

*Maison De'ville of Harvey*

NURSING HOME & REHABILITATION

*A tradition of carina*

2233 8<sup>th</sup> street  
Harvey, LA 70058

(504) 362-9522 phone  
(504) 368-4118 fax

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March 1, 2019

Jefferson Parish -- Louisiana  
Emergency Management  
EMS Compliance Division

Re: 2019 Emergency Plans

Dear Ms. Ward,

Please accept a copy of our updated changes for our Emergency Plan for 2019.

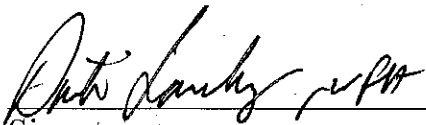
Sincerely,

**RECEIVED**  
MAR 06 2019

Dante' Landry, LNFA  
Administrator of Maison Deville of Harvey

**HEALTH STANDARDS**

Jefferson Parish – Louisiana – Emergency Management – EMS Compliance Division have received an official copy of the updated changes to the Emergency Plan for 2019 from Maison Deville of Harvey Nursing Home.

  
Signature

2/26/19  
Date

*"Family Owned and Operated"*

# 2019 Nursing Home Emergency Preparedness Plan Survey

For Year: 2019

Facility Name (Print):

Maison Deville Nursing Home of Harvey

Name of Administrator (Print):

Dante' Landry, LNFA

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

Phone #: 504-362-9522

Cell Phone #: 225-288-4936

Administrator E-Mail: dlandry@devilleharvey.com

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

Name: Donette Pinkney, RN

Position: DON

Phone #: 504-362-9522

Cell Phone #: \_\_\_\_\_

E-Mail: don@devilleharvey.com

Physical or Geographic address of Facility (Print):

2233 8th Street

Harvey, La 70058

Longitude: -90.07414

Latitude: 29.90449

**RECEIVED**  
**MAR 06 2019**

**HEALTH STANDARDS**

# 2019 Nursing Home Emergency Preparedness Plan Survey

VERIFICATION of OHSEP SUBMITTAL for Year: 2019

Nursing Facility's Name: Maison Deville Nursing Home of Harvey

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

Jefferson Parish Department of Emergency Management

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

Date submitted: 03/01/2019

**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.

# 2019 Nursing Home Emergency Preparedness Plan Survey

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

A. Are the facility's goals, in regards to emergency planning, documented in plan?

YES

➤ NO, if goals are NOT in plan add the facility's goals and indicate completion by marking YES.

B. Does the facility's plan enable the achievement of those goals?

YES

➤ NO, if plan does NOT provide for the achievement of goals, correct the plan and indicate completion by marking YES.

C. Determinations, **by the facility**, for sheltering in place or evacuation due to Hurricanes.

1. Utilizing all current, available, and relevant information answer the following:

a) MARK the **strongest** category of hurricane the facility can safely shelter in place for?

i.  Category 1- winds 74 to 95 mph

ii.  Category 2- winds 96 to 110 mph

iii.  Category 3- winds 111 to 130 mph

iv.  Category 4- winds 131 to 155 mph

v.  Category 5- winds 156 mph and greater

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

i. 72 Hours before the arrival of the hurricane.

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

i. 60 Hours before the arrival of the hurricane.

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

TITLE/POSITION: owner

NAME: Bob G. Dean Jr.

2. Utilizing all current, available, and relevant information answer the following:

a) MARK the **weakest** category of hurricane the facility will have to evacuate for?

i.  Category 1- winds 74 to 95 mph

ii.  Category 2- winds 96 to 110 mph

iii.  Category 3- winds 111 to 130 mph

iv.  Category 4- winds 131 to 155 mph

v.  Category 5- winds 156 mph and greater

b) At what time, **in hours** before the hurricanes arrival, will the decision to evacuate have to be made by facility?

i. 72 Hours before the arrival of the hurricane.

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

i. 60 Hours before the arrival of the hurricane.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

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

TITLE/POSITION: owner

NAME: Bob G. Dean Jr.

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

A. Facility Description:

1. What year was the facility built? 1966

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.

Isu survey

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. Slosh Model included

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 -1.3 feet above sea level.

b) Air conditioner (HVAC) is .79 feet above sea level.

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- c) Generator(s) is .79 naved 88 feet above sea level.
- d) Lowest electrical service box(s) is .79 naved 88 feet above sea level.
- e) Fuel storage tank(s), if applicable, is \_\_\_\_\_ feet above sea level.
- f) Private water well, if applicable, is N/A feet above sea level.
- g) Private sewer system and motor, if applicable, is N/A feet above sea level.

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

- Yes. Use SLOSH to answer A.5.a. and b.  
➤ If No. Obtain SLOSH, incorporate into planning, and then indicate that this has been done by marking yes.

- a) Is the building or any of its essential systems susceptible to flooding from storm surge as predicted by the SLOSH model?
- i.  Yes- answer A.5.b
- ii.  No, go to A. 6.
- b) If yes, what is the **weakest** SLOSH predicted category of hurricane that will cause flooding?
- i.  Category 1- winds 74 to 95 mph
- ii.  Category 2- winds 96 to 110 mph
- iii.  Category 3- winds 111 to 130 mph
- iv.  Category 4- winds 131 to 155 mph
- v.  Category 5- winds 156 mph and greater

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

- a)  **B and X** – Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. B Zones are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile. **Moderate to Low Risk Area**
- b)  **C and X** – Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level. Zone C may have ponding and local drainage problems that don't warrant a detailed study or designation as base floodplain. Zone X is the area determined to be outside the 500-year flood and protected by levee from 100-year flood. **Moderate to Low Risk Area**
- c)  **A** – Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones. **High Risk Area**
- d)  **AE** – The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30 Zones. **High Risk Area**
- e)  **A1-30** – These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format). **High Risk Area**
- f)  **AH** – Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of

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

- g)  **AO** – River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones. **High Risk Area**
- h)  **AR** – Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations. **High Risk Area**
- i)  **A99** – Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones. **High Risk Area**
- j)  **V** – Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones. **High Risk – Coastal Areas**
- k)  **VE, V1 – 30** – Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones. **High Risk – Coastal Areas**
- l)  **D** – Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk. **Undetermined Risk Area**

7. What is the area's Base Flood Elevation (BFE) if given in flood mapping?

- ❖ See the **A** zones. Note: **AE** zones are now used on new format FIRMs instead of A1-A30 Zones. The BFE is a computed elevation to which floodwater is anticipated to rise. Base Flood Elevations (BFEs) are shown on Flood Insurance Rate Maps (FIRMs) and flood profiles.
- ❖ The facility's Base Flood Elevation(BFE) is: 3 feet above HEAG

8. Does the facility flood during or after heavy rains?

- a)  Yes
- b)  No

9. Does the facility flood when the water levels rise in nearby lakes, ponds, rivers, streams, bayous, canals, drains, or similar?

- a)  Yes
- b)  No

10. Is facility protected from flooding by a levee or flood control or mitigation system (levee, canal, pump, etc)?

- a)  Yes
- b)  No

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11. Have the areas of the building that are to be used for safe zones/sheltering been identified?
- Yes
  - 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?
- Yes
  - 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?
- Yes
  - No. Evaluate and identify areas then indicate that this has been done by answering Yes.
14. Emergency Generator - **generator information should match MSTAT!**
- Is the generator(s) intended to be used to shelter in place during hurricanes (extended duration)?
    - Yes. The generator(s) will be used for Sheltering in place for Hurricanes.
    - No. The generator(s) will **NOT** be used for Sheltering In Place for Hurricanes.
  - What is the **wattage(s)** of the generator(s)? Give answer in **kilowatts (kW)**.  
 1st; 20kw                                      2nd generator; \_\_\_\_\_                                      3rd generator; \_\_\_\_\_
  - Mark which primary **fuel** each generator(s) uses?
 

i. <input type="checkbox"/> natural gas;	2nd generator; <input type="checkbox"/> natural gas;	3rd generator; <input type="checkbox"/> natural gas
ii. <input checked="" type="checkbox"/> propane;	2nd generator; <input type="checkbox"/> propane;	3rd generator; <input type="checkbox"/> propane
iii. <input type="checkbox"/> gasoline;	2nd generator; <input type="checkbox"/> gasoline;	3rd generator; <input type="checkbox"/> gasoline
iv. <input type="checkbox"/> diesel;	2nd generator; <input type="checkbox"/> diesel;	3rd generator; <input type="checkbox"/> diesel
  - How many **total hours** would generator(s) run on the fuel supply always on hand? (enter NG if Natural Gas)  
 1st 72 Hours    2nd \_\_\_\_\_ Hours    3rd \_\_\_\_\_ Hours
  - If generator will be used for sheltering in place for a hurricane (extended duration), are there provisions for a seven day supply of fuel?
    - Not applicable. The facility will not use the generator for sheltering in place during hurricanes.
    - Yes. Facility has a seven day supply on hand at all times or natural gas.
    - Yes. Facility has signed current contract/agreement for getting a seven day fuel supply before hurricane.
    - 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.
  - Will life sustaining devices, that are dependent on electricity, be supplied by these generator(s) during outages?
    - Yes
    - No

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- g) Does generator provide for air conditioning?
- i.  Yes. Mark closest percentage of the building that is cooled?
    - 100 % of the building cooled
    - 76% or more of the building is cooled
    - 51 to 75% of the building is cooled
    - 26 to 50% of the building is cooled
    - Less than 25% of the building is cooled
  - No. The generator does not provide for any air conditioning.
  - ii. If air conditioning fails, for any reason, does the facility have procedures (specific actions) in place to prevent heat related medical conditions?
    - Yes
    - No
- h) Does facility have in the plan, a current list of what equipment is supplied by each generator?  
 Yes  
If No - Evaluate, identify then indicate that this has been done by answering Yes.

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

- a) Who supplies electricity to the facility?
- i. Suppliers name: Entergy
  - ii. Account #: 23089857
- b) Who supplies water to the facility? (supplier's name)
- i. Suppliers name: Jefferson Parish Water Board
  - ii. Account #: 305739 & 305740
- c) Who supplies fuels (natural gas, propane, gasoline, diesel, etc) to the facility? If applicable.
- i. Suppliers name: Atmos
  - ii. Account #: 25-000789848-0285348-5
- d) Does plan contain the emergency contact information for the utility providers? (Contact names, 24 hour emergency phone numbers)?
- i.  Yes
  - ii. No. Please obtain contact information for your utility providers.

### 16. Floor Plans

- a) Does plan have current legible floor plans of the facility?
- i.  Yes
  - ii. No. Please obtain, then indicate that this has been done by answering Yes
- b) Indicate if the following locations are marked, indicated or described on floor plan:
- i. Safe areas for sheltering:  Yes. If No- Please identify on floor plan and mark Yes.
  - ii. Storage areas for supplies:  Yes. If No- indicate on floor plan and mark Yes.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

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

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

#### 1. Residents information

- a) What is the facility's total number of state licensed beds?

Total Licensed Beds: 100

- 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: 23

- 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: 32

- 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: 45

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

- i. Each resident's current and active diagnosis?

Yes. If No - Obtain and mark Yes.

- ii. Each resident's current list of medications including dosages and times?

Yes. If No - Obtain and mark Yes.

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- iii. Each resident's allergies, if any?  
 Yes. If No - Obtain and mark Yes.
- iv. Each resident's current dietary needs or restrictions?  
 Yes. If No - Obtain and mark Yes.
- v. Each resident's next of kin or responsible party and their contact information?  
 Yes. If No - Obtain and mark Yes.
- vi. Each resident's current transportation requirements? (advanced life support ambulance, basic ambulance, wheel chair accessible vehicle, car-van-bus)  
 Yes. If No - Obtain and mark Yes.

### 2. Staff

- a) Is each of the following provided in the list(s) or roster(s) of all current staff that is kept in or used with the facility emergency preparedness plan: **do not send in this list or roster.**
  - i. Emergency contact information for all current staff?  
 Yes. If No - Obtain and mark Yes.
  - ii. Acknowledgement of if they will work during emergency events like hurricanes or not?  
 Yes. If No - Obtain and mark Yes.
- b) What is **total number** of planned **staff** and other **non residents** that will require facility transportation for an evacuation or need to be sheltered?  
20

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

- a) Does facility have transportation, or have current or currently verified contracts or agreements for emergency evacuation transportation?  
 Yes. If No - Obtain transportation and mark Yes.
  - i. Is the capacity of planned emergency transportation adequate for the transport of all residents, planned staff and supplies to the evacuation host site(s)?  
 Yes. If No - Obtain adequate transport and mark Yes.
  - ii. Is all transportation air conditioned?  
 Yes, go to B. 3. a) iv.  
 No, go to B. 3. a) iii.
  - iii. If not air conditioned are there provisions (specific actions and supplies) in plan to prevent and treat heat related medical conditions?  
 Yes. If No - make plans (specific actions and supplies) and mark Yes.
  - iv. Is there a specified time or timeline (H-Hour) that transportation supplier will need to be notified by?  
 Yes. What is that time \_\_\_\_\_ hours?  
 No. There is no need for a specified time or timeline for contacting transportation.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- b) Does each contract or agreement for NON-AMBULANCE- transportation contain the following information? **NOTE: Vehicles that are not owned by but at the disposal of the facility shall have written usage agreements (with all required information) that are signed and dated. Vehicles that are owned by the facility will need to verify ownership.**
- i. The complete name of the transportation provider?  
 Yes. If No - obtain and mark Yes.
  - ii. The number of vehicles and type (van, bus, car) of vehicles contracted for?  
 Yes. If No - obtain and mark Yes.
  - iii. The capacity (number of people) of each vehicle?  
 Yes. If No - obtain and mark yes.
  - iv. Statement of if each vehicle is air conditioned?  
 Yes. If No - obtain and mark Yes.
  - v. Verification of facility ownership, if applicable; copy of vehicle's title or registration?  
 Yes. If No - obtain and mark Yes.
- c) Have copies of each **signed and dated contract/agreement** been included for submitting?  
 Yes. If no, obtain and mark Yes.
- d) Has a cover page been completed and attached for each contract/agreement. *(blank form provided)*  
 Yes. If No - complete and mark Yes.
4. Host Site(s)-*extra pages for multiple sites have been included with forms near end of survey. (should match what is in MSTAT!)*
- a) Does the facility have current contracts or verified agreements for a primary evacuation host site(s) outside of the primary area of risk?  
 Yes. If No - obtain and mark Yes.
  - b) Provide the following information:(list all sites, if multiple sites **list each** - see extra pages )
    - i. What is the name of each primary site(s)?  
 plaquemine plaza holding LLC
    - ii. What is the physical address of each host site(s)?  
 129 Calhoun Street  
 Independence lan 70443
    - iii. What is the distance to each host site(s)?  
 74 miles
    - iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?  
 \_\_\_\_\_
    - v. Does plan include map of route to be taken and written directions to host site?  
 Yes. If No - obtain and mark Yes.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- vi. Who is the contact person at each **primary** host site(s)?  
 Name: Angie Courville  
 Phone: 225-343-9152  
 Email: anglec@deancompanies.com  
 Fax: 225-612-6603
- vii. What is the capacity (number of residents allowed) of each **primary** host site(s)?  
 ➤ Capacity that will be allowed at each site: 500  
 ➤ Total Capacity of all primary sites: 500  
 ➤ 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?  
old manufacturing warehouse  
 ➤ What is host site currently being used for?  
Shelter for Nursing Home  
 ➤ Is the square footage of the space to be used adequate for the residents?  
 Yes  
 No  
 ➤ What is the age of the host facility(s)?  
N/A  
 ➤ Is host facility(s) air conditioned?  
 Yes  
 No  
 ➤ What is the current physical condition of facility?  
 Good  
 Fair  
 Poor  
 ➤ Are there adequate provisions for food preparation and service?  
 Yes  
 No  
 ➤ Are there adequate provisions for bathing and toilet accommodations?  
 Yes  
 No  
 ➤ Are any other facilities contracted to use this site?  
 Yes  
 No
- x. Is the capacity of primary host site(s) adequate for staff?  
 Yes  
 No. If No - where will staff be housed?

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- xi. Is there a specified time or timeline (H-Hour) that **primary** host site will need to be notified by?  
 Yes. If Yes - what is that time? \_\_\_\_\_  
 No.
- c) Does the facility have current contracts or verified agreements for an **alternate or secondary** host site(s)?  
 Yes. If No - obtain and mark Yes.
- d) Provide the following information:(list all sites, if multiple sites **list each** - see extra pages )
- i. What is the name of each **alternate/secondary** site(s)?  
West Jesfferson Healthcare
  - ii. What is the physical address of each **alternate/secondary** host site(s)?  
1020 Manhattan Blvd  
Harvey, La 70058
  - iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?  
1.1 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: Tamara White, LNFA  
 Phone: 504-362-2020  
 Email: twhite@westjeffcaring.com  
 Fax: 504-367-9674
  - 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:  
100
    - Total Capacity of all **alternate/secondary** sites:  
100
    - Is this adequate for all evacuating residents?  
 Yes. If No - obtain and mark Yes.
  - viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?  
 Yes, go to - B.4.d) x.  
 No, go to - B.4.d) ix.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- 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 Facility type incl here

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  - What is host site currently being used for?  
 Nursing Facility

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  - 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? \_\_\_\_\_  
 No.
- e) Have copies of each **signed and dated contract/agreement** been included for submitting?  
 Yes. If No - obtain and mark Yes.
- f) Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)  
 Yes. If No - complete and mark Yes.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

5. **Non-perishable food or nourishment** – for sheltering in place or for host site(s)
- a) For Sheltering In Place, does facility have – **on site** - a seven day supply of non-perishable food/nourishment that meets all resident's needs?
- Yes. If yes go to - B. 5. c)  
 No. If no go to - B. 5. b)
- b) Provide the following if no onsite supply:
- i. Does facility have a current or currently verified contract to have a seven day supply of non-perishable food that meets all resident's needs delivered prior to a foreseeable emergency event?
- Yes, go to - B. 5.b). ii, iii, iv  
If No - obtain supply or contract then mark appropriate answer.
- ii. Does each contract contain all of the following?
- name of supplier?
  - specified time or timeline (H-Hour) that supplier will need to be notified
  - contact information of supplier
- Yes. If No - obtain information then mark Yes.
- iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
- Yes. If No - obtain and mark Yes.
- iv. Has a cover page been completed and attached for each contract/agreement.  
*(blank form provided)*
- Yes. If No - complete and mark Yes.
- c) For evacuations, does facility have provisions for **food/nourishment supplies at host site(s)**?
- Yes. If No - make necessary arrangements then mark Yes.
- d) Is there a means to prepare and serve food/nourishment at host site(s)?
- Yes. If No - make necessary arrangements then mark Yes.
6. **Drinking Water or fluids** – for sheltering in place – one gallon per day per resident.
- a) Does facility have – **on site** - a seven day supply of **drinking water or fluids** for all resident's needs?
- Yes. Go to B. 6. c)  
 No. If No See B. 6.b)
- b) If no, provide the following:
- i. Does facility have a current contract for a seven day supply of drinking water or fluids to be delivered prior to a foreseeable emergency event?
- Yes, see B. 6.b). ii, iii, iv,  
If No - please obtain supply or contract.

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- ii. Does each contract for **Drinking Water or fluids** contain all of the following?
- name of supplier?
  - specified time or timeline (H-Hour) that supplier will need to be notified
  - contact information of supplier
- Yes. If No - obtain information then mark Yes.
- iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
- Yes. If no - obtain and mark Yes
- iv. Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)
- Yes. If no - complete and mark Yes
- c) Does facility have a supply of water for needs other than drinking?
- Yes
- If No - make necessary provisions for water for non drinking needs then mark Yes.
- d) **For evacuations**, does host site(s) have an adequate supply of water for all needs?
- Yes
- If No - make necessary provisions for water for non drinking needs then mark Yes
7. **Medications**- for sheltering in place or for host site(s)
- a) Does facility have – **on site** - a seven day supply of **medications for all resident's needs**?
- Yes. go to - B. 7. c)
- No. go to - B. 7.b) i,ii,iii,iv
- b) If no, provide the following:
- i. Does facility have a current or currently verified contract to have a seven day supply of **medications** delivered prior to a foreseeable emergency event?
- Yes, see B. 7.b). ii, iii, iv
- If No - please obtain supply or contract then mark Yes.
- ii. Does contract for **medications** contain the following?
- Name of supplier?
  - Specified time or timeline (H-Hour) that supplier will need to be notified
  - Contact information of supplier
- Yes. If No - obtain information then mark Yes.
- iii. Have copies of each **signed and dated contract/agreement** been included for submitting?
- Yes. If no - obtain and mark Yes.
- iv. Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)
- Yes. If no - complete and mark Yes.

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## 2019 Nursing Home Emergency Preparedness Plan Survey

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, cellphone emergency alerts, television, email or text from Region 1 Coordinator

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

Yes. Name equipment: Emergency Crank Radio

No

iii. Is the equipment tested?

Yes

No

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- 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?  
Cellphone \_\_\_\_\_
- ii. Is there back up or alternate equipment used to send/receive and what is it?  
 Yes. Name equipment: \_\_\_\_\_  
 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.

## 2019 Nursing Home Emergency Preparedness Plan Survey

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

A. Plans for **sheltering in place**

1. Does facility have written viable plans for sheltering in place during emergencies?

Yes

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

a) Does the plan for sheltering in place take into account all known limitations of the facility to withstand flooding and wind? (This includes if limits were undetermined as well)

Yes

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

b) Does the plan for sheltering in place take into account all requirements (if any) by the local Office of Homeland Security and Emergency Preparedness?

Yes

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

2. Does facility have written viable plans for adequate staffing when sheltering in place?

Yes

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

3. Does facility have written viable plans for sufficient supplies to be on site prior to an emergency event which will enable it to be totally self-sufficient for seven days? (potable and non-potable water, food, fuel, medications, medical, personal hygiene, sanitary, repair, etc)

Yes

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

4. Does facility have communication plans for sheltering in place?

Yes

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

a) Does facility have written viable plans for contacting staff pre event?

Yes

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

b) Does facility have written viable plans for notifying resident's responsible party before emergency event?

Yes

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

c) Does facility have written viable plans for monitoring emergency alerts and broadcasts before, during, and after event?

Yes

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

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- 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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## 2019 Nursing Home Emergency Preparedness Plan Survey

2. Does facility have written viable plans for adequate transportation for the return of all residents to the facility?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- a) Does facility have written viable plans for staffing to load residents and supplies at the shelter site for the return to facility?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- b) Does facility have written viable plans for staffing to ensure that all residents have access to licensed nursing staff and appropriate nursing services provided during the return to facility?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- c) Does facility have written viable plans for staffing for the unloading of residents and supplies after return to facility?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
3. Does facility have written viable plans for the management of staff, including provisions for adequate qualified staffing and the distribution and assignment of responsibilities and functions at the evacuation host site(s)?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
4. Does facility have written viable plans to have sufficient supplies – to be totally self sufficient - at or delivered to the evacuation host site(s) prior to or to coincide with arrival of residents? (potable and non-potable water, food, fuel, medications, medical goods, personal hygiene, sanitary, clothes, bedding, linens, etc)  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
5. Does facility have written viable plans for communication during evacuation?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- a) Does facility have written viable plans for contacting host site prior to evacuation?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- b) Does facility have written viable plans for contacting staff before an emergency event?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes

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## 2019 Nursing Home Emergency Preparedness Plan Survey

- 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

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## 2019 Nursing Home Emergency Preparedness Plan Survey

2. Does plan include providing the following information to Health Standards Section of the Department of Health and Hospitals?
- a) Is it a full facility evacuation, partial facility evacuation or shelter in place?
  - b) The date(s) and approximate time(s) of full or partial evacuation?
  - c) The names and locations of all host site(s)?
  - d) The emergency contact information for the person in charge of evacuated residents at each host site(s)?
  - e) The names of all residents being evacuated and the location each resident is going to?
  - f) A plan to notify Health Standards Section within 48 hours of any deviations or changes from original notification?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
3. Does facility have written viable plans for receiving and sending emergency information during emergencies?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
4. Does facility have written viable plans for monitoring emergency alerts and broadcasts at all times?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
5. Does facility have written viable plans for notifying authorities of decision to shelter in place or evacuate?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
6. Does facility have written viable plans for notifying authorities and responsible parties of the locations of all residents and any changes of those locations?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- E. Does facility have written viable plans for entering all required information into the Health Standards Section's (HSS) emergency preparedness webpage?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes
- F. Does facility have written viable plans for triaging residents according to their transportation needs?  
 Yes  
If No - Planning is needed for compliance. Complete then mark Yes

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## 2019 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: Bob G. Dean Jr.  
Position: owner  
Emergency contact information:  
Phone: 225-343-9152  
Email: 1@deancompanies.com  
Fax: 225-343-9152

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

Provide Name: Dante' Landry, LNFA  
Position: Administrator  
Emergency contact information:  
Phone: 504-362-9522  
Email: dlandry@devilleharvey.com  
Fax: 504-263-5099

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

Provide Name: Dante' Landry, LNFA  
Position: Administrator  
Emergency contact information:  
Phone: 504-362-9522  
Email: dlandry@devilleharvey.com  
Fax: 504-263-5099

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

Provide Name: Donette Pinkney, RN  
Position: DON  
Emergency contact information:  
Phone: 504-362-2020  
Email: don@devilleharvey.com  
Fax: 504-263-5099

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

Provide Name: Dante' Landry, LNFA  
Position: Administrator  
Emergency contact information:  
Phone: 504-362-9522  
Email: dlandry@devilleharvey.com  
Fax: 504-263-5099

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## 2019 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:  

---

    - 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:  

---
  
  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?  

---

    - 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?  

---

## 2019 Nursing Home Emergency Preparedness Plan Survey

### V. Administration & Logistics

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

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

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

### VI. Plan Development and Maintenance

- A. Has the plan been developed in cooperation with the local Office of Homeland Security and Emergency Preparedness?
- Yes  
 No
- B. If not, was there an attempt by facility to work with the local Office of Homeland Security and Emergency Preparedness?
- Yes  
 No
- C. During the review of the facility's emergency preparedness plan were the following steps taken?
1. Were all out dated or non essential information and material removed?  
 Yes  
No - Complete this step then mark Yes
  2. Were all contracts or agreements updated, renewed or verified?  
 Yes  
No - Complete this step then mark Yes
  3. Was all emergency contact information for suppliers, services, and resources updated?  
 Yes  
No - Complete this step then mark Yes
  4. Was all missing information obtained added to plan and the planning revised to reflect new information?  
 Yes  
No - Complete this step then mark Yes

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Revised for 2019

## 2019 Nursing Home Emergency Preparedness Plan Survey

5. Were all updates, amendments, modifications or changes to the nursing facility's emergency preparedness plan submitted to the Health Standards Section along with this survey?

Yes

No - Complete this step then mark Yes

### VII. Authentication

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

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

# Emergency Operations Plan

## Transportation Agreement Cover Sheet

Name of transportation resource provider:

**Nicolls Limousine and Shuttle Service**

Contact Person:

**Mike Nicoll**

Physical Address or location of transportation provider:

**4305 Williams Blvd., Kenner, LA 70065**

Time Restrictions:

**72 Hours**

Type and quantity of transportation:

**4 - Buses**

Number and type of passengers accommodated:

**25**

Date of Agreement: **3/1/2019**

Date Agreement Ends: **2/29/2020**

*"Family Owned and Operated"*

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

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

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

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

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

NAME: Raceland Manor  
4302 Highway 1  
Raceland, LA 70394  
(985) 537-3569

NAME: Uptown Healthcare Center  
1420 General Taylor Street  
New Orleans, LA 70115  
(504) 895-7755

NAME: Plaquemine Manor  
59355 River West Drive  
Plaquemine, LA 70764  
(225) 387-1345

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.

MISCELLANEOUS

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

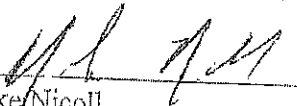
As space is available, provider will transport, on the buses, mattresses, wheelchairs, medical supplies, etc. as needed.

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, 2019, and end on February 29, 2020, unless extended by mutual written agreement by the parties hereto.

Signed this 5<sup>th</sup> day of February, 2019.

Nicoll's Limousine and Shuttle Service

By:   
Mike Nicoll

LA Health Care Consultants, LLC (LHCC)

By: 

# 2019 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):**

Contact Person: Kevin Spansel

Phone # of Contact Person: 800-259-3333

Physical Address of transportation provider:

1065 Robert Blvd.  
Slidell, La 70458

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

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

48 hours

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

as soon as possible

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

30 minutes

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

ambulance

Total number of transport vehicles to be provided: up to 3

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

Is the transportation air conditioned?  YES  NO

**IF transportation is facility owned attach verification of ownership.**

Date of agreement/contract/verification: 1/14/19

Date agreement/ contract ends: 1/14/20



# Emergency Operations Plan

## Transportation Agreement Cover Sheet

Name of transportation resource provider:

**ACADIAN AMBULANCE**

Contact Person:

**Kevin Spansel**

Physical Address or location of transportation provider:

**1065 Robert Blvd., Slidell, LA 70458**

Time Restrictions:

**48 Hours**

Type and quantity of transportation:

**Ambulances – As many as needed**

Number and type of passengers accommodated:

**Up to 3**

Date of Agreement: **1/14/2019**

Date Agreement Ends: **1/14/2020**

*"Family Owned and Operated"*

**Acadian**  
**AMBULANCE SERVICE**  
of NEW ORLEANS, L.L.C.

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

AMBULANCE  
DISPATCH  
511  
800-259-1111

ADMINISTRATION  
337-291-3333  
800-259-3333

BILLING  
800-259-2222

January 1, 2019


Maison DeVille Nursing Home of Harvey  
c/o Administrator  
2233 Eight Street  
Harvey, LA 70058

Re: Evacuation Agreement

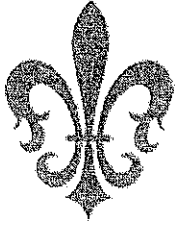
To whom it may concern:

In response to a request for verification from Maison DeVille Nursing Home of Harvey (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.

Sincerely,



Kevin C. Spansel  
Community Relations Supervisor  
Acadian Ambulance Service, Inc.



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

**Year 2019 Hurricane Evacuation Plan**  
**Effective Date: 1/1/2019**

To:

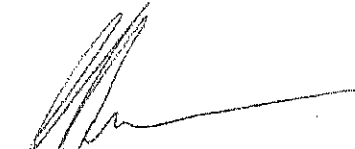
- MAISON DEVILLE NURSING HOME OF HARVEY, LLC
- MAISON DEVILLE NURSING HOME, INC.
- PLAQUEMINE MANOR NURSING HOME, INC. D/B/A IBERVILLE OAKS NURSING & REHAB, INC.
- RACELAND MANOR NURSING HOME, INC. D/B/A SOUTH LAFOURCHE NURSING & REHAB, INC.
- UPTOWN HEALTHCARE CENTER, LLC D/B/A MAISON ORLEANS HEALTHCARE OF NEW ORLEANS, LLC
- ST. ELIZABETH'S CARING, LLC D/B/A West Jefferson Health Care Center LLC

The letter serves as confirmation of our arrangement that in the event of an emergency evacuation. Depending on the acuity of your residents, we have three different sites in which we will deploy services and residents through fiscal year 2019. Evacuation sites are below:

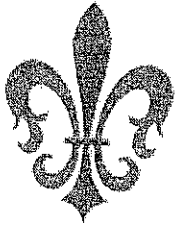
	<u>Evacuation Site Address:</u>
1	24320 Ferdinand Street, Plaquemine, LA70769
2	129 Calhoun Street Independence, LA 70443
3	59355 Riverwest Dr. Plaquemine, LA 70764

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

Sincerely,



Bob G Dean  
Man. Member



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

Year 2019 Hurricane Evacuation Plan

TO: PLAQUEMINE MANOR NURSING HOME, INC. D/B/A IBERVILLE OAKS NURSING & REHAB, INC.

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

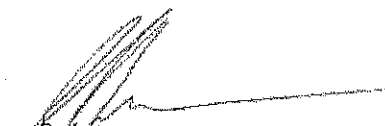
	Evacuation Site Address:	Bed Availability
1	24320 Ferdinand Street, Plaquemine, LA 70769	120 beds
2	129 Calhoun Street Independence, LA 70443	120 beds

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

Facility	Address				Phone	Bed Availability
MAISON DE'VILLE NURSING HOME, INC.	107 S HOLLYWOOD RD	HOUMA	LA	70360	985-876-3250	20 Beds
ST. ELIZABETH'S CARING, LLC	1020 MANHATTAN BLVD	HARVEY	LA	70058	504-362-2020	20 Beds
MAISON DE'VILLE NURSING HOME OF HARVEY, LLC	2233 8TH ST	HARVEY	LA	70058	504-362-9522	20 Beds
SOUTH LAFOURCHE NURSING & REHAB, INC.	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

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

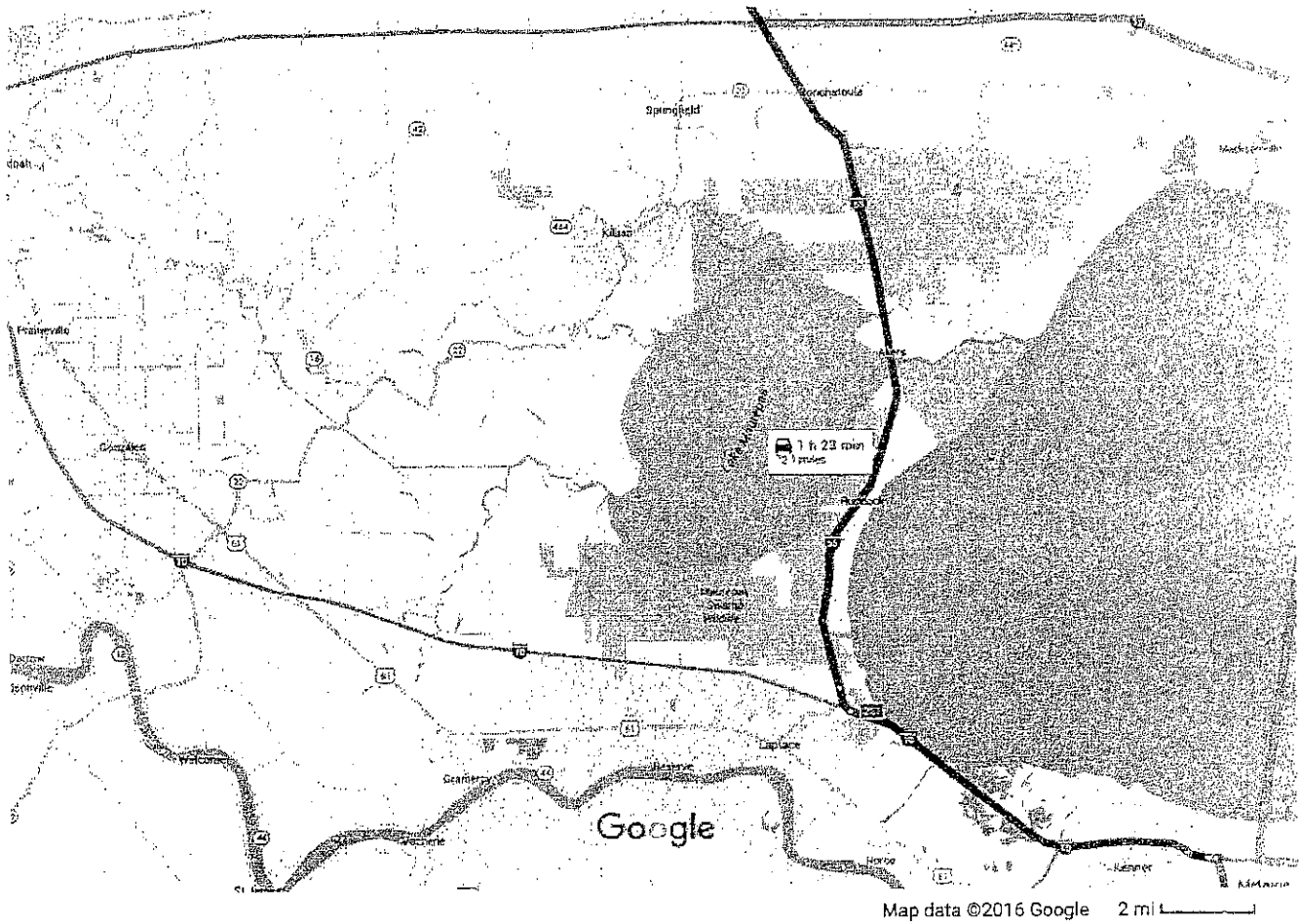
Sincerely,

  
 Bob G. Dean  
 Man. Member

Google Maps

2233 8th Street, Harvey, LA to 129 Calhoun St, Independence, LA 70443

Drive 72.1 miles, 1 h 23 min



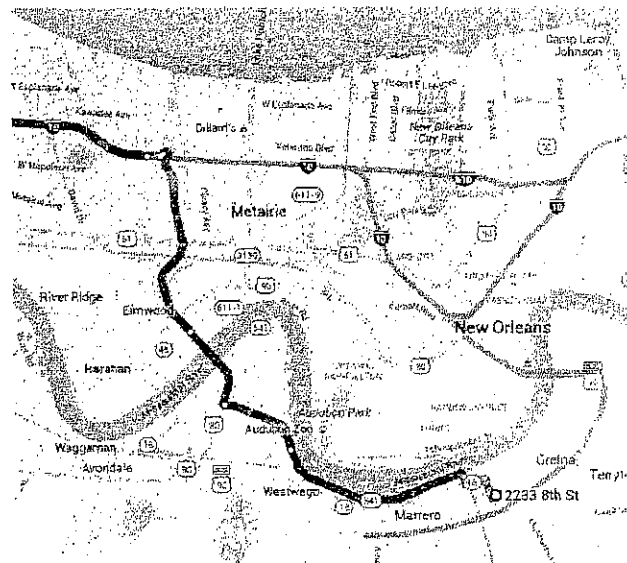
2233 8th St  
Harvey, LA 70058

Get on I-10 W in Metairie from River Rd, Seven Oaks Blvd, Huey P Long Bridge and S Clearview Pkwy

26 min (13.0 mi)

- ↑ 1. Head west on 8th St toward Marion St
- ↘ 2. Turn right onto Brown Ave
- ↙ 3. Turn left onto 4th St
- ↘ 4. Turn right onto Destrehan Ave

427 ft  
0.4 mi  
0.4 mi  
0.2 mi



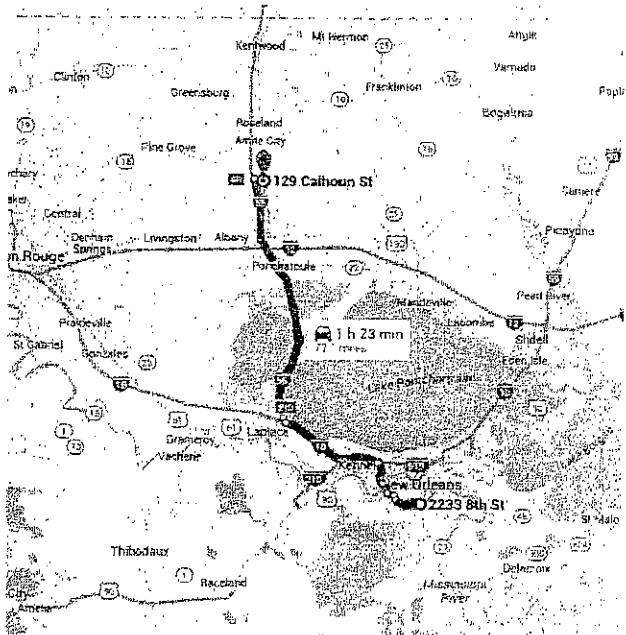
- ↑ 5. Continue onto River Rd  
4.0 mi
- ↗ 6. Slight right to stay on River Rd  
0.5 mi
- ↑ 7. Continue onto Seven Oaks Blvd  
1.3 mi
- ↗ 8. Slight right to merge onto Huey P Long Bridge  
1.7 mi
- ↖ 9. Keep left to continue on S Clearview Pkwy  
3.9 mi
- ↗ 10. Use the right lane to take the I-10 W ramp to Baton Rouge  
0.4 mi
- ↖ 11. Keep left at the fork and merge onto I-10 W  
0.3 mi



Follow I-10 W and I-55 N to LA-40 E in 3. Take exit 40 from I-55 N

49 min (57.5 mi)

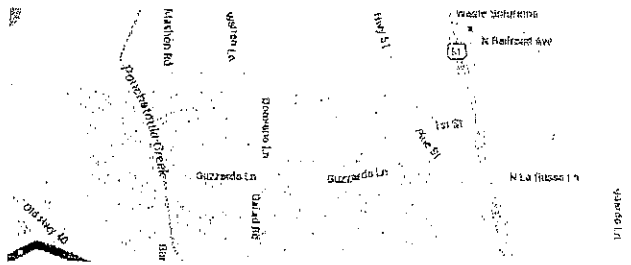
- ↗ 12. Merge onto I-10 W  
16.4 mi
- ↗ 13. Use the right 2 lanes to take exit 210 for Interstate 55 N toward Hammond  
1.1 mi
- ↑ 14. Continue onto I-55 N  
39.8 mi
- ↗ 15. Take exit 40 for LA-40 toward Independence  
0.2 mi



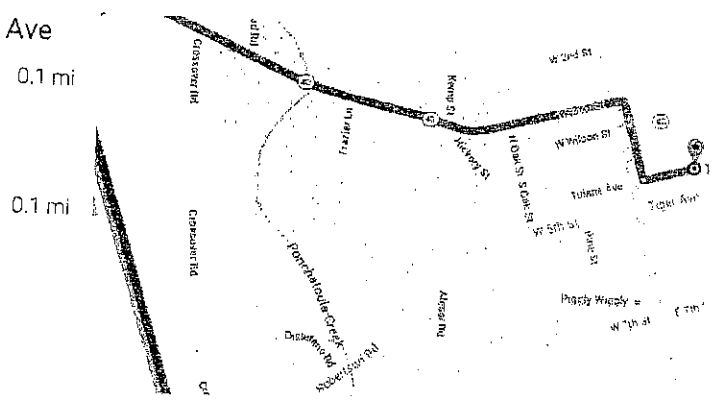
Continue on LA-40 E. Drive to Calhoun St in Independence

5 min (1.7 mi)

- ↗ 16. Slight right onto LA-40 E (signs for Independence)  
1.4 mi



- ↑ 17. Continue straight onto E Railroad Ave
- ↶ 18. Turn left onto Calhoun St  
📍 Destination will be on the left



129 Calhoun St  
Independence, LA 70443

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your route.

Google Maps





# South Lafourche Nursing and Rehab

146 East 28th St  
Cutoff, LA 70364

(985) 693-1045 main  
(985) 693-1011 fax

February 7th, 2019

RE: Emergency Evacuation for 2019

Iberville Oaks Nursing and Rehab  
South Lafourche Nursing and Rehab

Maison DeVile of Harvey  
Maison DeVile of Houma  
West Jefferson Healthcare  
Maison Orleans

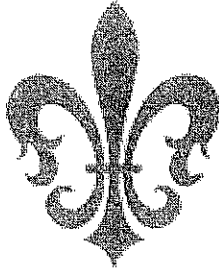
To whom it may Concern:

South Lafourche Nursing and Rehab located at 146 East 28th St Cutoff, LA 70364 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.

Please access the following contact information as needed: Facility phone number: (985) 693-1045  
24 hour emergency number(s) Bob Duet (985) 856-8005.

Sincerely,

*Bob J. Duet*  
Bob J. Duet, NFA



*Maison De'ville of Harvey*

NURSING HOME & REHABILITATION

*A tradition of carina*

2233 8<sup>th</sup> street  
Harvey, LA 70058

(504) 362-9522 phone  
(504) 368-4118 fax

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**Date: February 18 , 2019**

**To: Raceland Manor  
Plaquemine Manor  
Maison Deville of Houma  
West Jefferson Healthcare Center  
UPTOWN CARE CENTER**

**From: Dante' Landry, Administrator**

**RE: Emergency Evacuation Procedures**

Maison Deville of Harvey is at your disposal for use during any evacuation event. Space within this facility will be made available to your residents and staff in case of an emergency. Contact phone number (504) 362-9522, Fax (504) 263-5099.

Sincerely,

Dante' Landry, NFA  
Administrator

*"Family Owned and Operated"*

# West Jefferson Healthcare Center

*"A Tradition of Caring"*



1020 Manhattan Blvd  
Harvey LA 70058  
Phone 504-362-2020  
Fax: (504) 362-9620

February 4, 2019

Maison De'Ville of Harvey  
Maison De'Ville of Houma  
Maison Orleans  
Iberville Oaks  
South Lafourche Nursing & Rehab

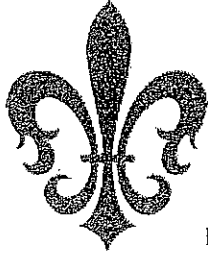
In the event of an emergency, West Jefferson Healthcare Center, located at 1020 Manhattan Blvd., Harvey, LA, 70058, will work to accommodate your evacuation needs. The ESF-8 Portal will be updated to reflect census and open beds.

Feel free to utilize the following contact information as needed:  
Facility: (504)362-2020  
E-Fax: (504)336-2147  
24 hour After Hours Contact: (504) 237-4854

Thanks.

A handwritten signature in cursive script, appearing to read "Tamara White". The signature is fluid and elegant, with a large initial "T" and a long, sweeping underline.

Tamara White, LNFA, MBA, RN  
Administrator



*Maison Orleans Healthcare*

NURSING HOME & REHABILITATION

1420 GENERAL TAYLOR STREET  
NEW ORLEANS, LA 70115

*A tradition of caring*

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

February 20, 2019

Re: Emergency Evacuation for 2019

Iberville Oaks Nursing and Rehab  
South Lafourche Nursing and Rehab  
Maison DeVile of Harvey  
Maison DeVile of Houma  
West Jefferson Healthcare

To Whom It May Concern:

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

Please access the following contact information as needed: Facility phone number: (504) 895-7755 24 hour emergency number(s) Lindsay Dukes (504) 421-0145.

Sincerely,

*Lindsay Dukes, LNFA*  
Lindsay Dukes, LNFA

*"Family Owned and Operated"*

**IBERVILLE OAKS NURSING & REHAB**

59355 River West Drive

Plaquemine, LA 70764

225-385-4332

February 26, 2019

**RE: Emergency Evacuation for 2019**

*Iberville Oaks Nursing & Rehab*

*South Lafourche Nursing & Rehab*

*Maison Deville of Harvey*

*Maison Deville of Houma*

*West Jefferson Healthcare*

*Maison Orleans*

**To Whom It May Concern:**

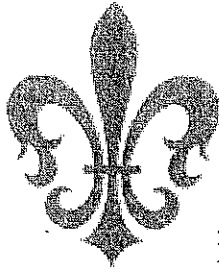
*Iberville Oaks Nursing & Rehab located at 59355 River West Drive, Plaquemine, LA 70764 is at your disposal for use of any and all evacuation procedures. Space within the facility will be made available to you, your residents, and staff in case of an emergency. We will coordinate our open beds with the ESF-8 Portals.*

*Please access the following contact information as needed. Facility phone number is: 225-385-4332 and 24 hour emergency number (s) Gwen Masters 225-603-1558.*

*Sincerely,*

*Gwen Masters*

*Gwen Masters, LNFA*



Maison De'ville of Harvey

NURSING HOME & REHABILITATION

A tradition of carina

2233 8th street  
Harvey, LA 70058

(504) 362-9522 phone  
(504) 368-4118 fax

Emergency Plans – 2019

SUPPLIER AGREEMENT

Reinhart Foodservice

Contact Person: Shannon Hayes

Phone # of Contact Person: 225-288-1279

Email address: sphayes@RFSDelivers.com

Indicate where the supplies are to be delivered to:

- Evacuation Host Site
- Nursing Home's Licensed Facility
- Determined upon decision of sheltering or evacuating

Time lines or Restrictions: H – Hour or the number of hours needed

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

72 Hours

How long will it take to receive the delivery?

24 Hours

Date of agreement/contract/verification: January 11, 2019

Date agreement/contract ends: January 11, 2020

Signature: \_\_\_\_\_

"Family Owned and Operated"



---

Reinhart Foodservice  
918 Edwards Ave  
New Orleans, LA 70123

January 11, 2019

Maison DeVille  
2233 8<sup>th</sup> Street  
Harvey, La. 70058

Valued Customer:

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

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

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

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

- Emergency seven-day food supply with a 72-hour notice (we reserve the right to Make alternative product substitutions).

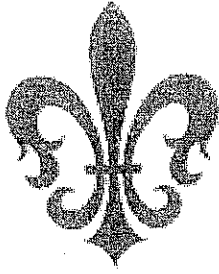
Refer to your state's Department of Health and Human Services guidelines for food and water supply for emergencies. Reinhart will provide to you, upon request, a Disaster Planning Kit which gives information on recommended perishable and non-perishable food and water to keep on hand in case an emergency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

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

Thank you.  
Sincerely,

A handwritten signature in black ink, appearing to read "Steve Wood", is written over a horizontal line.

Area President-SHR/NOR  
Steve Wood



**Maison De'ville of Harvey**  
NURSING HOME & REHABILITATION

*A tradition of carina*

2233 8<sup>th</sup> street  
Harvey, LA 70058

(504) 362-9522 phone  
(504) 368-4118 fax

Emergency Plans – 2019

**SUPPLIER AGREEMENT**

\_\_\_\_\_ People's Drug Store

Contact Person: \_\_\_\_\_ Susan Brunet

Phone # of Contact Person: \_\_\_\_\_ 985-381-2995

Email 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 the supplier can be contacted according to the agreement?

\_\_\_\_\_ 72 Hours

How long will it take to receive the delivery?

\_\_\_\_\_ 8 Hours

Date of agreement/contract/verification: \_\_\_\_\_ January 10, 2018

Date agreement/contract ends: \_\_\_\_\_ January 10, 2020

Signature: \_\_\_\_\_

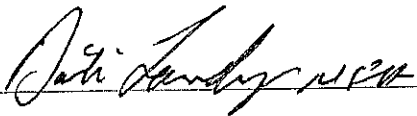
*"Family Owned and Operated"*




Peoples DRUG STORE, INC.

Emergency Medications Agreement

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

  
\_\_\_\_\_

Maison deVille of Harvey  
2233 Eighth Street  
Harvey, LA 70058  
Date 1/15/19

  
\_\_\_\_\_

Peoples Drug Store  
7869 Main Street  
Houma, LA 70360  
Date 01/15/19

# Peoples Drug Store

Phone 985-873-8003

Fax 985-873-8541

Our driver leaves at 4:30PM. If you know you are getting an admission, please let us know and we can detain her to include your delivery.

## After hours phone numbers

\*\*\* For any refill or new order that can wait until the next morning, call the pharmacy number and leave a detailed message on the answering machine. Please let us know if you need the medication before our regular delivery.

## For medication emergencies, call:

Jarrold Cell 985-438-0055

Ronnie Cell 985-860-1316

Susan cell 985-381-2995

## Store Hours

Mon-Thurs 8:00 AM to 6:30 PM

Fri 8:00 to 6:00 PM

Sat 8:00 to 5:00 PM

Sunday Closed

# 2019 Nursing Home Emergency Preparedness Plan Survey

## EVACUATION HOST SITE COVER SHEET

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

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

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

Name of EVACUATION HOST SITE:

PLAQUEMINE PLAZA HOLDING

Contact Person: BOB DEAN JR.

Phone # of Contact Person: 225-343-9152

FAX#: 225-612-6603

E-Mail Address: 1@deancompanies.com

Physical Address of evacuation site:

129 CATHON STREET

INDEPENDENCE, LA 70443

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

What is the latest time that evacuation host site can be contacted according to agreement?

N/A

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

74 miles

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

1 hour

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: 500

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

Date of agreement/contract/verification: 1/14/19

Date agreement/contract ends: 2/14/20

# 2019 Nursing Home Emergency Preparedness Plan Survey

## AUTHENTICATION

Facility Name (Print):

129 Calhoun Street

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: 2/1/19

Facility Administrator Name (PRINT): DAVE LINDSEY, N/A

Facility Administrator Signature: *Dave Lindsey*

Comments: