South Lafourche 2/26/2021

2021 Nursing Home Emergency Preparedness Plan Survey

For Year: **2021**

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

Facility Name (Print):

South Lafourche Nursing and Rehab

Name of Administrator (Print):

Bob Duet, NFA

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

Phone #: 985-693-1048

Cell Phone #: 985-856-8005

Administrator E-Mail: bobduet@southlanr.com

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

Name: Lizza Mae Mitchell

Position: Business Office Manager

Phone #: 985-693-1047

Cell Phone #: 985-213-8411

E-Mail: lmitchell@southlanr.com

Physical or Geographic address of Facility (Print):

146 E 28th St.

Cut Off, LA 70345

Longitude: -90.582382986

Latitude: 29.714753778

2021 Nursing Home Emergency Preparedness Plan Survey

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

Nursing Facility's Name: South Lafourche Nursing and Rehab

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

Lafourche Parish OEP
(Name of the Local/Parish Office of Homeland Security and Emergency Preparedness)
Date submitted: 2/25/2021

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

   c) What is the **latest time, in hours** before the hurricanes arrival, which preparations will need to start in order to safely shelter in place?
      i. 72 **Hours** before the arrival of the hurricane.

   d) Who is responsible for making the decision to shelter in place?
      TITLE/POSITION: Administrator
      NAME: Bob J. Duet

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

   b) At what time, **in hours** before the hurricanes arrival, will the decision to evacuate have to be made by facility?
      i. 48 Hours before the arrival of the hurricane.

   c) What is the **latest time, in hours** before the hurricane's arrival, which preparations will need to start in order to safely evacuate?
      i. 72 Hours before the arrival of the hurricane.

d) Who is responsible for making the decision to evacuate?
TITLE/POSITION: Administrator
NAME: Bob J. Duet

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

A. Facility Description:

1. What year was the facility built? 2017

2. How many floors does facility have? 1

3. Is building constructed to withstand hurricanes or high winds?
☒ Yes, answer 3.a, b, c, d
☐ No/Unknown, answer 3.e

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

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

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

d) MARK if the windows are resistant to or are protected from wind and windblown debris?
i. ☒ Yes
ii. ☐ No

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

4. What are the elevations **(in feet above sea level, use NAVD 88 if available)** of the following:
a) Building's lowest living space is 3.51 feet above sea level.

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

c) Generator(s) is 7.51 feet above sea level.

d) Lowest electrical service box(s) is 3.51 feet above sea level.

e) Fuel storage tank(s), if applicable, is 7.51 feet above sea level.

f) Private water well, if applicable, is n/a feet above sea level.

g) Private sewer system and motor, if applicable, is 3.51 feet above sea level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. What is the area's Base Flood Elevation (BFE) if given in flood mapping?
   - ❖ See the **A** zones. Note: **AE** zones are now used on new format FIRMs instead of A1-A30 Zones. The BFE is a computed elevation to which floodwater is anticipated to rise. Base Flood Elevations (BFEs) are shown on Flood Insurance Rate Maps (FIRMs) and flood profiles.
   - ❖ The facility's Base Flood Elevation(BFE) is: 3.51

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

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

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

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; _____ 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)
    1st168 Hours 2nd_____ Hours 3rd_____ Hours

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

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

g) Does generator provide for air conditioning?

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

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

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

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

☒ Yes

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

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

a) Who supplies electricity to the facility?
- i. Suppliers name: Entergy
- ii. Account #: 153228341

b) Who supplies water to the facility? (supplier's name)
- i. Suppliers name: Lafourche Parish Water
- ii. Account #: 491-0820-01

c) Who supplies fuels (natural gas, propane, gasoline, diesel, etc) to the facility? If applicable.
- i. Suppliers name: Gaubert Oil
- ii. Account #: 19168

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: 102

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

i. How many high risk patients (RED) will need to be transported by **advanced life support ambulance** due to dependency on mechanical or electrical life sustaining devices or very critical medical condition? Give the total number of residents that meet these criteria the facility would need its named ambulance provider to transport.
RED: 12

ii. How many residents (YELLOW) will need to be transported by a **basic ambulance** who are not dependent on mechanical or electrical life sustaining devices, but who cannot be transported using normal means (buses, vans, cars). For example, this category might include patients that cannot sit up, are medically unstable, or that may not fit into regular transportation? Give the total number of residents that meet these criteria the facility would need its named ambulance provider to transport.
YELLOW: 0

iii. How many residents (GREEN) can only travel using **wheelchair accessible transportation**? Give the total number of residents that meet these criteria the facility would need its named transportation provider to transport.
GREEN WHEEL CHAIR: 0

iv. How many residents (GREEN) need no specialized transportation could go **by car, van, or bus**? Give the total number of residents that meet these criteria the facility would need its named transportation provider to transport.
GREEN: 80

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

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

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

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

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

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

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

2. Staff

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

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

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

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

_____

3. Transportation - **<u>should match what is in MSTAT!</u>**

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

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

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

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

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

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)?
Independence

ii. What is the physical address of each host site(s)?
129 Calhoun Street
Independece, LA
70443

iii. What is the distance to each host site(s)?
64.3

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: Angie Courville
Phone:225-343-9152
Email: angiec@deancompanies.com
Fax: 225-343-9152; 225-912-6603

vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
- Capacity that will be allowed at each site:
  700
- Total Capacity of all primary sites:
- 700
- 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?
  Warehouses and Manufactory Plan
- What is host site currently being used for?
  Evacuation Center
- 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)?
  29 years
- 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? 24 hrs
☐ No.

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

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

i. What is the name of each **alternate/secondary** site(s)?
Maison De'Ville of Harvey

ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th St.
Harvey, LA
70058

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

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

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

vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: Dante Landy
Phone:504-362-9522
Email: dlandy@devilleharvey.com
Fax: 504-368-4118

vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
- Capacity that will be allowed at each **alternate/secondary** site:
  75
- Total Capacity of all **alternate/secondary** sites:
  572
- Is this adequate for all evacuating residents?
  ☒ Yes. If No - obtain and mark Yes.

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

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

- What type of facility it is?

  _____
- What is host site currently being used for?

  _____
- Is the square footage of the space to be used adequate for the residents?
  ☐Yes
  ☐No
- What is the age of the host facility(s)?

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

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

_____

xi. Is there a specified time or timeline (H-Hour) that **alternate/secondary** host site will need to be notified by?
☒Yes. If yes what is that time? 24 hrs
☐No.

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

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

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, TV, Internet, Phone

      ii. Is there back up or alternate equipment and what is it?
      ☒Yes. Name equipment: Satelite Phone
      ☐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?
Satelite Phones and cell phones

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

2. Does facility have written viable plans for adequate transportation for the return of all residents to the facility?

   ☒Yes

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

   a) Does facility have written viable plans for staffing to load residents and supplies at the shelter site for the return to facility?

      ☒Yes

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

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

      ☒Yes

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

   c) Does facility have written viable plans for staffing for the unloading of residents and supplies after return to facility?

      ☒Yes

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

3. Does facility have written viable plans for the management of staff, including provisions for adequate qualified staffing and the distribution and assignment of responsibilities and functions at the evacuation host site(s)?

   ☒Yes

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

4. Does facility have written viable plans to have sufficient supplies – to be totally self sufficient - at or delivered to the evacuation host site(s) prior to or to coincide with arrival of residents? (potable and non-potable water, food, fuel, medications, medical goods, personal hygiene, sanitary, clothes, bedding, linens, etc)

   ☒Yes

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

5. Does facility have written viable plans for communication during evacuation?

   ☒Yes

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

   a) Does facility have written viable plans for contacting host site prior to evacuation?

      ☒Yes

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

   b) Does facility have written viable plans for contacting staff before an emergency event?

      ☒Yes

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

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

☒Yes

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

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

☒Yes

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

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

☒Yes

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

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

☐Yes ☒ Evacuating to a licensed site

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

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

☒Yes

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

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

☒Yes

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

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

☒Yes

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

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

☒Yes

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

2. Does plan include providing the following information to Health Standards Section of the Department of Health and Hospitals?

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

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

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

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

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

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

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

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

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

A. Who is responsible for the **decision to shelter in place or evacuate**?
Provide Name: Bob Duet
Position: Administrator
Emergency contact information:
Phone: 985-856-8005
Email: bobduet@southlanr.com
Fax: 985-693-1011

B. Who is the backup/second in line responsible for **decision** to **sheltering in place/evacuating**?
Provide Name: Lizza Mae Mitchell
Position: Business Office Manager

Emergency contact information:
Phone: 985-213-8411
Email: lmitchell@southlanr.com
Fax: 985-693-1011

C. Who will be **in charge when sheltering in place**?
Provide Name: Bob J. Duet
Position: Administrator
Emergency contact information:
Phone: 985-856-8005
Email: bobduet@southlanr.com
Fax: 985-693-1011

D. Who will be the backup/second in line **when sheltering in place**?
Provide Name: Lizza Mae Mitchell
Position: Business Office Manager
Emergency contact information:
Phone: 985-213-8411
Email: lmitchell@southlanr.com
Fax: 985-693-1011

E. Who will be **in charge at** each evacuation **host site**(s)?
Provide Name: Bob J. Duet
Position: Administrator
Emergency contact information:
Phone: 985-856-8005
Email: bobduet@southlanr.com
Fax: 985-693-1011

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

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

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

3. Title or position of person(s) assigned to securely attach the following information to each resident during an emergency so that it remains with the resident at all times?
   Ward Clerk/Medical Records
   a) Resident's identification.

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

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

5. Title(s) or position(s) of person(s) assigned for contacting emergency services and monitoring emergency broadcasts and alerts?
Administrator

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.

2021 Nursing Home Emergency Preparedness Plan Survey

EVACUATION HOST SITE COVER SHEET

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

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

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

Name of EVACUATION HOST SITE:

Independence

Contact Person: Angie Courville

Phone # of Contact Person: 225-343-9152
FAX#: 225-343-9154
E-Mail Address: angiec@deancompanies.com

Physical Address of evacuation site:
129 Calhoun Street
Independence
70443

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

24 hrs

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

1 hr and 24 mins

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

2 hrs

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

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

Total number of residents and staff that facility is willing to host: 120

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

Date of agreement/contract/verification: 01/01/2021

Date agreement/contract ends: Renews Annually

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

Year 2021 Hurricane Evacuation Plan Effective Date 1/1/2021

To:

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

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

	Evacuation Site Address:
1	129 Calhoun Street Independence, LA 70443

Sincerely,

Bob G Dean
Man. Member

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

Year 2021 Hurricane Evacuation Plan

Evacuation Site Address	Bed Availability
1. 129 Calhoun Street Independence, LA 70443	700 Beds

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

Facility	Address	Phone	Bed Availability
Maison Deville Nursing Home, Inc.	107 S Hollywood Rd Houma, LA 70360	985-876-3250	80 Beds
St. Elizabeth's Caring, LLC	1020 Manhattan Blvd. Harvey, LA 70058	504-362-9522	20 Beds
Maison Deville Nursing Home of Harvey	2233 8th Street Harvey, LA 70058	504-362-9522	20 Beds
South Lafourche Nursing and Rehab	4302 Highway 1 Raceland, LA 70394	985-693-1065	20 Beds
Maison Orleans Healthcare of New Orleans	1420 General Taylor Street New Orleans, LA 70115	504-895-7755	20 Beds
River Palms Nursing Home	5301 Tullis Dr. New Orleans, LA 70131	504-394-5807	20 Beds
Park Place Nursing & Rehab	535 Commerce St. Gretna, LA 70053	504-393-9595	50 Beds

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

Sincerely,

Bob G. Dean
Man. Member

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)?
Maison De'Ville of Houma

ii. What is the physical address of each **alternate/secondary** host site(s)?
107 S. Hollywood Blvd
Houma, LA
70360

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

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

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

vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: William Daigre
Phone: 985-876-3250
Email: wdaigre@devillehouma.com
Fax: 985-873-0046

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

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

ix. If alternate/secondary host site is not a licensed nursing home provide a description of host site(s) including;
- What type of facility it is?
  Nursing Home/LTC
- What is host site currently being used for?
  Nursing Home/LTC

2021 Nursing Home Emergency Preparedness Plan Survey

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

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

xi. Is there a specified time or timeline (H-Hour) that **alternate/secondary** host site will need to be notified by?
☒Yes. If yes what is that time? 24 hrs
☐No.

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

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

MAISON DE'VILLE of HOUMA

Nursing Home & Rehabilitation

107 South Hollywood Rd
Houma, LA 70360

(985) 876-3250 main
(985) 873-0046 fax

January 1, 2021

RE: Emergency Evacuation for 2021

Maison Deville of Harvey

Maison Orleans Healthcare

West Jefferson Health Care Center

River Palms Nursing and Rehab

South Lafourche Nursing and Rehab

Park Place Nursing and Rehab

To Whom It May Concern:

Masion Deville Nursing Home of Houma is at your disposal for use of any and all evacuation procedures. Space within the facility will be made available to you, your residents and staff in case of emergency. We will coordinate our open beds with the ESF-8 Portals.

Sincerely,

William Daigre

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):

Nichols Limousine and Shuttle Services

Contact Person: Mike Nichols

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

Physical Address of transportation provider:

4302 Williams Blvd
Kenner, LA 70065

Time Lines or Restrictions: H-Hour or the number of hours needed.

What is the latest time that transportation resource can be contacted according to agreement?

24 hrs

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

2 hrs

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

3 hrs

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

Bus

Total number of transport vehicles to be provided: 2

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

380

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: March 1, 2021

Date agreement/ contract ends: Renews Annually

TRANSPORTATION AGREEMENT
FOR
LA HEALTH CARE CONSULTANTS, LLC

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

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

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

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

NAME: West Jefferson Health Care
1020 Manhattan Blvd.
Harvey, LA 70058
(504) 363-0165

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

NAME: Park Place Rehab &Nursing
535 Commerce Street
Gretna, LA 70056
(504) 393-9595

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

PURPOSE

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

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

MISCELLANEOUS

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

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

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

This agreement shall commence on March 1, 2021, and end on February 28, 2022, unless extended by mutual written agreement by the parties hereto.

Signed this 2nd day of February, 2021.

Nicoll's Limousine and Shuttle Service

By: _____
Mike Nicoll

LA Health Care Consultants, LLC (LHCC)

By: _____

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):

Lafourche Ambulance #1

Contact Person: Brady Daigle

Phone # of Contact Person: (985) 632-7192

Physical Address of transportation provider:

17078 W Main St
Cut Off, LA
70345

Time Lines or Restrictions: H-Hour or the number of hours needed.

What is the latest time that transportation resource can be contacted according to agreement?

48 hrs

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

20 mins

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

20 mins

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

Ambulance

Total number of transport vehicles to be provided: 4

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

Stretcher

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: 2/24/2021

Date agreement/ contract ends: Renews Annually

LaFourche Ambulance District #1

"Quality Emergency Medical Care"
(985) 632-7192

February 24, 2021

South Lafourche Nursing and Rehabilitation

146 E28th St.

Cut Off, LA 70345

To Whom it may concern:

This letter is in response to a request for verification from South Lafourche Nursing and Rehabilitation. Please allow this letter as confirmation that there is an agreement in place between Lafourche Ambulance District #1 and South Lafourche Nursing and Rehabilitation for evacuation of Bed Bound patients/residents from their facility in cases of disaster. The agreement between the two facility auto renews annually, unless otherwise terminated by either facility. To this date (2/24/2021) there has been no record of cancellation from either facility.

Sincerely,

Brady Daigle

Operations Manager

Lafourche Ambulance District #1

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: Pharmacy

Name of Supplier:

Peoples Pharmacy

Contact Person: Susan Brunet
Phone # of Contact Person: 985-873-8526
FAX#: 985-873-8541
E-Mail Address: jacesjaces@bellsouth.net

Indicate where the supplies are to be delivered to;

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

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

How long will it take to receive the delivery?

2 hrs

Date of agreement/contract/verification: 2/2/2021

Date agreement/contract ends: Renews Annually

Peoples DRUG STORE, INC.

Emergency Medications Agreement

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

South Lafourche Nursing

148 East 28th Street

Cutoff, LA 70345

Date: 2-2-2021

Peoples Drug Store

7869 Main Street

Houma, LA 70360

Date: 2/2/2021

Peoples DRUG STORE.INC.

Pharmacy Service Agreement

This agreement is entered into South Lafourche Nursing and Rehab between Peoples Drug Store, referred to as Pharmacy and South Lafourche Nursing and Rehab hereinafter referred to as referred to as the "FACILITY").

Whereas the facility desires to employ the services of a pharmacy, and whereas the Pharmacy is desirous of offering pharmacy services, it is therefore mutually agreed that the facility does employ the pharmacy and he agrees to provide pharmacy services to all residents without regard to race, color, national origin, age, gender, religion, or disability under the following terms and conditions:

Pharmacy responsibilities:

Supervise the overall functions of the facility's pharmaceutical services in that the pharmacist shall:

1. Assume the administrative authority, responsibility, and accountability of implementing our pharmaceutical services, policies, and procedures.
2. Supervise the procedures for the control and accountability for all drugs and biologicals throughout the facility.
3. Assure that drugs and biologicals are approved and dispensed in compliance with federal and state laws as well as our policies and procedures.
4. Supervise the records of receipt and distribution of all controlled substances and the maintenance of such records in sufficient detail to allow for an accurate reconciliation.
5. Maintain monthly reviews of the drug regimen of each resident. Report any irregularities to the director of nursing, charge nurse, and the resident's attending physician. If no corrective action is taken, report such incidents to the medical director and administrator.
6. Supervise the labeling of all drugs and biologicals to insure that labeling is based on currently accepted professional principals and practices and includes the appropriate accessory and cautionary instructions as well as the expiration date when applicable.
7. Assist in the development and implementation of our written pharmaceutical policies and procedures.
8. Develop and participate in in-service education and training programs for nursing service and other related services.
9. Devote such time, energy, and skill necessary to maintain high quality pharmaceutical services.

10. Provide written, dated, and signed reports of each consultation visit to the administrator. Such reports shall contain at least the consultants:

    a. Findings

    b. Recommendations

    c. Plans for implementation; and

    d. Plans for continued assessments.

    e. The pharmacy will provide the facility with a consultant to provide these reports.

11. Provide written reports, at least quarterly, to the Administrator and Director of Nursing on the status of the facility's pharmaceutical service and performance.

12. Provide continuous services to the facility during the term of this agreement and, in accordance therewith, to provide services of another licensed pharmacist during an absence, vacation, period of illness, or limited period when the consultant is not available.

13. Obtain and maintain during the term of this agreement a suitable professional liability and malpractice insurance policy.

14. Serve the facility as an independent contractor. Our facility has full control over the acts of all our employees and agencies supplying or administering drugs within the facility, and in accordance herewith, the pharmacy shall not be responsible to the facility for any losses or liabilities sustained as a result of their independent malfeasance or negligence.

15. Maintain the confidentiality of resident information as established by our facility's policies and procedures.

16. Stay abreast of all other responsibilities required of a consultant as set forth in any federal or state laws, statutes, or regulations as enacted or may be enacted or amended.

17. Follow the duties and responsibilities as outlined in the pharmacy's position description and our established policies and procedures.

Qualifications:

The pharmacy/pharmacist certifies that he/she is:

A. Is licensed to practice pharmacy in the State of Louisiana.

B. Has at least a Bachelor of Science degree from a college of pharmacy accredited by the American Council of Pharmaceutical Education.

C. Meets the requirements as set forth by current state, federal, and local laws, guidelines and regulations governing pharmaceutical services in a long term care facility.

D. Meets the qualifications standards in our pharmacy's position description.

E. Maintains the required continuing education hours (annually) relative to the practice of a pharmacist to assure continued competence.

Duration of this Agreement

This agreement is for five years and shall automatically renew automatically for the same and requires a majority of all residents.

Time Commitment

The pharmacy/pharmacist agrees that he/she shall devote sufficient number of hours, based upon the needs of the facility, to carry out the responsibilities outlined in this agreement, as well as our established policies and procedures.

The Facility shall be responsible for:

1. Retaining the professional and administrative responsibility for all services provided by the pharmacy.
2. Making prompt payment for all services rendered.
3. Assuring that the pharmacy has complete access to all records and supplies within the facility necessary for the performance of his/her duties.
4. Returning any equipment or supplies that the pharmacy may have loaned the facility upon termination of this agreement or upon the pharmacy's request.

5. Delegating the necessary administrative authority, responsibility, and accountability necessary for the pharmacy to perform his/her services.

In witness thereof, the parties have duly set their hands and seals the day and year first above written.

2/11/2021

Susan Brunet, Pharmacy Owner

Peoples Drug Store

Bob Duet, Administrator

Raceland Manor Nursing Home Inc, d/b/a South Lafourche Nursing & Rehab, Inc.

2021 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

Type of Supply: Diesel/Fuel

Name of Supplier:

Gaubert Oil

Contact Person: Louis A. Leblanc
Phone # of Contact Person: 985-4447-3811
FAX#: 985-873-8541
E-Mail Address: Louis@gaubertoil.com

Indicate where the supplies are to be delivered to;

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

Time Lines or Restrictions: H-Hour or the number of hours needed.
What is the latest time that supplier can be contacted according to agreement?
3-5 days prior to threat

How long will it take to receive the delivery?

48 hrs

Date of agreement/contract/verification: 02/19/2021

Date agreement/contract ends: Renews Annually

GAUBERT OIL COMPANY, INC. • 10 RIENZI DRIVE • THIBODAUX, LOUISIANA 70301
PHONE: 800-256-1250 • fax: 985-447-1614

February 19, 2021

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

Dear Lizza,

This letter is a follow-up as to how Gaubert Oil Co., Inc can be of assistance in your emergency Preparedness Planning at Raceland Manor South Lafourche Nursing Home and Rehab Inc. Gaubert Oil Co.,Inc will provide diesel fuel at market valaue of that time. Although Gaubert Oil Co., Inc has multiple supply points to work from and large storage tanks, we also have many obstacles in emergency situations, such as downed refineries, employee evacuations and fuel allocations. It is strongly advised that you top off your tanks three to five days prior to any threatening emergency.

If you have any questions, please contact me at 985.447.3811.

Sincerely,

Louis A. LeBlanc

2021 Nursing Home Emergency Preparedness Plan Survey

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Type of Supply: Food, Water, Linen

Name of Supplier:

Reinhart/DBA Reyes

Contact Person: Adrienne Huffman
Phone # of Contact Person: 225-715-8227
FAX#: 504-734-5270
E-Mail Address: jacesjaces@bellsouth.net

Indicate where the supplies are to be delivered to;

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

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

How long will it take to receive the delivery?

72 hrs

Date of agreement/contract/verification: 2/16/2021

Date agreement/contract ends: Renews Annually

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.

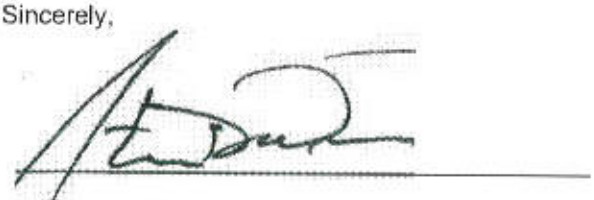
If your facility is involved in a disaster or emergency, Performance Foodservice may supply the following items upon request and depending upon availability:

- 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

2021 Nursing Home Emergency Preparedness Plan Survey

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Type of Supply: Water

Name of Supplier:

Rouses Supermarket #18

Contact Person: Bradley Gaudet
Phone # of Contact Person: 985-693-4858
FAX#: n/a
E-Mail Address: n/a

Indicate where the supplies are to be delivered to;

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

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

How long will it take to receive the delivery?

Upon contact

Date of agreement/contract/verification: 01/01/2021

Date agreement/contract ends: Renews Annually

Rouses Supermarkets #18

13980 West Main Street

Lu. ose, La 70373

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

Bradley Gaudet

Store Director

Rouses #18

985-693-4858

2021 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

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

Type of Supply: Linen

Name of Supplier:

West Port Linen

Contact Person: Eddie Lafeaux
Phone # of Contact Person: 225-268-3393
FAX#: 225-218-8885
E-Mail Address: elefeaux@westpointlinen.et

Indicate where the supplies are to be delivered to;

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

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

How long will it take to receive the delivery?

24 hrs

Date of agreement/contract/verification: 02/10/2021

Date agreement/contract ends: Renews Annually

WESTPORT LINEN SERVICES

EMERGENCY LINEN ADDENDUM

(Effective February 10, 2021 – February 28, 2024)

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

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

Legal Entity	DBA	Street Address	City	Zip Code	Phone
Park Place Healthcare LLC		535 Commerce St	Gretna	70056-7316	
River Palms Nursing & Rehab		5301 Tullis	New Orleans	70131	504-394-5607
Raceland Manor Nursing Home	South Lafourche Nursing & Rehab	146 East 28th St	Cut Off	70345	985-693-1050
Maison Deville Nursing Home, Inc		107 S. Hollywood Rd.	Houma	70360	985-876-3250
Maison Deville Nursing Home of Harvey, LLC		2233 8th St	Harvey	70058	504-362-9522
St. Elizabeth's Caring, LLC	West Jefferson Healthcare Center	1020 Manhattan Blvd	Harvey	70058	504-362-2020
Uptown Healthcare Center LLC	Maison Orleans Healthcare of New Orleans	1420 General Taylor St	New Orleans	70115	504-895-7755

If activated the Evacuation site addresses are as follows:

24320 Ferdinand St
Plaquemine LA 70769

129 Calhoun St
Independence, LA 70764

Prices are $.60 per pound received by Westport.
If transported by a Westport Delivery truck, delivery fee is $1.55 per mile driven.
If Westport carts are used during the service, carts will be rented at $5.00 per day.
carts are to be returned to Westport, if not carts will be billed at $350 each.

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

Signature

Westport Linen Services, LLC.

Eddie R. Lefeaux, CEO

February 10, 2021

Angie Courville
Signature

Plaza Holdings LLC.

CFO
Title

02/24/2021
Date

Renewal 2022:

Signature Date	Signature Date
Title	Title

Renewal 2023:

Signature Date	Signature Date
Title	Title

Renewal 2024:

Signature Date	Signature Date
Title	Title

Renewal 2025:

Signature Date	Signature Date
Title	Title

2021 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

South Lafourche Nursing and Rehab

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

Date: 2/25/2021

Facility Administrator Name (PRINT): **Bob J. Duet**

Facility Administrator Signature: 

Comments: