

2019 Nursing Home Emergency Preparedness Plan Survey

For Year: 2019

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

Facility Name (Print):

Maison Orleans

Name of Administrator (Print):

Lindsay Dukes

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

Phone #: 504-895-7755

Cell Phone #: 504-421-0145

Administrator E-Mail: LDukes@maisonorleansnola.com

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

Name: LaToya King

Position: Assistant Administrators

Phone #: 504-895-7755

Cell Phone #: 469-216-1071

E-Mail: lking@maisonorleansnola.com

Physical or Geographic address of Facility (Print):

1420 General Taylor Street

New Orleans, LA 70115

Longitude: 90.096115

Latitude: 29.925609

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MAR 04 2019
HEALTH STANDARDS

2019 Nursing Home Emergency Preparedness Plan Survey

VERIFICATION of OHSEP SUBMITTAL for Year: 2019

Nursing Facility's Name: Maison Orleans

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**.

City Of New Orleans Office Of Emergency Preparedness

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

Date submitted: FEB 28, 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 hurricane's arrival, which preparations will need to start in order to safely shelter in place?

i. 168 Hours before the arrival of the hurricane.

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

TITLE/POSITION: Owner

NAME: Bob Dean 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 hurricane's 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. 168 Hours before the arrival of the hurricane.

2019 Nursing Home Emergency Preparedness Plan Survey

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

TITLE/POSITION: Owner

NAME: Bob 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? 1970

2. How many floors does facility have? 6

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. The wind speed rating isn't available due to the age of the building

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 15 feet above sea level.

b) Air conditioner (HVAC) is 6 feet above sea level.

2019 Nursing Home Emergency Preparedness Plan Survey

- c) Generator(s) is 4 feet above sea level.
- d) Lowest electrical service box(s) is 4 feet above sea level.
- e) Fuel storage tank(s), if applicable, is 4 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

2019 Nursing Home Emergency Preparedness Plan Survey

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: 5.2

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

2019 Nursing Home Emergency Preparedness Plan Survey

11. Have the areas of the building that are to be used for safe zones/sheltering been identified?
 a) Yes
 b) No. Identify these areas then indicate that this has been completed by marking Yes.
12. Have the facility's internal and external environments been evaluated to identify potential chemical or biological hazards?
 a) Yes
 b) No. Evaluate and identify areas then indicate that this has been done by marking Yes.
13. Has the facility's external environment been evaluated to identify potential hazards that may fall or be blown onto or into the facility?
 a) Yes
 b) No. Evaluate and identify areas then indicate that this has been done by answering Yes.
14. Emergency Generator - **generator information should match MSTAT!**
- a) Is the generator(s) intended to be used to shelter in place during hurricanes (extended duration)?
 i. Yes. The generator(s) will be used for Sheltering in place for Hurricanes.
 ii. No. The generator(s) will **NOT** be used for Sheltering In Place for Hurricanes.
- b) What is the **wattage(s)** of the generator(s)? Give answer in **kilowatts (kW)**.
 1st; 150 2nd generator; _____ 3rd generator; _____
- c) Mark which primary **fuel** each generator(s) uses?
 i. natural gas; 2nd generator; natural gas; 3rd generator; natural gas
 ii. propane; 2nd generator; propane; 3rd generator; propane
 iii. gasoline; 2nd generator; gasoline; 3rd generator; gasoline
 iv. diesel; 2nd generator; diesel; 3rd generator; diesel
- d) How many **total hours** would generator(s) run on the fuel supply **always on hand**? (enter NG if Natural Gas)
 1st 300 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

2019 Nursing Home Emergency Preparedness Plan Survey

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 #: 111469458

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

i. Suppliers name: Sewerage & Water Board of New Orleans

ii. Account #: 152193-04-5 & 167761-03-0933

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

i. Suppliers name: WES-PET INC.

ii. Account #: Cash on Delivery

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.

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: 200

- 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: 8

- 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: _____

- 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: 110

- 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: 57

- 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.

2019 Nursing Home Emergency Preparedness Plan Survey

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

2. Staff

- a) Is each of the following provided in the list(s) or roster(s) of all current staff that is kept in or used with the facility emergency preparedness plan: **do not send in this list or roster.**
 - i. Emergency contact information for all current staff?
 Yes. If No - Obtain and mark Yes.
 - ii. Acknowledgement of if they will work during emergency events like hurricanes or not?
 Yes. If No - Obtain and mark Yes.
- b) What is **total number** of planned **staff** and other **non residents** that will require facility transportation for an evacuation or need to be sheltered?
35+

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

- a) Does facility have transportation, or have current or currently verified contracts or agreements for emergency evacuation transportation?
 Yes. If No - Obtain transportation and mark Yes.
 - i. Is the capacity of planned emergency transportation adequate for the transport of all residents, planned staff and supplies to the evacuation host site(s)?
 Yes. If No - Obtain adequate transport and mark Yes.
 - ii. Is all transportation air conditioned?
 Yes. go to B. 3. a) iv.
 No, go to B. 3. a) iii.
 - iii. If not air conditioned are there provisions (specific actions and supplies) in plan to prevent and treat heat related medical conditions?
 Yes. If No - make plans (specific actions and supplies) and mark Yes.
 - iv. Is there a specified time or timeline (H-Hour) that transportation supplier will need to be notified by?
 Yes. What is that time 24 hours?
 No. There is no need for a specified time or timeline for contacting transportation.

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 Holdings, LLC
 - ii. What is the physical address of each host site(s)?
24320 Ferdinand Street
Plaquemine LA.
70769
 - iii. What is the distance to each host site(s)?
88.0
 - iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
NO

2019 Nursing Home Emergency Preparedness Plan Survey

- v. Does plan include map of route to be taken and written directions to host site?
 Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at **each primary** host site(s)?
Name: Angie Courville
Phone: 225-343-9152
Email: ACourville@DeanCompanies.com
Fax: 225-343-9154
- vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
➤ Capacity that will be allowed at each site:
120
➤ Total Capacity of all primary sites:
➤ _____
➤ Is this adequate for all evacuating residents?
 Yes. If No - obtain and mark Yes.
- viii. Is the **primary** site a currently licensed nursing home(s)?
 Yes, go to- B.4.b) x.
 No, go to- B.4.b) ix.
- ix. If **primary** host site is **not a licensed nursing home** provide a description of host site(s) including;
➤ What type of facility it is?
Formerly an acute care hospital
➤ What is host site currently being used for?
Evacuations
➤ 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)?
Approximately 27 years old
➤ 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

2019 Nursing Home Emergency Preparedness Plan Survey

- 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 HOURS
 - No.
-

2019 Nursing Home Emergency Preparedness Plan Survey

- 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 Hours
 No.
- c) Does the facility have current contracts or verified agreements for an **alternate or secondary** host site(s)?
 Yes. If No - obtain and mark Yes.
- d) Provide the following information:(list all sites, if multiple sites list each - see extra pages)
- i. What is the name of each **alternate/secondary** site(s)?
Maison De'Ville of Harvey
- ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th Street
Harvey, LA
70058
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
7.8 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: Cheryl Carter
Phone: 504-362-9522
Email: CCarter@Devilleharvey.com
Fax: 504-263-5099
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
- Capacity that will be allowed at each **alternate/secondary** site:
20
 - Total Capacity of all **alternate/secondary** sites:
20
 - Is this adequate for all evacuating residents?
 Yes. If No - obtain and mark Yes.

2019 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 HOURS
 No.
- g) Have copies of each **signed and dated contract/agreement** been included for submitting?
 Yes. If No - obtain and mark Yes.
- h) Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)
 Yes. If No - complete and mark Yes.

2019 Nursing Home Emergency Preparedness Plan Survey

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

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.

2019 Nursing Home Emergency Preparedness Plan Survey

- 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.

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? Televisions, Computers, Cell phones

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

Yes. Name equipment: Solar Powered/Hand Crank

No

iii. Is the equipment tested?

Yes

No

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?
Battery and Solar Powered Radios, TV's, Computers, and Cell Phones
- ii. Is there back up or alternate equipment used to send/receive and what is it?
 Yes. Name equipment: Solar Powered Radio and Cell 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.

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

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

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

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

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

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

2019 Nursing Home Emergency Preparedness Plan Survey

- f) A plan to notify Health Standards Section within 48 hours of any deviations or changes from original notification?

Yes

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

3. Does facility have written viable plans for receiving and sending emergency information during emergencies?

Yes

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

4. Does facility have written viable plans for monitoring emergency alerts and broadcasts at all times?

Yes

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

5. Does facility have written viable plans for notifying authorities of decision to shelter in place or evacuate?

Yes

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

6. Does facility have written viable plans for notifying authorities and responsible parties of the locations of all residents and any changes of those locations?

Yes

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

-
- E. Does facility have written viable plans for entering all required information into the Health Standards Section's (HSS) emergency preparedness webpage?

Yes

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

- F. Does facility have written viable plans for triaging residents according to their transportation needs?

Yes

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

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

- A. Who is responsible for the **decision to shelter in place or evacuate**?

Provide Name: Bob Dean Jr.

Position: Owner

Emergency contact information:

Phone: 225-343-9152

Email: 1@BobDeanCompanies.com

Fax: 225-343-9154

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

Provide Name: Lindsay Dukes

Position: Administrator

2019 Nursing Home Emergency Preparedness Plan Survey

Emergency contact information:

Phone: 504-421-0145

Email: LDukes@maisonorleansnola.com

Fax: 504-355-4876

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

Provide Name: Lindsay Dukes

Position: Administrator

Emergency contact information:

Phone: 504-421-0145

Email: LDukes@maisonorleansnola.com

Fax: 504-355-4876

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

Provide Name: LaToya King

Position: Assistant Administrator

Emergency contact information:

Phone: 469-216-1071

Email: Lking@maisonorleansnola.com

Fax: 504-355-4876

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

Provide Name: Lindsay Dukes

Position: Administrator

Emergency contact information:

Phone: 504-421-0145

Email: LDukes@maisonorleansnola.com

Fax: 504-355-4876

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 Workers

- If facility is going to shelter in place or evacuate.
- The date and approximate time that the facility is evacuating.
- The name, address, and all contact information of the evacuation site.
- An emergency telephone number for responsible party to call for information.

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

Administrator/Assistant 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?

D.O.N, A.D.O.N, or MDS Coordinator

- Resident's identification.

2019 Nursing Home Emergency Preparedness Plan Survey

- 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?
Administrator, Assistant Administrators, or D.O.N
- 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 or D.O.N

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

2019 Nursing Home Emergency Preparedness Plan Survey

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.

2019 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

Maison Orleans Healthcare

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: 0228-19

Facility Administrator Name (PRINT): Jandson Dukes, CNF A

Facility Administrator Signature: Amanda Duke, CNFA

Comments:

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):

NICOLL'S LIMOSINE AND SHUTTLE SERVICE

Contact Person: MIKE NICOLL

Phone # of Contact Person: 504-522-5656

Physical Address of transportation provider:

840 POYDRAS STREET
NEW ORLEANS, LA
70112

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?

72 HOURS

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

1-2 HOURS

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

2-3 HOURS

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

BUSES

Total number of transport vehicles to be provided: 5

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

SEATED-25

Is the transportation air conditioned? YES NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: march 1, 2019

Date agreement/ contract ends: Feb 29, 2020

**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 5th 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):

ACADIAN AMBULANCE

Contact Person: KEVIN SPANSEL

Phone # of Contact Person: 504-451-2610

Physical Address of transportation provider:

5670 HAYNES BLVD
NEW ORLEANS, LA
70126

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?

72 HOURS

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

1-2 HOURS

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

2-3 HOURS

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

VAN AND AMBULANCE

Total number of transport vehicles to be provided: 25 VANS AND 25 AMBULANCE

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

A VAN CAN ACCOMMODATE 2 WHEELCHAIRS. AMBULANCE ACCOMODATES 1 STRETCHER

Is the transportation air conditioned? YES NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: January 14, 2019

Date agreement/ contract ends: Ongoing

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 14, 2019

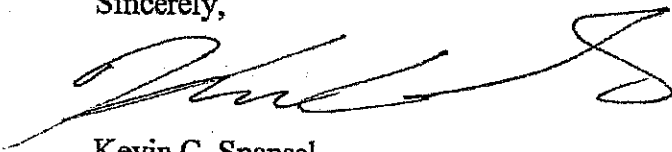
Uptown Healthcare DBA Maison Orleans
C/O Administrator
1420 General Taylor
New Orleans, LA 70115

Re: Evacuation Agreement

Dear: Administrator,

In response to a request for verification from Facility (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.

2019 Nursing Home Emergency Preparedness Plan Survey

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

- I. Provide the following information:(list **primary** sites in this area, if multiple sites list **each**)
 - i. What is the name of each **primary** site(s)?
PLAQUEMINE PLAZA HOLDINGS,LLC
 - ii. What is the physical address of each host site(s)?
129 CALHOUN STREET
INDEPENDENCE LA, 70443

 - iii. What is the distance to each host site(s)?
69.9 miles
 - iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
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 primary** host site(s)?
Name: ANGIE COURVILLE
Phone: 225-343-9152
Email: ACOURVILLE@DEANCOMPANIES.COM
Fax: 225-3439154

- vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
 - Capacity that will be allowed at each site:
120
 - Is this adequate for all evacuating residents?
Yes. If No - obtain and mark Yes.
- viii. Is the **primary** site a currently licensed nursing home(s)?
Yes, go to- B.4.b) x.
No, go to- B.4.b) ix.
- ix. If **primary** host site is **not a licensed nursing home** provide a description of host site(s) including;
 - What type of facility it is?
FORMELY AN ACUTE CARE CENTER
 - What is host site currently being used for?
EVACUATIONS
 - 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)?
APPROX. 27 YEARS OLD
 - Is host facility(s) air conditioned?
Yes



**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:

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

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

<u>Facility</u>	<u>Address</u>				<u>Phone</u>	<u>Bed Availability</u>
MAISON DE'VILLE NURSING HOME, INC.	107 S HOLLYWOOD RD	HOUMA	LA	70360	985-876-3250	20 Beds
ST. ELIZABETH'S CARING, LLC	1020 MANHATTAN BLVD	HARVEY	LA	70058	504-362-2020	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



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

YOUR TRIP TO:

129 Calhoun St, Independence, LA, 70443-2735



1 HR 9 MIN | 69.9 MI

Est. fuel cost: \$3.91

Trip time based on traffic conditions as of 6:44 AM on January 24, 2019. Current Traffic: Light



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on General Taylor St toward Pitt St.

Then 0.06 miles 0.06 total miles



2. Take the 2nd **right** onto Saint Charles Ave.
Saint Charles Ave is just past Pitt St.

If you reach Carondelet St you've gone a little too far.

Then 1.81 miles 1.87 total miles



3. Turn **left** onto Calliope St.
If you reach Lee Cir you've gone a little too far.

Then 0.14 miles 2.00 total miles



4. Take the **I-10** ramp.

Then 0.24 miles 2.24 total miles



5. Merge onto Pontchartrain Expy/US-90 Bus N.

Then 1.50 miles 3.74 total miles



6. Pontchartrain Expy/US-90 Bus N becomes I-10 W.

Then 23.55 miles 27.29 total miles



7. Keep **right** to take I-55 N via EXIT 210 toward **Hammond**.

Then 40.79 miles 68.08 total miles



8. Take the **LA-40** exit, EXIT 40, toward **Independence**.

Then 0.22 miles 68.30 total miles



9. Merge onto LA-40 toward **Independence**.

Then 1.35 miles 69.65 total miles



10. Turn **right** onto E Railroad Ave/LA-40. Continue to follow E Railroad Ave.

Then 0.20 miles 69.85 total miles



11. Take the 3rd **left** onto Calhoun St.

Calhoun St is just past E 4th St.

If you reach Tiger Ave you've gone a little too far.


Then 0.07 miles

69.92 total miles

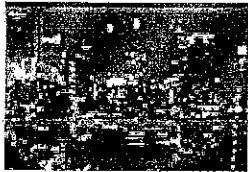
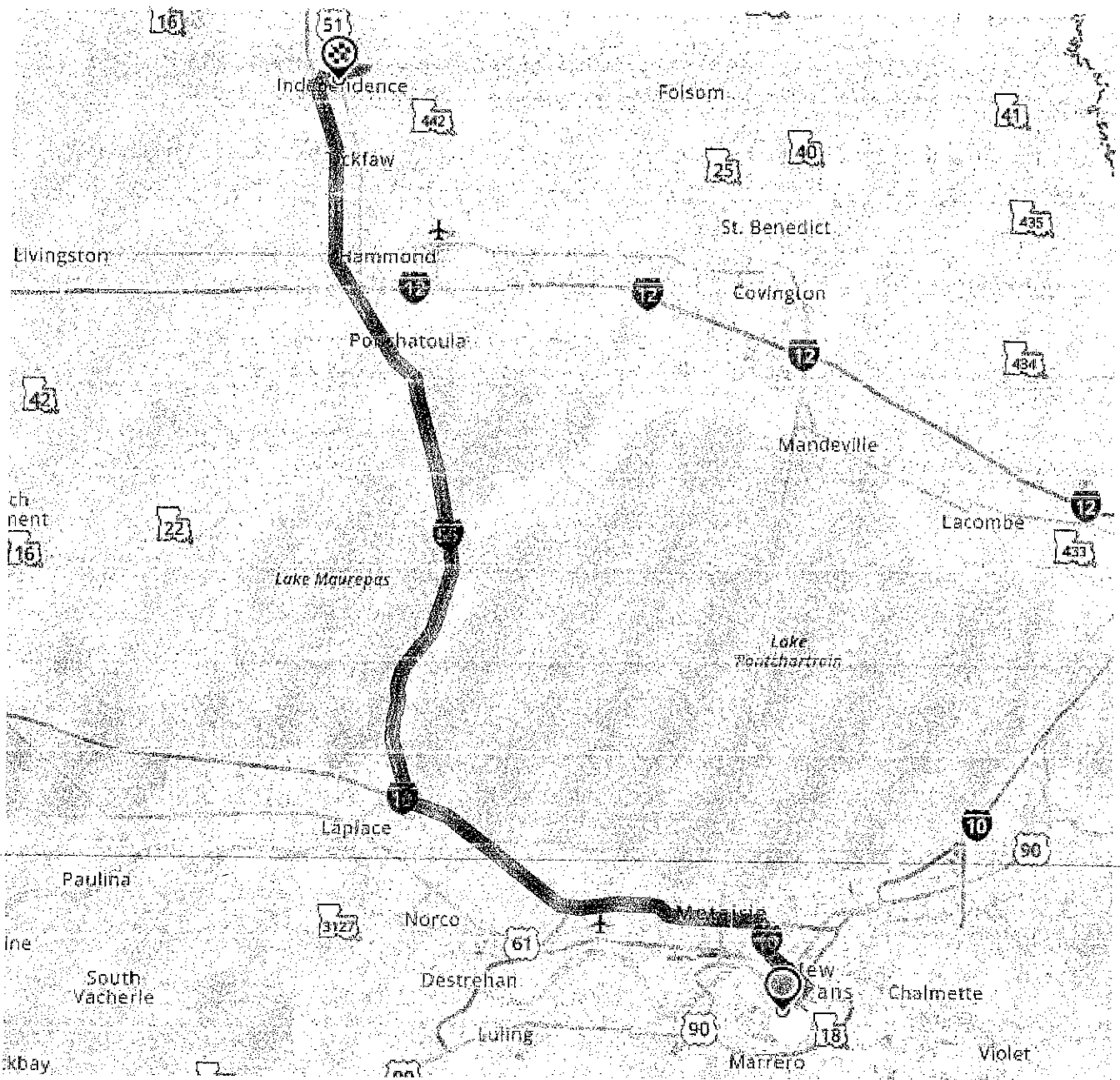


12. 129 Calhoun St, Independence, LA 70443-2735, 129 CALHOUN ST is on the **left**.

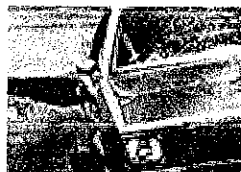
If you reach Cypress St you've gone a little too far.

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MapQuest Roadside
Assistance is here:
(1-888-461-3625)

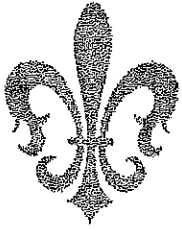
2019 Nursing Home Emergency Preparedness Plan Survey

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)?
SOUTH LaFOURCHE NURSING AND REHAB
- ii. What is the physical address of each **alternate/secondary** host site(s)?
146 E 28th ST
CUT OFF, LA
70345
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
66.4
- 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: BOB DUET
Phone: 985-537-3569
Email: BOBDUET@RACELANDMANOR.COM
Fax: 985-537-3020
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
 - Capacity that will be allowed at each **alternate/secondary** site:
20
 - 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?



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 DeVille of Harvey
Maison DeVille 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 70345 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

YOUR TRIP TO:

148 E 28th St



1 HR 19 MIN | 66.4 MI

Est. fuel cost: \$3.81

Trip time based on traffic conditions as of 2:19 PM on February 4, 2019. Current Traffic: Light



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on General Taylor St toward Pitt St.

Then 0.06 miles

0.06 total miles



2. Take the **2nd right** onto Saint Charles Ave.

Saint Charles Ave is just past Pitt St.

If you reach Carondelet St you've gone a little too far.

Then 1.81 miles

1.87 total miles



3. Turn **left** onto Calliope St.

If you reach Lee Cir you've gone a little too far.

Then 0.18 miles

2.05 total miles



4. Turn **left** onto Baronne St.

Baronne St is just past Carondelet St.

If you reach Oretha Castle Haley Blvd you've gone a little too far.

Then 0.01 miles

2.06 total miles



5. Merge onto Pontchartrain Expy/US-90 Bus N.

If you reach Calliope St you've gone a little too far.

Then 1.69 miles

3.75 total miles



6. Pontchartrain Expy/US-90 Bus N becomes I-10 W.

Then 12.82 miles

16.57 total miles



7. Merge onto I-310 S via EXIT 220 toward **Boutte/Houma**.

Then 11.91 miles

28.48 total miles



8. Take the **US-90 W** exit toward **Houma**.

Then 0.48 miles

28.96 total miles



9. Take US-90 W.

Then 17.02 miles

45.97 total miles



10. Take the **LA-308** exit, **EXIT 215B**, toward **Raceland**.

Then 0.33 miles

46.31 total miles



11. Turn **left** onto Highway 308/LA-308.

Then 17.34 miles

63.65 total miles



12. Turn **left** onto E Main St/LA-308.

E Main St is 0.2 miles past Twin Oaks Trl.

If you are on W 15th St and reach W Main St you've gone a little too far.

Then 2.52 miles

66.17 total miles



13. Turn **left** onto E 26th St.

E 26th St is just past E 31st Pl.

If you reach E 30th St you've gone a little too far.

Then 0.03 miles

66.20 total miles



14. Take the 1st **left** onto E 28th St (Portions unpaved).

If you reach the end of E 28th St you've gone about 1.4 miles too far.

Then 0.15 miles

66.35 total miles

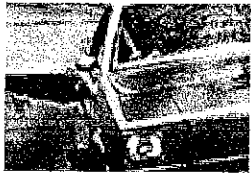
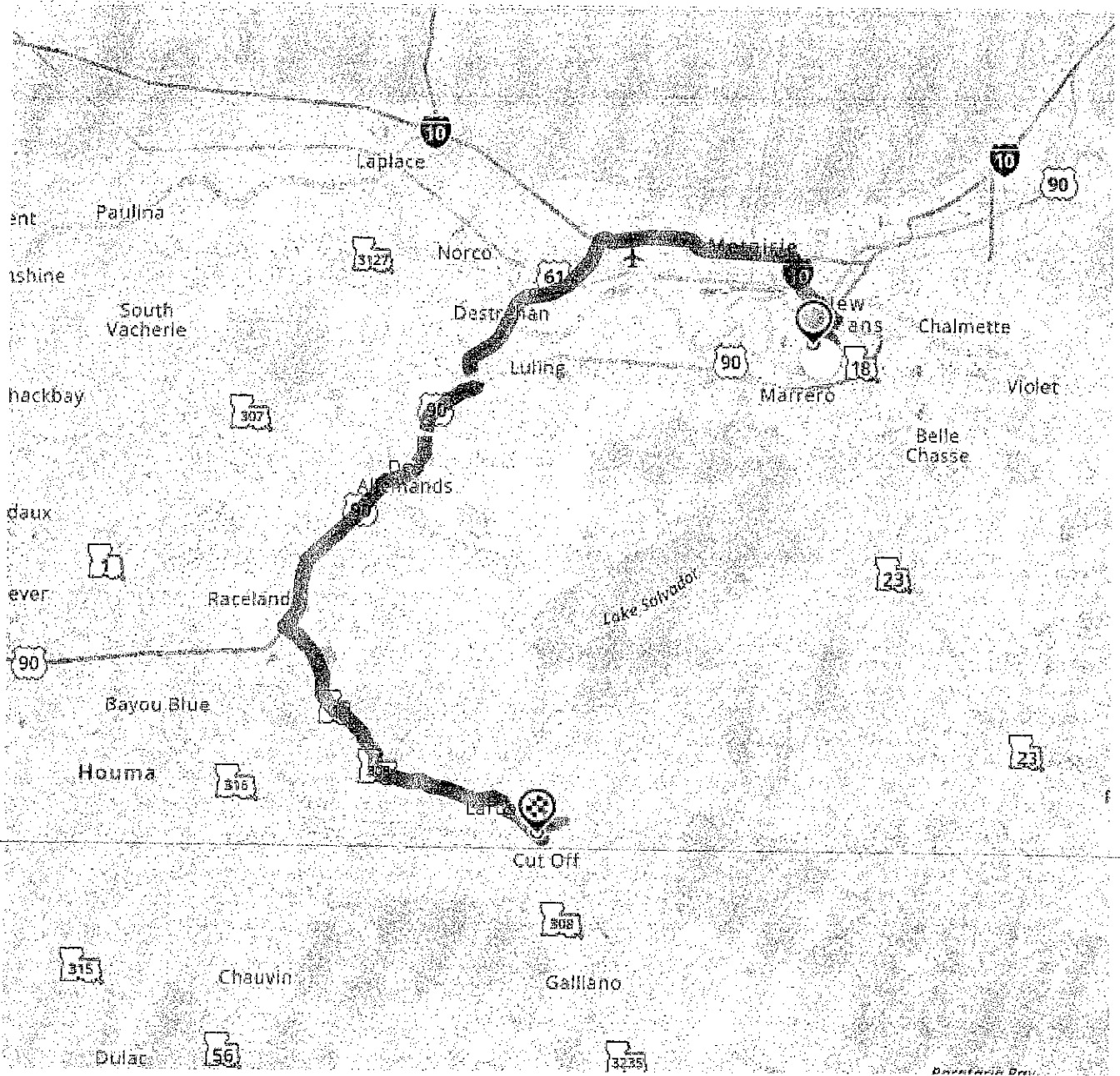


15. 146 E 28th St, Cut Off, LA 70345-2209, 146 E 28TH ST is on the **left**.

If you reach E 29th St you've gone about 0.2 miles too far.

Save to My Maps

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Car trouble mid-trip?
 MapQuest Roadside Assistance
 is here:
 (1-888-461-3625)

2019 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)?
IBERVILLE OAKS
- ii. What is the physical address of each **alternate/secondary** host site(s)?
59355 RIVERWEST DRIVE
PLAQUEMINE, LA
70769
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
7.5
- 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: TRACY GARCIA
Phone: 225-405-4242
Email: TGARCIA@PLAQUEMINEMANOR.COM
Fax: 222-238-2030
- 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:
10
 - 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?

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

YOUR TRIP TO:

59355 River West Dr



1 HR 40 MIN | 88.5 MI

Est. fuel cost: \$4.94

Trip time based on traffic conditions as of 6:54 AM on January 24, 2019. Current Traffic: Light



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on General Taylor St toward Pitt St.

Then 0.07 miles

0.07 total miles



2. Turn **left** onto Saint Charles Ave.

If you reach Carondelet St you've gone a little too far.

Then 0.33 miles

0.40 total miles



3. Turn **right** onto Napoleon Ave.

Napoleon Ave is just past General Pershing St.

If you reach Jena St you've gone a little too far.

Then 0.94 miles

1.34 total miles



4. Turn **right** onto S Claiborne Ave/US-90 E.

S Claiborne Ave is just past Willow St.

If you reach S Derbigny St you've gone a little too far.

Then 1.29 miles

2.63 total miles



5. Merge onto Pontchartrain Expy/US-90 Bus N toward I-10 W/Baton Rouge.

Then 1.07 miles

3.71 total miles



6. Pontchartrain Expy/US-90 Bus N becomes I-10 W.

Then 50.64 miles

54.34 total miles



7. Take the **LA-22** exit, EXIT 182, toward Donaldsonville/Sorrento.

Then 0.31 miles

54.65 total miles



8. Keep **left** to take the ramp toward Donaldsonville/Sunshine Bridge.

Then 0.04 miles

54.69 total miles



9. Turn **left** onto Highway 22/LA-22.

Then 0.52 miles

55.21 total miles

↶ 10. Turn **left** onto Highway 70/LA-70. Continue to follow Highway 70.

Highway 70 is 0.2 miles past Patricia Dr.

If you are on Highway 22 and reach Panama Rd you've gone about 0.5 miles too far.

..... Then 9.33 miles 64.54 total miles

↑ 11. Highway 70 becomes LA-3089.

..... Then 2.98 miles 67.52 total miles

↑ 12. LA-3089 becomes Louisiana Scenic Bayou Byway.

..... Then 18.46 miles 85.98 total miles

↶ 13. Turn **left** onto Saint Louis Rd.

If you reach Senator Gay Blvd you've gone about 0.3 miles too far.

..... Then 1.46 miles 87.45 total miles

↗ 14. Turn **slight right** onto Tenant Rd.

..... Then 0.98 miles 88.43 total miles

↘ 15. Turn **right** onto River West Dr.

River West Dr is 0.1 miles past Ragusa Rd.

If you reach Sam Distefano St you've gone about 0.1 miles too far.

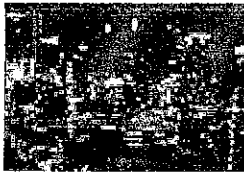
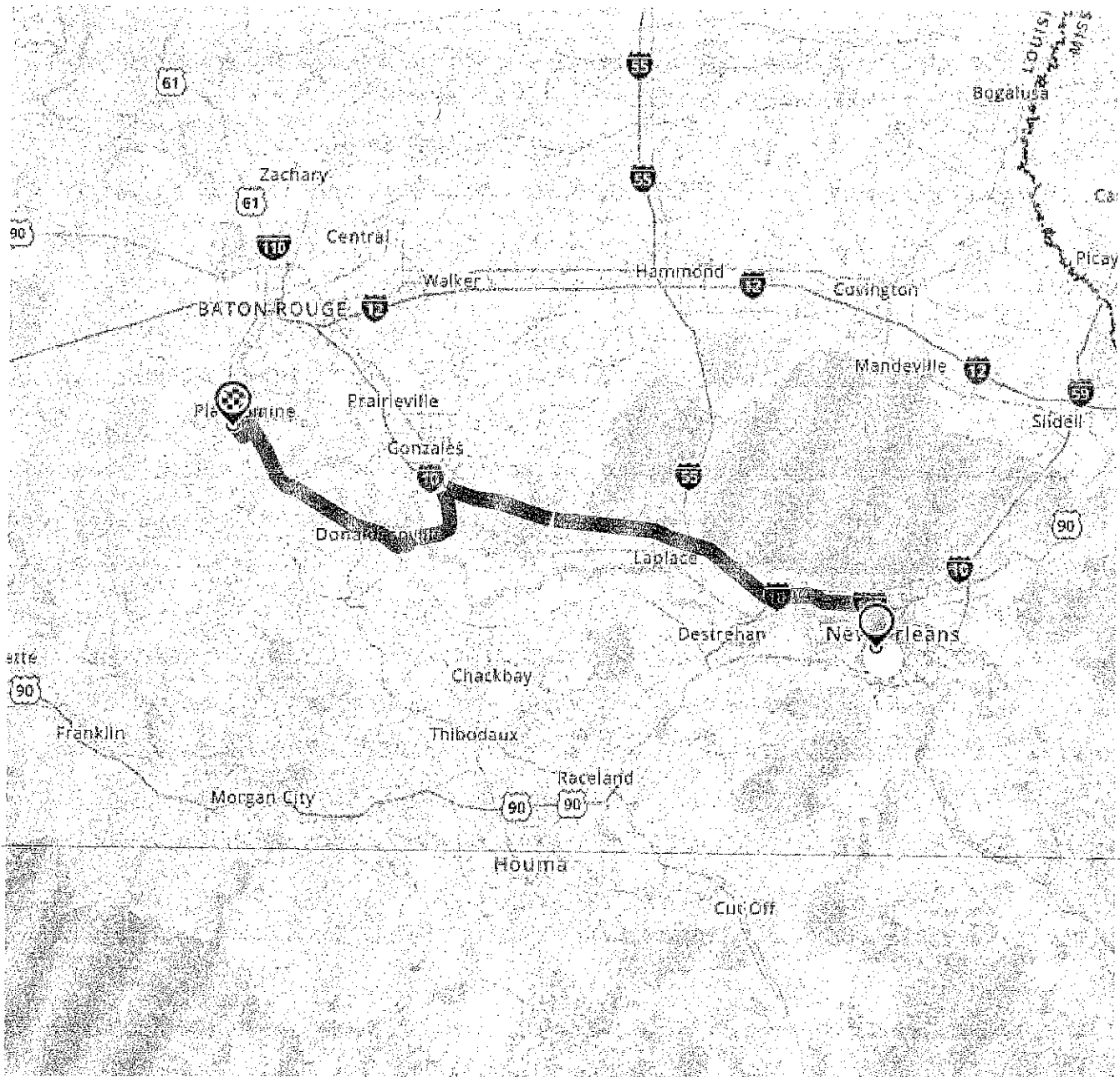
..... Then 0.11 miles 88.54 total miles



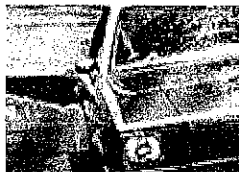
16. 59355 River West Dr, Plaquemine, LA 70764-6553, 59355 RIVER WEST DR is on the **right**.

If you reach the end of River West Dr you've gone about 0.2 miles too far.

📍 Save to My Maps



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(1-877-577-5766)



**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
(1-888-461-3625)

2019 Nursing Home Emergency Preparedness Plan Survey

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

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

- i. What is the name of each **alternate/secondary** site(s)?
WEST JEFFERSON HEALTHCARE CENTER
- 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)?
7.5 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
Phone: 504-362-2020
Email: TWHITE@WESTJEFFCARING.COM
Fax: 504-362-9620
- 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:
10
> 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?

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 'T. White'. The signature is fluid and elegant, with a large initial 'T'.

Tamara White, LNFA, MBA, RN
Administrator

YOUR TRIP TO:

1020 Manhattan Blvd



13 MIN | 7.5 MI

Est. fuel cost: \$0.58

Trip time based on traffic conditions as of 7:08 AM on January 24, 2019. Current Traffic: Moderate



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on General Taylor St toward Pitt St.

Then 0.06 miles 0.06 total miles



2. Take the 2nd **right** onto Saint Charles Ave.

Saint Charles Ave is just past Pitt St.

If you reach Carondelet St you've gone a little too far.

Then 1.78 miles 1.83 total miles



3. Turn **right** onto Calliope St.

Calliope St is just past Clio St.

If you reach Lee Cir you've gone a little too far.

Then 0.17 miles 2.01 total miles



4. Merge onto US-90 Bus S via the ramp on the **left**.

Then 4.79 miles 6.80 total miles



5. Take EXIT 6 toward **Manhattan Blvd**.

Then 0.31 miles 7.11 total miles



6. Merge onto Westbank Expy.

Then 0.08 miles 7.19 total miles



7. Take the 1st **left** onto Manhattan Blvd.

If you reach Maple Ave you've gone about 0.3 miles too far.

Then 0.26 miles 7.45 total miles

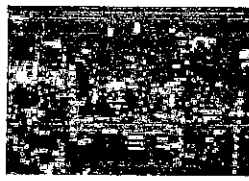
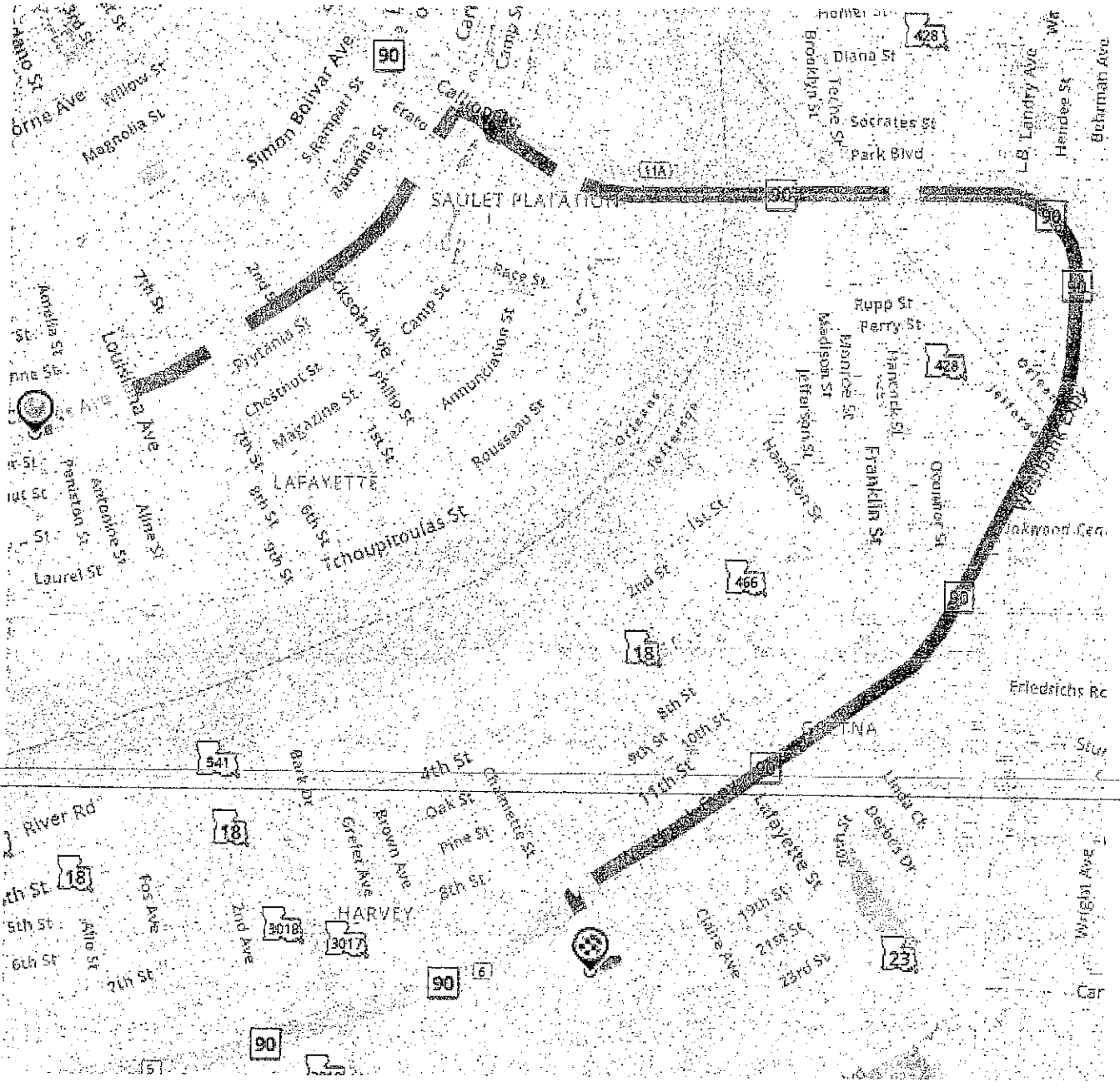


8. 1020 Manhattan Blvd, Harvey, LA 70058-4626, 1020 MANHATTAN BLVD.

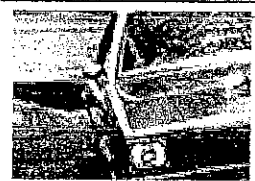
Your destination is 0.2 miles past Westbank Expy.

If you reach Apache Dr you've gone a little too far.

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(1-888-461-3625)

2019 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

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

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

Type of Supply: FOOD

Name of Supplier:

REINTEGRITY

Contact Person: CANDICE FALER

Phone # of Contact Person: 985-778-8449

FAX#: 504-734-5270

E-Mail Address: CJFALER@RFDELIVERS.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?

24 HOURS

How long will it take to receive the delivery?

NEXT DAY

Date of agreement/contract/verification: January 18, 2019

Date agreement/contract ends: January 18, 2020



Reinhart Foodservice
918 Edwards Ave
Harahan, LA 70123
January 18, 2019

Bd-Uptown Healthcare
1420 General Taylor
New Orleans, LA 70115

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:

Freezer/refrigerated trailer (requires signed Food Trailer Usage Agreement)
Additional off-day delivery
Emergency drinking water supply
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 Healthcare Specialist at 1-800-256-1336.

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

2019 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

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

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

Type of Supply: LINEN

Name of Supplier:

WESTPORT LINEN SERVICES

Contact Person: EDDIE OEFEAUX

Phone # of Contact Person: 225-218-8878

FAX#: 225-927-7739

E-Mail Address: elefeaux@westportlinen.net

Indicate where the supplies are to be delivered to;

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

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

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

24 HOURS

How long will it take to receive the delivery?

NEXT DAY

Date of agreement/contract/verification: 1-22-19

Date agreement/contract ends: 2-28-21

**WESTPORT LINEN SERVICES
EMERGENCY LINEN ADDENDUM**

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

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

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

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

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

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

West Jefferson Healthcare Center
1020 Manhattan Blvd
Harvey, LA 70058

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

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

If activated the Evacuation site addresses are as follows:

59355 River West Dr
Plaquemine, LA 70764

24320 Ferdinand St
Plaquemine LA 70769

129 Calhoun St
Independence, LA 70764

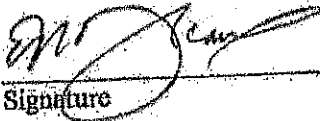
Prices are \$.60 per pound received by Westport.

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

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

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

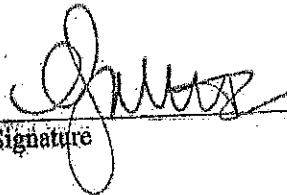
Invoice Billing is weekly and to be paid with a Credit Card submitted to Westport on first day of service.


Signature

Westport Linen Services, LLC.

CEO
Title

1/31/19
Date

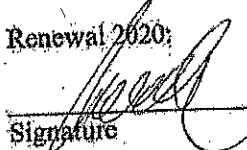

Signature

Plaza Holdings LLC.


COO
Title

1/31/2019
Date

Renewal 2020:


Signature 2-1-19
Date

Owner
Title


Signature 2-1-19
Date

Administrator
Title

Renewal 2021:

Signature Date

Title

Signature Date

Title

2019 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: MEDICATIONS

Name of Supplier:

PEOPLE'S DRUG STORE

Contact Person: SUSAN BURNETT

Phone # of Contact Person: 985-873-8003

FAX#: 985-873-8451

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?

24 HOURS

How long will it take to receive the delivery?

NEXT DAY

Date of agreement/contract/verification: 01-15-19

Date agreement/contract ends: 2-15-19

Peoples DRUG STORE, INC.

Emergency Medications Agreement

This agreement is entered into between Maison Orleans of NOLA and Peoples Drug Store. During emergency situations. Peoples Drug Store will provide medications to Maison Orleans of NOLA 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.

Sunday NOLA, NOLA

Maison Orleans of NOLA
1420 General Taylor Drive
New Orleans, LA 70115
Date 01/15/19

Steve B...

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