisions that the underwriter will have no right of recovery or subrogation against the other party.

ARTICLE VIII
MISCELLANEOUS

8.1 Other Programs. Nothing contained in this Agreement shall prevent the FACILITY, FACILITY'S policyholders, policy owners, employers subject to Health Plans, Payors or SUPPLIER from participating in or contracting with any other health care or other provider, provider organization, health maintenance organization or other health delivery or insurance program.

8.2 Independent Entities. The relationship of SUPPLIER to FACILITY and any Payor shall continue to be as independent entities, and no such party is an employee, agent or representative of any other party by virtue of this Agreement, nor shall any such party have any expressed or implied right or authority to assume or create any obligation or responsibility on behalf of or in the name of any other party by virtue of this Agreement.

8.3 Confidentiality. SUPPLIER and FACILITY shall maintain the confidentiality of medical records of Covered Persons in accordance with HIPAA Compliance and other applicable local, state, and federal laws.

8.4 Governing Law. This Agreement shall be subject to and governed according to the laws of the State of Louisiana, irrespective of the fact that either party is or may become a resident of another state.

8.5 Binding Effect. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their respective successors, assigns or other legal representatives.

8.6 Assignment. No right or obligation hereunder may in any way whatsoever be assigned or delegated to a third party without the express prior written consent of the other party hereto, and any attempted assignment without such consent shall be considered null and void. Notwithstanding the above, this Agreement, or any or all of the services required herein, may be assigned, or subcontracted to any of SUPPLIER'S affiliates.

8.7 Legal Fees. In the event either party brings any action for any relief, declaratory or otherwise, arising out of this Agreement or on account of any breach or default hereof, the prevailing party shall be entitled to receive from the other party, reasonable attorneys' fees, costs, and expenses related to such action.

8.8 Severability. If any portion or portions of this Agreement shall be for any reason invalid or unenforceable, the remaining portion(s) shall be valid and enforceable and carried into effect unless to do so would clearly violate the present legal and valid intention of the parties hereto.

8.9 Notices. Any notice required or permitted to be given pursuant to any provisions of this Agreement shall be given in writing, and either delivered in person, by electronic transmission, deposited in the United States mail, postage pre-paid, registered or certified mail, return receipt requested, properly addressed, or by a nationally recognized overnight courier service, to the following addresses:

If to SUPPLIER:
Acadian Ambulance Service, Inc
PO Box 98000
Lafayette, LA 70509-8000
Attn: Executive Vice President / CFO

If to FACILITY:
Vermilion Healthcare
14008 Chenoau Road
Kaplan, LA 70548

Either party may change the notification addresses listed above with proper notice as listed above. If a notice that otherwise fulfills the requirements of this Section is rejected by the addressee, or if an addressee refuses to accept such a notice, or if a change in address for which no notice was given causes the notice to be undeliverable, then the notice is effective upon the occurrence of such rejection, refusal or undeliverability.

8.10 Entire Agreement. This Agreement constitutes the entire agreement and understanding between the parties with respect to the subject matter hereof and superseded any previous agreement or understanding, whether oral or otherwise. No modification of this Agreement shall be valid unless in writing and signed by each of the parties hereto.

8.11 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

8.12 Execution and Delivery of Original Signed Agreement. This Agreement must be properly executed by authorized parties and shall be deemed effectively executed upon the receipt by both parties hereto of the fully executed Agreement. Each party to this Agreement agrees to deliver an original, inked and signed Agreement within two (2) weeks of receiving the executed hereof. Failure to return this executed Agreement to SUPPLIER within 30 days of the commencing date written above shall render this Agreement null and void and any services provided to facility shall be charged and billed at customary rates.

8.13 Force Majeure. The performance by Ambulance Provider shall be excused in the event and during an event of Force Majeure. For purposes of this Agreement an Event of Force Majeure shall be defined as an event such that performance is rendered unsafe or prevented by the following: acts of God; acts of war, riot, accident, flood or sabotage; unavailability of adequate fuel, labor, power or materials; judicial or governmental laws, regulations, requirements, orders or actions; injunctions or restraining orders which are ultimately determined to have been wrongfully granted.

SIGNATURES:

In WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their authorized representative on the day and year first written above.

SUPPLIER Acadian Ambulance Service, Inc	FACILITY Vermilion Healthcare
By: DocuSigned by: Troy Guidry A9B07C453CD967D...	By: DocuSigned by: Gary Green EEE456DEACB2412...
Name: Troy Guidry	Name: Gary Green
Title: Regional Vice President	Title: administrator
Date: 2/25/2021 | 1:05 PM PST	Date: 2/25/2021 | 1:49 PM CST

SCHEDULE A
PAYMENT AND BILLING

Ground Ambulance:
Except as specifically stated below, SUPPLIER shall bill and collect for its services from the patient's third party payer or from the patient directly, and FACILITY shall have no obligation to pay SUPPLIER for its services.

FACILITY shall pay SUPPLIER directly for ambulance transports as described on the attached Exhibit A only when any of the following circumstances exists:

- When the transport is not considered a medical necessity as defined by Center for Medicare and Medicaid Services ("CMS") in 42 CFR Part 410.40 ("Medical Necessity"), and the payer is Medicare or Medicaid.

- When the transport is for roundtrip transport of patients covered by FACILITY'S inpatient Medicare DRG, Medicaid DRG, Consolidated Billing or Prospective Payment System guidelines.

- When the patient is indigent (Refer to Article I DEFINITIONS).

- When authorized, scheduled or requested by FACILITY.

For ground ambulance inpatient roundtrip transports in which the patient is a Beneficiary of Medicaid or a Medicaid managed care plan where FACILITY is responsible for ground ambulance transportation, FACILITY shall be subject to 100% of the then Medicaid Allowable. All other rates will be billed at the then prevailing Medicare rate.

EXHIBIT A – Acadian Ambulance Service, Inc
Transport Rates & Service Descriptions
Vermilion Healthcare
Medicare Local 99LA

A. Ground Ambulance

Item	HCPC	Rate	Medicaid Rate
BLS Non Emergency	A0428	100% Medicare Allowable	100% Medicaid Allowable
ALS1 Non Emergency	A0426	100% Medicare Allowable	100% Medicaid Allowable
BLS Emergency	A0429	100% Medicare Allowable	100% Medicaid Allowable
ALS1 Emergency	A0427	100% Medicare Allowable	100% Medicaid Allowable
ALS2 Emergency	A0433	100% Medicare Allowable	100% Medicaid Allowable
Specialty Care	A0434	100% Medicare Allowable	100% Medicaid Allowable
Mileage	A0425	100% Medicare Allowable	100% Medicaid Allowable

Rates are subject to change annually when rates are published by the Centers for Medicare and Medicaid Services. You may refer to the CMS link below for more information.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html

B. Other

Bariatric Surcharge *(Rate is applied in addition to appropriate base rate and mileage.)*	$250.00

Service Descriptions

HCPC Code	Type of Service	Description of Service
A0428	BLS	Basic Life Support (BLS): Where medically necessary, the provision of basic life support (BLS) services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous (IV) line, to the extent permitted by State law.
A0429	BLS-E	Same as above, but rendered under emergency conditions.
A0426	ALS	Advanced Life Support, Level 1 (ALS1): Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider and/or the provision of one or more ALS interventions. An ALS provider is defined as a provider trained to the level of EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint, to the extent permitted by State law.
A0427	ALS-E	Same as above, but rendered under emergency conditions.
A0433	ALS2	Advanced Life Support, Level 2 (ALS2): Where medically necessary, transportation either by ground ambulance vehicle, medically necessary supplies and services, three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion excluding crystalloids (hypotonic, isotonic and hypertonic solutions) such as dextrose, normal saline or ringer's lactate, or transportation, medically necessary supplies and services, and the provision of at least one of the following procedures: Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, surgical airway, Intraosseous line.
A0434	SCT	Specialty Care Transport (SCT): Where medically necessary, in a critically injured or ill patient, a level of inter-facility service provided beyond the scope of the Paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care, or paramedic with additional training); to the extent permitted by State law.
A0424	Bariatric Surcharge	Bariatric services may be provided, based upon availability of barintric unit, patient necessity, for a patient whose weight is in excess of 500 pounds or request from FACILITY. Bariatric services consist of the use of special equipment, additional personnel and other services as needed based upon the patient's condition at the time of transport.