

Hbst contracts

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):

South Lafourche Nursing and Rehab

Name of Administrator (Print):

Bob Duet, NFA

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

Phone #: 985-693-1048

Cell Phone #: 985-856-8005

Administrator E-Mail: bobduet@racelandmanor.com

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

Name: Krystal Howard

Position: Assistant Administrator

Phone #: 985-693-1049

Cell Phone #: 985-414-4336

E-Mail: khoward@racelandmanor.com

Physical or Geographic address of Facility (Print):

146 E 28th St

CutOff, LA 70345

Longitude: -90.582382986

Latitude: 29.714753778

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MAR 01 2019
HEALTH STANDARDS

2019 Nursing Home Emergency Preparedness Plan Survey

VERIFICATION of OHSEP SUBMITTAL for Year: 2019

Nursing Facility's Name: South Lafourche Nursing and Rehab

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

Lafourche Parish OEP

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

Date submitted: 02/28/2019

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.

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

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

☒ YES

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

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

☒ YES

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

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

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

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

i. ☐ Category 1- winds 74 to 95 mph

ii. ☐ Category 2- winds 96 to 110 mph

iii. ☐ Category 3- winds 111 to 130 mph

iv. ☐ Category 4- winds 131 to 155 mph

v. ☒ Category 5- winds 156 mph and greater

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

i. 72 Hours before the arrival of the hurricane.

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

i. 72 Hours before the arrival of the hurricane.

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

TITLE/POSITION: Administrator

NAME: Bob J. Duet

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

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

i. ☐ Category 1- winds 74 to 95 mph

ii. ☐ Category 2- winds 96 to 110 mph

iii. ☐ Category 3- winds 111 to 130 mph

iv. ☐ Category 4- winds 131 to 155 mph

v. ☒ Category 5- winds 156 mph and greater

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

i. 48 Hours before the arrival of the hurricane.

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

i. 72 Hours before the arrival of the hurricane.

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

TITLE/POSITION: Bob J Duet

NAME: Administrator

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

A. Facility Description:

1. What year was the facility built? 2017

2. How many floors does facility have? 1

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

☒ Yes, answer 3.a, b, c, d

☐ No/Unknown, answer 3.e

a) MARK the **highest category** of hurricane or wind speed that building can withstand?

i. ☐ Category 1- winds 74 to 95 mph

ii. ☐ Category 2- winds 96 to 110 mph

iii. ☐ Category 3- winds 111 to 130 mph

iv. ☐ Category 4- winds 131 to 155 mph

v. ☒ Category 5- winds 156 mph and greater

vi. ☐ Unable to determine : see A.3.e

b) MARK the **highest category** of hurricane or wind speed that facility roof can withstand?

i. ☐ Category 1- winds 74 to 95 mph

ii. ☐ Category 2- winds 96 to 110 mph

iii. ☐ Category 3- winds 111 to 130 mph

iv. ☐ Category 4- winds 131 to 155 mph

v. ☒ Category 5- winds 156 mph and greater

vi. ☐ Unable to determine : see A.3.e

c) MARK the source of information provided in a) and b) above? (DO NOT give names or wind speeds of historical storms/hurricanes that facility withstood.)

i. ☐ Based on professional/expert report,

ii. ☐ Based on building plans or records,

iii. ☒ Based on building codes from the year building was constructed

iv. ☐ Other non-subjective based source. Name and describe source.

d) MARK if the windows are resistant to or are protected from wind and windblown debris?

i. ☒ Yes

ii. ☐ No

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

4. What are the elevations (in feet above sea level, use NAVD 88 if available) of the following:

a) Building's lowest living space is 3.51 feet above sea level.

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

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- c) Generator(s) is 7.51 feet above sea level.
- d) Lowest electrical service box(s) is 3.51 feet above sea level.
- e) Fuel storage tank(s), if applicable, is 7.51 feet above sea level.
- f) Private water well, if applicable, is n/a feet above sea level.
- g) Private sewer system and motor, if applicable, is 3.51 feet above sea level.

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

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

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

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

i. ☒ Yes- answer A.5.b

ii. ☐ No, go to A. 6.

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

i. ☐ Category 1- winds 74 to 95 mph

ii. ☐ Category 2- winds 96 to 110 mph

iii. ☒ Category 3- winds 111 to 130 mph

iv. ☐ Category 4- winds 131 to 155 mph

v. ☐ Category 5- winds 156 mph and greater

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

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

Moderate to Low Risk Area

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

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

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

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

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

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

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

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

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

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

- a) ☐ Yes
- b) ☒ No

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

- a) ☐ Yes
- b) ☒ No

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

- a) ☒ Yes
- b) ☐ No

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11. Have the areas of the building that are to be used for safe zones/sheltering been identified?
 - a) ☒ Yes
 - b) No. Identify these areas then indicate that this has been completed by marking Yes.

12. Have the facility's internal and external environments been evaluated to identify potential chemical or biological hazards?
 - a) ☒ Yes
 - b) No. Evaluate and identify areas then indicate that this has been done by marking Yes.

13. Has the facility's external environment been evaluated to identify potential hazards that may fall or be blown onto or into the facility?
 - a) ☒ Yes
 - b) No. Evaluate and identify areas then indicate that this has been done by answering Yes.

14. Emergency Generator - **generator information should match MSTAT!**
 - a) Is the generator(s) intended to be used to shelter in place during hurricanes (extended duration)?
 - i. ☒ Yes. The generator(s) will be used for Sheltering in place for Hurricanes.
 - ii. ☐ No. The generator(s) will **NOT** be used for Sheltering In Place for Hurricanes.

 - b) What is the **wattage(s)** of the generator(s)? Give answer in **kilowatts (kW)**.
 1st: 500kw 2nd generator: _____ 3rd generator: _____

 - c) Mark which primary **fuel** each generator(s) uses?

i. <input type="checkbox"/> natural gas;	2nd generator: <input type="checkbox"/> natural gas;	3rd generator: <input type="checkbox"/> natural gas
ii. <input type="checkbox"/> propane;	2nd generator: <input type="checkbox"/> propane;	3rd generator: <input type="checkbox"/> propane
iii. <input type="checkbox"/> gasoline;	2nd generator: <input type="checkbox"/> gasoline;	3rd generator: <input type="checkbox"/> gasoline
iv. <input checked="" type="checkbox"/> diesel;	2nd generator: <input type="checkbox"/> diesel;	3rd generator: <input type="checkbox"/> diesel

 - d) How many **total hours** would generator(s) run on the fuel supply **always on hand**? (enter NG if Natural Gas)
 1st 168 Hours 2nd _____ Hours 3rd _____ Hours

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

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

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g) Does generator provide for air conditioning?

i. ☒ Yes. Mark closest percentage of the building that is cooled?

☒ 100 % of the building cooled

☐ 76% or more of the building is cooled

☐ 51 to 75% of the building is cooled

☐ 26 to 50% of the building is cooled

☐ Less than 25% of the building is cooled

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

ii. If air conditioning fails, for any reason, does the facility have procedures (specific actions) in place to prevent heat related medical conditions?

☒ Yes

☐ No

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

☒ Yes

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

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

a) Who supplies electricity to the facility?

i. Suppliers name: Entergy

ii. Account #: 370001318361

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

i. Suppliers name: Lafourche Parish Water

ii. Account #: 3-300-6601-00

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

i. Suppliers name: Louisiana Propane

ii. Account #: cutoff

d) Does plan contain the emergency contact information for the utility providers? (Contact names, 24 hour emergency phone numbers)?

i. ☒ Yes

ii. No. Please obtain contact information for your utility providers.

16. Floor Plans

a) Does plan have current legible floor plans of the facility?

i. ☒ Yes

ii. No. Please obtain, then indicate that this has been done by answering Yes

b) Indicate if the following locations are marked, indicated or described on floor plan:

i. Safe areas for sheltering: ☒ Yes. If No- Please identify on floor plan and mark Yes.

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

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

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

1. Residents information

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

Total Licensed Beds: 102

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

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

RED: 12

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

YELLOW: 0

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

GREEN WHEEL CHAIR: 0

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

GREEN: 80

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

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

☒ Yes. If No - Obtain and mark Yes.

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

☒ Yes. If No - Obtain and mark Yes.

- iii. Each resident's allergies, if any?

☒ Yes. If No - Obtain and mark Yes.

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- iv. Each resident's current dietary needs or restrictions?
☒ Yes. If No - Obtain and mark Yes.
 - v. Each resident's next of kin or responsible party and their contact information?
☒ Yes. If No - Obtain and mark Yes.
 - vi. Each resident's current transportation requirements? (advanced life support ambulance, basic ambulance, wheel chair accessible vehicle, car-van-bus)
☒ Yes. If No - Obtain and mark Yes.
2. Staff
- a) Is each of the following provided in the list(s) or roster(s) of all current staff that is kept in or used with the facility emergency preparedness plan: **do not send in this list or roster.**
 - i. Emergency contact information for all current staff?
☒ Yes. If No - Obtain and mark Yes.
 - ii. Acknowledgement of if they will work during emergency events like hurricanes or not?
☒ Yes. If No - Obtain and mark Yes.
 - b) What is **total number** of planned **staff** and other **non residents** that will require facility transportation for an evacuation or need to be sheltered?

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

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- b) Does each contract or agreement for **NON-AMBULANCE**- transportation contain the following information? **NOTE: Vehicles that are not owned by but at the disposal of the facility shall have written usage agreements (with all required information) that are signed and dated. Vehicles that are owned by the facility will need to verify ownership.**
- The complete name of the transportation provider?
☒ Yes. If No - obtain and mark Yes.
 - The number of vehicles and type (van, bus, car) of vehicles contracted for?
☒ Yes. If No - obtain and mark Yes.
 - The capacity (number of people) of each vehicle?
☒ Yes. If No - obtain and mark yes.
 - Statement of if each vehicle is air conditioned?
☒ Yes. If No - obtain and mark Yes.
 - Verification of facility ownership, if applicable; copy of vehicle's title or registration?
☒ Yes. If No - obtain and mark Yes.
- c) Have copies of each **signed and dated contract/agreement** been included for submitting?
☒ Yes. If no, obtain and mark Yes.
- d) Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)
☒ Yes. If No - complete and mark Yes.
4. Host Site(s)-***extra pages for multiple sites have been included with forms near end of survey. (should match what is in MSTAT!)***
- Does the facility have current contracts or verified agreements for a **primary** evacuation host site(s) outside of the primary area of risk?
☐ Yes. If No - obtain and mark Yes.
 - Provide the following information:(list all sites, if multiple sites **list each - see extra pages**)
 - What is the name of each **primary** site(s)?
Plaquemine Manor Nursing Home/Old River West Hospital
 - What is the physical address of each host site(s)?
59355 RiverWest Dr
Plaquemine, LA
70821
 - What is the distance to each host site(s)?
87.8
 - Is the host site(s) located outside of the parishes identified as hurricane risk areas?
Yes

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- v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at **each primary** host site(s)?
Name: Angie Courville
Phone: 225-343-9152
Email: angiec@deancompanies.com
Fax: 225-343-9152, 225-912-6603
- vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
➤ Capacity that will be allowed at each site:
572
➤ Total Capacity of all primary sites:
572
➤ Is this adequate for all evacuating residents?
☒ Yes. If No - obtain and mark Yes.
- viii. Is the **primary** site a currently licensed nursing home(s)?
☒ Yes, go to- B.4.b) x.
☐ No, go to- B.4.b) ix.
- ix. If **primary** host site is **not a licensed nursing home** provide a description of host site(s) including:
➤ What type of facility it is?

➤ What is host site currently being used for?

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

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

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

- xi. Is there a specified time or timeline (H-Hour) that **primary** host site will need to be notified by?
☒ Yes. If Yes - what is that time? 24 hrs
☐ No.
- c) Does the facility have current contracts or verified agreements for an **alternate or secondary** host site(s)?
☒ Yes. If No - obtain and mark Yes.
- d) Provide the following information:(list all sites, if multiple sites **list each** - see extra pages)
- i. What is the name of each **alternate/secondary** site(s)?
Maison Deville of Harvey
- ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th st
Harvey, LA

- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.7 Miles
- iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
☐ Yes
☒ No
- v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: Dante Landry
Phone: 504-362-9522
Email: dlandry@devilleharvey.com
Fax: 504-368-4118
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
➤ Capacity that will be allowed at each **alternate/secondary** site:
75
➤ Total Capacity of all **alternate/secondary** sites:
572
➤ Is this adequate for all evacuating residents?
☒ Yes. If No - obtain and mark Yes.

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- viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?
☒ Yes, go to - B.4.d) x.
☐ No, go to - B.4.d) ix.
- ix. If **alternate/secondary** host site is **not a licensed nursing home** provide a description of host site(s) including;
➤ What type of facility it is?

➤ What is host site currently being used for?

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

➤ Is host facility(s) air conditioned?
☐ Yes
☐ No
➤ What is the current physical condition of facility?
☐ Good
☐ Fair
☐ Poor
➤ Are there provisions for food preparation and service?
☐ Yes
☐ No
➤ What are the provisions for bathing and toilet accommodations?
☐ Yes
☐ No
➤ Are any other facilities contracted to use this site?
☐ Yes
☐ No
- x. Is the capacity of **alternate/secondary** host site(s) adequate for staff?
☒ Yes
☐ No. If No - where will staff be housed?

- xi. Is there a specified time or timeline (H-Hour) that **alternate/secondary** host site will need to be notified by?
☒ Yes. If yes what is that time? 24 hrs
☐ No.
- e) Have copies of each **signed and dated contract/agreement** been included for submitting?
☒ Yes. If No - obtain and mark Yes.
- f) Has a cover page been completed and attached for each contract/agreement. (**blank form provided**)
☒ Yes. If No - complete and mark Yes.

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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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- c) For **evacuation**, does facility have provisions for **medications at host site(s)**?

☒ Yes

If No - make necessary provisions for medications then mark Yes.

8. **Medical, Personal Hygiene, and Sanitary Supplies** – for sheltering in place or for host site(s)

- a) Does facility have **–on site–** medical, personal hygiene, and sanitary supplies to last seven days for all resident's needs?

☒ Yes. go to - B. 8. c)

☐ No. go to - B. 8. b) i,ii,iii,iv

- b) If no, provide the following:

- i. Does facility have a current or currently verified contract to have a seven day supply of medical, personal hygiene, and sanitary goods delivered prior to a foreseeable emergency event?

☐ Yes, see B. 7.b). ii, iii, iv

If No - please obtain supply or contract then mark Yes.

- ii. Does contract for medical, hygiene, and sanitary goods contain the following?

- Name of supplier?
- Specified time or timeline (H-Hour) that supplier will need to be notified
- Contact information of supplier

☐ Yes. If No, obtain information then mark Yes.

- iii. Have copies of each **signed and dated contract/agreement** been included for submitting?

☐ Yes. If no, obtain and mark Yes.

- iv. Has a cover page been completed and attached for each contract/agreement.

(blank form provided)

☐ Yes. If no, complete and mark Yes

- c) For evacuation, does facility have provisions for medical, personal hygiene, and sanitary supplies at host site(s)?

☐ Yes

If No - make necessary provisions for medications then mark Yes

9. Communications/Monitoring - all hazards

- a) **Monitoring Alerts.** Provide the following:

- i. What equipment/system does facility use to **monitor** emergency broadcasts or alerts? Radio, TV, Internet, Phone

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

☒ Yes. Name equipment: Satelite Phone

☐ No

- iii. Is the equipment tested?

☒ Yes

☐ No

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- iv. Is the **monitoring** equipment powered and operable during utility outages?
☒ Yes.
☐ No.
- v. Are there provisions/plans for facility to **monitor** emergency broadcasts and alerts at evacuation site?
☒ Yes
☐ No

b) **Communicating- send and receive-** with emergency services and authorities. Provide the following:

- i. What equipment does facility have to **communicate** during emergencies?
Satelite Phones and cell phones
- ii. Is there back up or alternate equipment used to send/receive and what is it?
☒ Yes. Name equipment: Satellite Phone
☐ No
- iii. Is the equipment tested?
☒ Yes
☐ No
- iv. Is the **communication** equipment powered and operable during utility outages?
☒ Yes.
☐ No
- v. Are there provisions/plans for facility to send and receive **communications** at evacuation site?
☒ Yes
☐ No

C. All Hazard Analysis

1. Has the facility identified potential emergencies and disasters that facility may be affected by, such as fire, severe weather, missing residents, utility (water/electrical) outages, flooding, and chemical or biological releases?

☒ Yes

If No - identify, and then mark **Yes** to signify that this has been completed.

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

A. Plans for **sheltering in place**

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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- d) Does facility have written viable plans for receiving information from emergency services and authorities before, during, and after event?

☒ Yes

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

- e) Does facility have written viable plans for contacting emergency services and authorities before, during, and after event?

☒ Yes

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

5. Does facility have written viable plans for providing emergency medical care if needed while sheltering in place?

☒ Yes

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

6. Does facility have written viable plans for the preparation and service of meals while sheltering?

☒ Yes

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

7. Does facility have written viable plans for repairing damages to the facility incurred during the emergency?

☒ Yes

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

B. Plans for Evacuation

1. Does facility have written viable plans for adequate transportation for transporting all residents to the evacuation host site(s)?

☒ Yes

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

- a) Does facility have written viable plans for adequate staffing for the loading of residents and supplies for travel to evacuation host site(s)?

☒ Yes

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

- b) Does facility have written viable plans for adequate staffing to ensure that all residents have access to licensed nursing staff and appropriate nursing services during all phases of the evacuation?

☒ Yes

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

- c) Does facility have written viable plans for adequate staffing for the unloading of residents and supplies at evacuation host site(s)?

☒ Yes

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

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

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- c) Does facility have written viable plans for notifying resident's responsible party - pre event- of intentions to evacuate?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
- d) Does facility have written viable plans for monitoring emergency alerts and broadcasts - while at host site- before, during, and after event?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
- e) Does facility have written viable plans for receiving information from and contacting emergency services and authorities –while at host site- before, during and after event?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
- f) Does facility have written viable plans for the need to remain at an unlicensed evacuation shelter site for more than five days, if evacuating to an unlicensed site?
☐ Yes ☒ Evacuating to a licensed site
If No - Planning is needed for compliance. Complete then mark Yes
6. Does facility have written viable plans to provide emergency medical care if needed while at evacuation site(s)?
☐ Yes
If No - Planning is needed for compliance. Complete then mark Yes
- C. Does facility have written viable plans for all identified potential hazards?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
- D. Does facility have written viable plans for communicating during all emergencies?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
1. Does facility have written viable plans for immediately providing **written** notification by hand delivery, facsimile, email or other acceptable method of the nursing home's decision to either shelter in place or evacuate due to any emergency to the Health Standards Section of the Department of Health and Hospitals?
☒ Yes
If No - Planning is needed for compliance. Complete then mark Yes
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?

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

☒ Yes

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

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

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

Provide Name: Bob Duet

Position: Administrator

Emergency contact information:

Phone: 985-856-8005

Email: bobduet@racelandmanor.com

Fax: 985-693-1011

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

Provide Name: Krystal Howard

Position: Assistant Administrator

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Emergency contact information:

Phone: 985-414-4336

Email: khoward@racelandmanor.com

Fax: 985-693-1011

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

Provide Name: Bob J. Duet

Position: Administrator

Emergency contact information:

Phone: 985-856-8005

Email: bobduet@racelandmanor

Fax: 985-693-1011

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

Provide Name: Krystal Howard

Position: Assistant Administrator

Emergency contact information:

Phone: 985-414-4336

Email: khoward@racelandmanor.com

Fax: 985-693-1011

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

Provide Name: Bob J Duet/ Krystal Howard

Position: Administrator/Asst. Administrator

Emergency contact information:

Phone: 985-856-8005 / 985-414-4336

Email: khoward@racelandmanor.com/bobduet@racelandmanor.cm

Fax: 985-693-1011

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

1. Title or position of person(s) assigned to notify the responsible party of each resident of the following information within 24 hours of the decision:

Social Services and wardclerk/Medical records

- 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:

Business Office Manager

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?

Director of Nursing and Ward Clerk

- a) Resident's identification.

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- 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?
Activities/PAC
- 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?
Business Office Manager

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

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C. During the review of the facility's emergency preparedness plan were the following steps taken?

1. Were all out dated or non essential information and material removed?

☒ Yes

No - Complete this step then mark Yes

2. Were all contracts or agreements updated, renewed or verified?

☒ Yes

No - Complete this step then mark Yes

3. Was all emergency contact information for suppliers, services, and resources updated?

☒ Yes

No - Complete this step then mark Yes

4. Was all missing information obtained added to plan and the planning revised to reflect new information?

☒ Yes

No - Complete this step then mark Yes

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

☒ Yes

No - Complete this step then mark Yes

VII. Authentication

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

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

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TRANSPORTATION COVER SHEET

TYPE or CLEARLY PRINT and attach a cover page to each transportation resource agreement, transportation contract, or verification of facility's ownership of transportation.

Example: If there are 5 transportation providers there should be 5 coversheets, one attached to the front of each signed and dated agreement, verification or contract.

If transportation is facility-owned, state that it is facility owned and provide verification of ownership and all applicable information. A photocopy of a vehicle's title or registration will be sufficient for verification of ownership. Ongoing contracts will need to be verified annually and signed by all parties.

Name of transportation resource provider (print):

Acadian Ambulance

Contact Person: Sue Szush

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

Physical Address of transportation provider:

PO Box 98000
Lafayette, LA
70509-8000

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

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

48 Hrs

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

20 Mins

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

20 Mins

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

Ambulance

Total number of transport vehicles to be provided: 4

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

Stretcher

Is the transportation air conditioned? ☒ YES ☐ NO

IF transportation is facility owned attach verification of ownership.

Date of agreement/contract/verification: Jan 2, 2019

Date agreement/ contract ends: Renews Annually



Acadian

Ambulance Service



NATIONALLY
ACCREDITED

P.O. Box 98000 • LAFAYETTE, LA • 70509-8000

EMPLOYEE
OWNED

AMBULANCE
DISPATCH
511
800-259-1111

ADMINISTRATION
337-291-3333
800-259-3333

BILLING
800-259-2222

January 2, 2019

Raceland Manor Nursing Home, Inc.
4302 State Hwy 1
Raceland, LA 70394

To whom it may concern:

In response to a request for verification from Raceland Manor Nursing Home, Inc. (hereinafter "Facility"), please allow this to serve as confirmation that Facility currently has in place an Agreement for the evacuation of resident/patients in the case of a disaster, as required by the Louisiana Department of Health and Hospitals and in accordance with the terms and conditions of such Agreement. The Agreement auto renews annually unless otherwise terminated by either party. As of this Date, no notice of termination has been received and therefore such Agreement remains in full force and effect for the 2017 calendar year.

Sincerely,

Susan D. Szush
Community Relations Supervisor
Acadian Ambulance Service, Inc.

**Emergency Evacuation Request
and Guarantee of Payment**

Raceland Manor Nursing Home (hereinafter referred to as "Facility"), whose address is 4302 Highway 1, Raceland, LA 70394 and [check one] ☐ Acadian Ambulance Service of New Orleans, LLC ☒ Acadian Ambulance Service, Inc. (hereinafter referred to as "Acadian") hereby enter into this agreement effective this 1 day of January, 2010 for purposes of facilitating the scheduled ground transportation* and evacuation of patients meeting medical necessity guidelines, from Facility, due to hurricane, natural disaster, or other act of God (hereinafter an "Event").

This Agreement have a primary term of one year from January 1, 2010 through December 31, 2010 and shall renew annually unless either party gives written notice to the other of its intent not to renew at least 30 days prior to the expiration of the term then in effect. In addition, either party may cancel this agreement by giving the other party 90 days written notice of such cancellation which shall cancellation shall become effective on the latter of the noticed date of cancellation or 91 days from the date of mailing same.

Facility agrees and understands that it is Facility's responsibility to request evacuation services under this Agreement which must be made as set forth herein and in the form attached hereto as Exhibit A (fully incorporated herein by reference). Acadian shall have no obligation to facilitate the transport of patients of Facility, who must meet medical necessity guidelines, until the fully completed Evacuation Request Form (Exhibit A) and the designation of a destination facility acceptable to the transporting agency are received by Acadian from Facility and such receipt has been confirmed. It is the sole responsibility of Facility to designate such a destination facility/ shelter and to confirm that such shelter/ facility is in agreement to accept Facility's patients. The designated shelter must be within a reasonable distance or 200 miles unless specifically accepted in writing by an authorized Acadian representative. Furthermore, should the shelter so designated by Facility stop accepting residents or if any designated destination is at a distance which would hinder Acadian's ability to facilitate the evacuation of other facilities, it shall be the responsibility of Facility to secure an alternate destination for transportation of patients satisfactory to Acadian. Facility understands and agrees that Acadian has limited resources. Therefore, Acadian agrees to use good faith efforts to accommodate any request with either internal resources or in coordination with state, federal and/or mutual aid assets when request for transport is made, as required herein, at a minimum of 48 hours prior to wind speeds reaching 40 mph. Thereafter, transportation shall be performed on an as available basis without any guaranty of performance. Furthermore, if mutual aid resources are not available for the request and Acadian resources are not available, Acadian may give notice of the request to the local EOC command with jurisdiction over the Event and Acadian shall notify Facility of same at which time Acadian's obligations hereunder shall be deemed fulfilled.

If, under any circumstance, Facility is not prepared to evacuate upon arrival by Acadian or coordinated resources, Acadian's obligation hereunder shall terminate. The schedule of evacuations shall be at the sole determination of Acadian and its mutual aid partners based on availability of resources and proximity of Facility to the threatened area. At the conclusion of the event and upon request of Facility and acceptance by Acadian, Acadian or coordinated resources shall at a mutually agreed upon time, return residents and inpatients from the designated shelter back to Facility.

Facility also understands and agrees should conditions in the area in which facility is located deteriorate so that labor and resources, if not immediately removed, would be put in harm's way, Acadian and its coordinated providers have the right to cease all transports under this agreement and resume when conditions allow. The decision to cease such operations shall be determined in good faith by the provider rendering services and Acadian shall not have any liability, obligation or otherwise to Facility or residents for non-performance under these circumstances. However, Acadian shall inform facility as soon as practicable of the removal of resources under this paragraph when known.

Facility hereby agrees to be responsible for and pay all cost associated with the transportation of patients from the Facility during the evacuation and post event. The rates that Acadian shall charge Facility when Facility pays Acadian for ground ambulance transports shall be the Medicaid Allowable rates in effect at the time service is provided, which shall fluctuate as those rates are amended by DHH. The parties acknowledge that the Medicaid rates as of the effective date are as follows: \$178.26 per transport + \$6.82 per mile per way for each transport performed under this Agreement. For multiple patients transported in the same vehicle, the mileage will be pro-rated by the number of patients transported in that same vehicle. Acadian shall notify Facility in writing when those rates change. Facility agrees that it shall pay all sums owed to Acadian Ambulance within 30 days of presentation of an invoice by Acadian Ambulance for services performed at the address set forth below. It shall be the facilities responsibility to bill any local, state or federal agency, including FEMA, for reimbursement of amounts expended for evacuation and return services. Acadian shall not be limited or restricted by the reimbursement schedule of any state or federal agency making payment or being called upon to make payment or reimbursement to Facility, in its collection of amounts owed hereunder.

Acadian shall not be responsible for any breach of this Agreement resulting from failure in communication systems not caused by the gross negligence of Acadian.

This Agreement is for the benefit of the named parties only, there being no third party beneficiaries with rights under same.

This Agreement shall be governed in accordance with the laws of the State of Louisiana. Any disputes arising in connection with this Agreement shall be venued in Lafayette, Louisiana.

All notices required to be given herein or payments made (if applicable) shall be made as follows:

Request for service, in the form attached hereto as Exhibit A With a follow-up phone call to confirm receipt.

Notice & Payment:

If to:

Acadian Ambulance Service, Inc.
Acadian Ambulance Service of New Orleans, LLC
PO Box 98000
Lafayette, LA 70509-8000

If to:

Raceland Manor Nursing Home
4302 Highway 1
Raceland, LA 70394

* Air services may be available upon request, but are not a covered service under this Agreement.

EXECUTED AND AGREED UPON THIS 1 DAY OF January, 2010

Raceland Manor Nursing Home

BY: Keelard Cheramie
Keelard Cheramie, Administrator

**Acadian Ambulance Service of New Orleans, LLC/
Acadian Ambulance Service, Inc.**

By: David L. Kelly
David L. Kelly, Executive Vice-President

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):

Nichols Limousine and Shuttle Services

Contact Person: Mike Nichols

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

Physical Address of transportation provider:

4302 Williams Blvd
Kenner, LA
70065

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

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

24 HRS

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

2 hrs

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

3hrs

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

Buss

Total number of transport vehicles to be provided: _____

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

340

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: Renews Annually

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

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

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

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

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

NAME: 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

EVACUATION HOST SITE COVER SHEET

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

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

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

Name of EVACUATION HOST SITE:

Plaquemine Manor Nursing Home

Contact Person: Angie Courville

Phone # of Contact Person: 225-343-9152

FAX#: 225-343-9154

E-Mail Address: angiec@deancompanies.com

Physical Address of evacuation site:

59355 River West Dr

Plaquemine, LA

70764

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

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

24 hrs

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

1 hrs 24 Mins

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

2hrs

Type of evacuation host site:

Is it the ☒ PRIMARY or ☐ ALTERNATE site?

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

Total number of residents and staff that facility is willing to host: 400

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

Date of agreement/contract/verification: _____

Date agreement/contract ends: Renews Annually



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

Year 2019 Hurricane Evacuation Plan

To:

- Maison Deville Nursing Home Inc.
- Maison Deville Nursing Home of Harvey LLC
- Raceland Manor Nursing Home Inc.
- West Jefferson Healthcare, LLC
- Plaquemine Manor Nursing Home, Inc.
- Uptown Healthcare 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 to.

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 2017 Hurricane Evacuation Plan

TO: PLAQUEMINE MANOR NURSING HOME, 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
RACELAND MANOR NURSING HOME, INC.	4302 HIGHWAY 1	RACELAND	LA	70394	985-537-3569	20 Beds
UPTOWN HEALTHCARE CENTER	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

2017 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)?
Uptown Healthcare Center
- ii. What is the physical address of each **alternate/secondary** host site(s)?
1420 General Taylor St
New Orleans, LA
70115
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
42.28 Miles, 50 Min
- 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: Theresa Viscardis
Phone: 504-895-7755
Email: theresaviscardis@gmail.com
Fax: 504-355-4876
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
 - Capacity that will be allowed at each **alternate/secondary** site:
75
 - Is this adequate for all evacuating residents?
☒ Yes. If No - obtain and mark Yes.
- viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?
☒ Yes go to - B.4.d) x.
☐ No, go to - B.4.d) ix.
- ix. If **alternate/secondary** host site is not a licensed nursing home provide a description of host site(s) including;
 - What type of facility it is?
Nursing Home/LTC
 - What is host site currently being used for?
Same as above

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 Manor Nursing Home
- ii. What is the physical address of each host site(s)?
59355 River West Dr
Plaquemine, LA
70764
- iii. What is the distance to each host site(s)?
87.8 Miles
- iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
yes
- v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at **each primary** host site(s)?
Name: Gwen Mesters
Phone: 225-603-1558
Email: gmaster@ihervilleoaks.com
Fax: 225-687-6136
- vii. What is the capacity (number of residents allowed) of **each primary** host site(s)?
 - Capacity that will be allowed at each site:
400
 - 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?
Nursing Home/LTC
 - What is host site currently being used for?
Nursing Home/LTC
 - Is the square footage/area of the space to be used adequate for the residents?
☒ Yes
☐ No
 - What is the age of the host facility(s)?
2015
 - Is host facility(s) air conditioned?

2019 Nursing Home Emergency Preparedness Plan Survey

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

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


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

YOUR TRIP TO:

59355 River West Dr

Iberville Oaks
Nursing +
Rehab.

mapquest

2 HR | 87.8 MI 

Est. fuel cost: \$5.52

Trip time based on traffic conditions as of 4:02 PM on February 26,
2019. Current Traffic: ModeratePrint a full health report of your car with HUM
vehicle diagnostics (800) 906-25011. Start out going **southwest** on E 28th St toward E 29th St.

Then 0.05 miles

0.05 total miles

2. Turn **right** onto E 25th A St.

Then 0.10 miles

0.15 total miles

3. Take the 1st **right** onto E Main St/LA-308.*If you reach W Main St you've gone a little too far.*

Then 2.31 miles

2.47 total miles

4. Turn **right** onto Highway 308/LA-308. Continue to follow LA-308.*LA-308 is 0.2 miles past Lee Rd.**If you are on E Main St and reach Twin Oaks Trl you've gone about 0.1 miles too far.*

Then 58.28 miles

60.75 total miles

5. Turn **left** onto Highway 70/LA-70.*If you reach Daggs St you've gone about 0.3 miles too far.*

Then 5.10 miles

65.85 total miles

6. Turn **right** onto Highway 69/LA-69. Continue to follow LA-69.*LA-69 is 0.1 miles past Grand Bayou St.**If you reach Gumbo St you've gone about 0.8 miles too far.*

Then 11.33 miles

77.18 total miles

7. Turn **left** onto Highway 1/Louisiana Scenic Bayou Byway/LA-1.*If you reach Latino St you've gone a little too far.*

Then 8.06 miles

85.24 total miles

8. 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

86.71 total miles



9. Turn **slight right** onto Tenant Rd.

Then 0.98 miles

87.69 total miles



10. 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

87.80 total miles



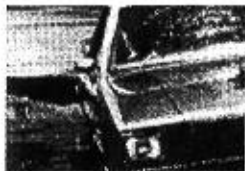
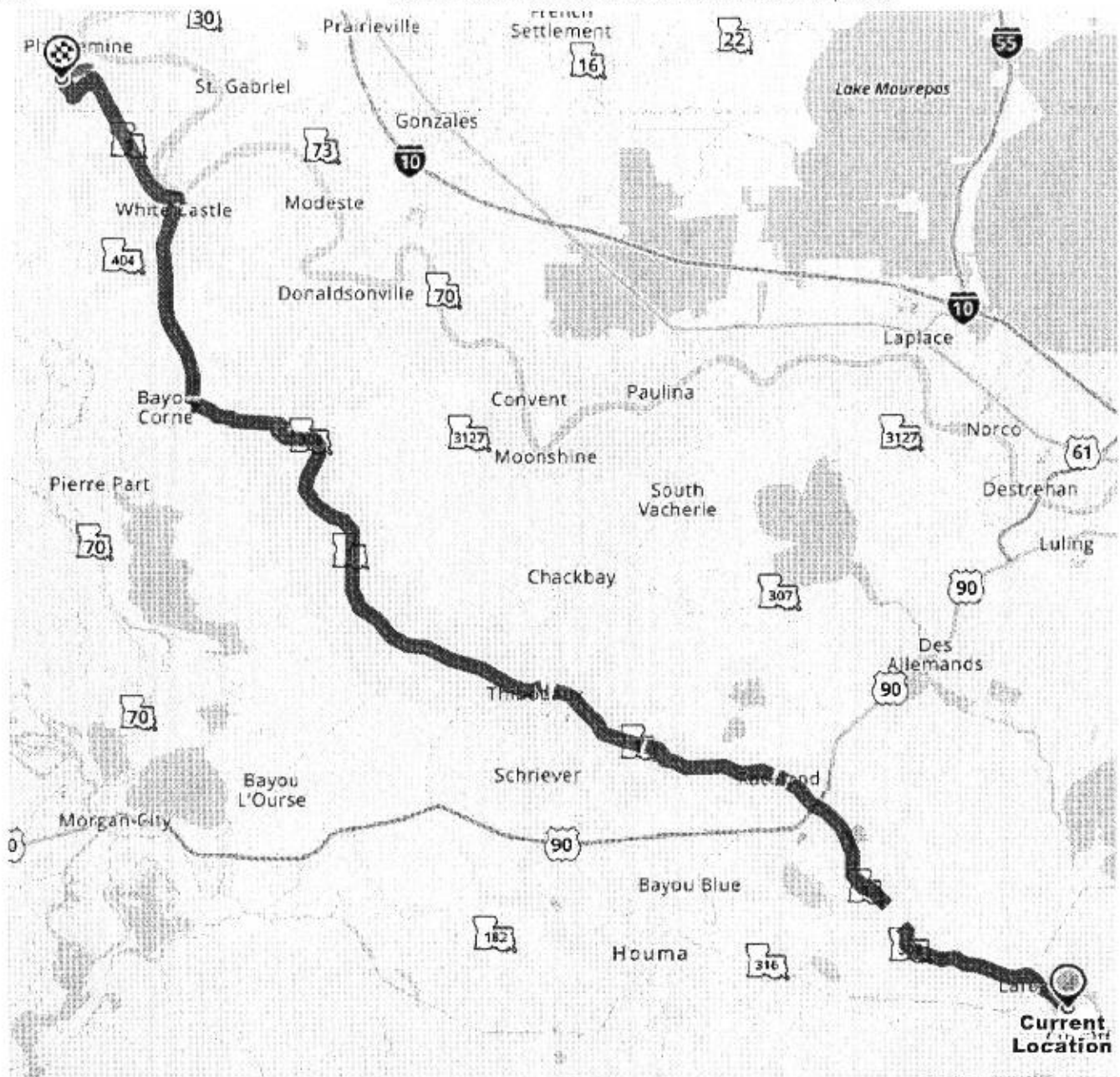
11. 59355 River West Dr, Plaquemine, LA 70764-6553, 59355 RIVER WEST DR
is on the **right**.

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



Save to My Maps

Use of directions and maps is subject to our [Terms of Use](#). We don't guarantee accuracy, route conditions or usability. You assume all risk of use.



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)?
Maison Deville of Harvey
- ii. What is the physical address of each **alternate/secondary** host site(s)?
2233 8th St
Harvey, LA
70058
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.7 Miles
- iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
☐ Yes
☒ No
- v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: Dante Landry
Phone: 504-362-9522
Email: dlandry@devilleharvey.com
Fax: 504-263-5099
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
 - Capacity that will be allowed at each **alternate/secondary** site:

 - Is this adequate for all evacuating residents?
☐ Yes. If No - obtain and mark Yes.
- viii. Is the **alternate/secondary** site a currently licensed nursing home(s)?
☒ Yes go to - B.4.d) x.
☐ No, go to - B.4.d) ix.
- ix. If **alternate/secondary** host site is **not a licensed nursing home** provide a description of host site(s) including;
 - What type of facility it is?

 - What is host site currently being used for?

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



Maison De'ville of Harvey

NURSING HOME & REHABILITATION

A tradition of carina

2233 8th street
Harvey, LA 70058

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

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"



10. Turn **left** onto 8th St.

8th St is 0.1 miles past Westbank Expy.

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

Then 0.41 miles

58.73 total miles



11. 2233 8th St, Harvey, LA 70058-4005, 2233 8TH ST is on the **right**.

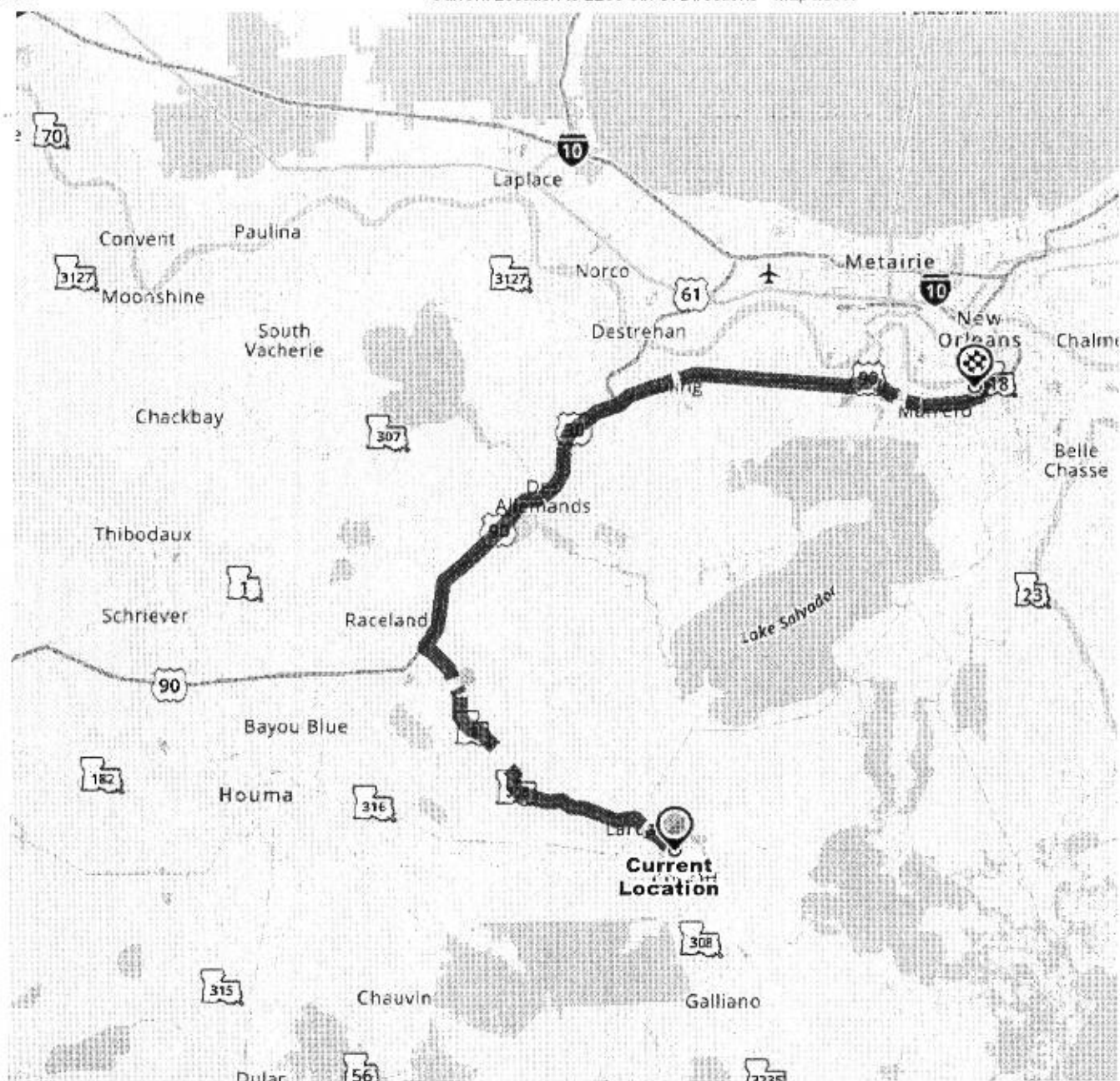
Your destination is just past Yetta Ave.

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



Save to My Maps

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Car trouble mid-trip?
MapQuest Roadside Assistance
is here:

(1-888-461-3625)



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

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"

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
- ii. What is the physical address of each **alternate/secondary** host site(s)?
1020 Manhattan Blvd
Harvey, LA
70058
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
58.3
- 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: 504-669-2904, 504-362-2020
Email: twhite@westieffcaring.com
Fax: 504-336-2147
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
 - Capacity that will be allowed at each **alternate/secondary** site:
75
 - 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?

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 Hrs
☐ No.

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

West Jefferson Healthcare Center

"A Tradition of Caring"



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

February 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 black ink, appearing to read "Tamara White", is written over a horizontal line.

Tamara White, LNFA, MBA, RN
Administrator

west Jefferson Healthcare

YOUR TRIP TO:

1020 Manhattan Blvd, Harvey, LA, 70058-4626

mapquest

1 HR 18 MIN | 58.3 MI 🚗

Est. fuel cost: \$3.66

Trip time based on traffic conditions as of 4:27 PM on February 28, 2019. Current Traffic: Light



Print a full health report of your car with H.O.M. vehicle diagnostics 1800/906-2501



1. Start out going southwest on E 28th St toward E 29th St.

Then 0.04 miles

0.04 total miles



2. Turn right onto E 25th St.

Then 0.10 miles

0.14 total miles



3. Take the 1st right onto E Main St/LA-308.

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

Then 2.31 miles

2.45 total miles



4. Turn right onto Highway 308/LA-308.

Highway 308 is 0.2 miles past Lee Rd.

If you are on E Main St and reach Twin Oaks Trl you've gone about 0.1 miles too far.

Then 17.16 miles

18.61 total miles



5. Merge onto US-90 E

Then 51.56 miles

50.69 total miles



6. Merge onto US-90 Bus E toward New Orleans.

Then 7.02 miles

57.71 total miles



7. Take EXIT 6 toward Manhattan Blvd.

Then 0.30 miles

58.02 total miles



8. Merge onto Westbank Expy.

Then 0.09 miles

58.10 total miles



9. Turn right onto 1020 Manhattan Blvd.

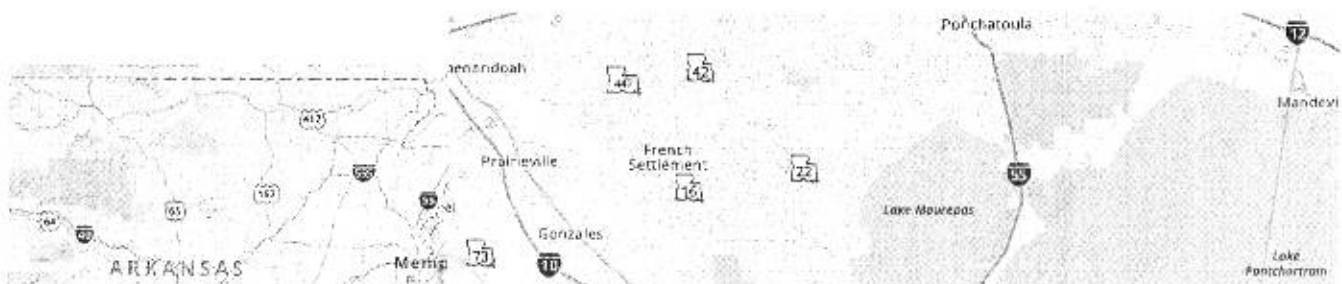
Then 0.02 miles

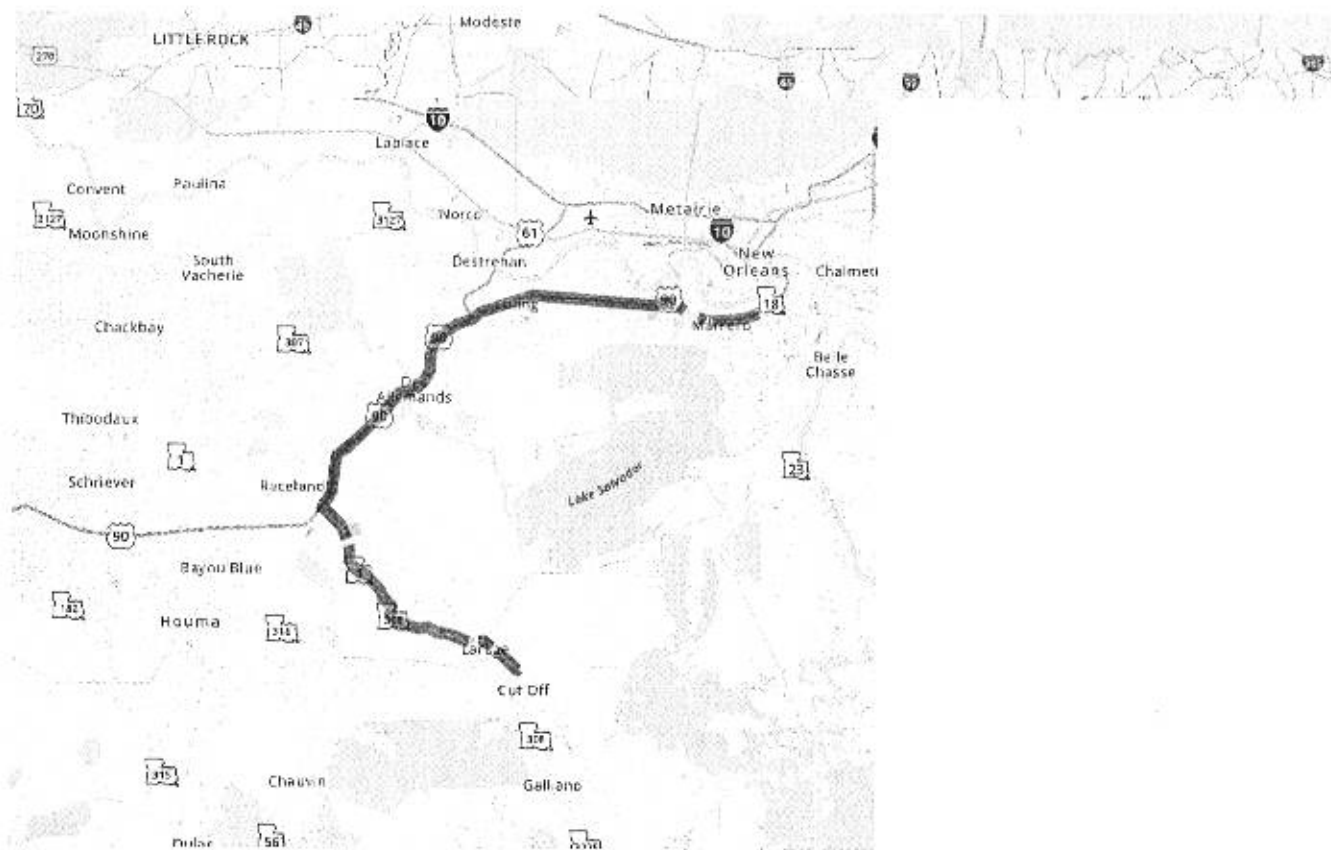
58.32 total miles



1020 MANHATTAN BLVD.

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Car trouble mid-trip? MapQuest
Roadside Assistance is here:
(1-888-468-3626)

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)?
Maison Orleans Healthcare
- ii. What is the physical address of each **alternate/secondary** host site(s)?
1420 General Taylor St
New Orleans, LA
70115
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
65.8
- 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: Lindey Dukes
Phone: 504-895-7755
Email: ldujkes@maisonorleansnola.com
Fax: 504-355-4876
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
➤ Capacity that will be allowed at each **alternate/secondary** site:
75
➤ 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?

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



Maison Orleans Healthcare

NURSING HOME & REHABILITATION

1420 GENERAL TAYLOR STREET
NEW ORLEANS, LA 70115

A tradition of caring

(504) 895-7755 PHONE

(504) 355-4876 FAX

February 20, 2019

Re: Emergency Evacuation for 2019

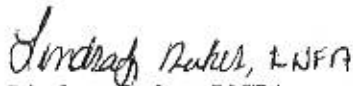
Iberville Oaks Nursing and Rehab
South Lafourche Nursing and Rehab
Maison DeVille of Harvey
Maison DeVille of Houma
West Jefferson Healthcare

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

"Family Owned and Operated"

Maison Orleans - uptown

YOUR TRIP TO:

1420 General Taylor St, New Orleans, LA, 70115-3718

mapquest

1 HR 22 MIN | 65.8 MI 🚗

Est. fuel cost: \$4.13

Trip time based on traffic conditions as of 4:28 PM on February 26, 2019. Current Traffic: Light



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



1. Start out going southwest on E 29th St toward E 29th St.

Then 0.04 miles 0.04 total miles



2. Turn right onto E 25th A St.

Then 0.10 miles 0.14 total miles



3. Take the 1st right onto E Main St/LA-308.

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

Then 2.31 miles 2.45 total miles



4. Turn right onto Highway 308/LA-308.

Highway 308 is 0.2 miles past Lee Rd.

If you are on E Main St and reach Twin Oaks Tr you've gone about 0.1 miles too far.

Then 17.18 miles 19.61 total miles



5. Merge onto Highway 90/US-90 E.

Then 17.93 miles 37.54 total miles



6. Take I-210 N toward Donaldsonville/New Orleans/LA-3127 N.

Then 11.23 miles 48.76 total miles



7. Merge onto I-10 E via EXIT 1A toward New Orleans.

Then 10.33 miles 59.06 total miles



8. Keep right to take I-10 E toward Business District/New Orleans.

Then 3.54 miles 62.63 total miles



9. Take EXIT 234A on the left toward

62.85 total miles



10. Take I-10 E toward Superdome.

64.32 total miles



11. Take the 1st left onto Prytanis St.

65.38 total miles



12. Turn right onto Prytanis St.

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

Then 0.33 miles 65.71 total miles



13. Take the 3rd right onto General Taylor St.

General Taylor St is just past Peniston St.

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

Then 0.04 miles 65.75 total miles



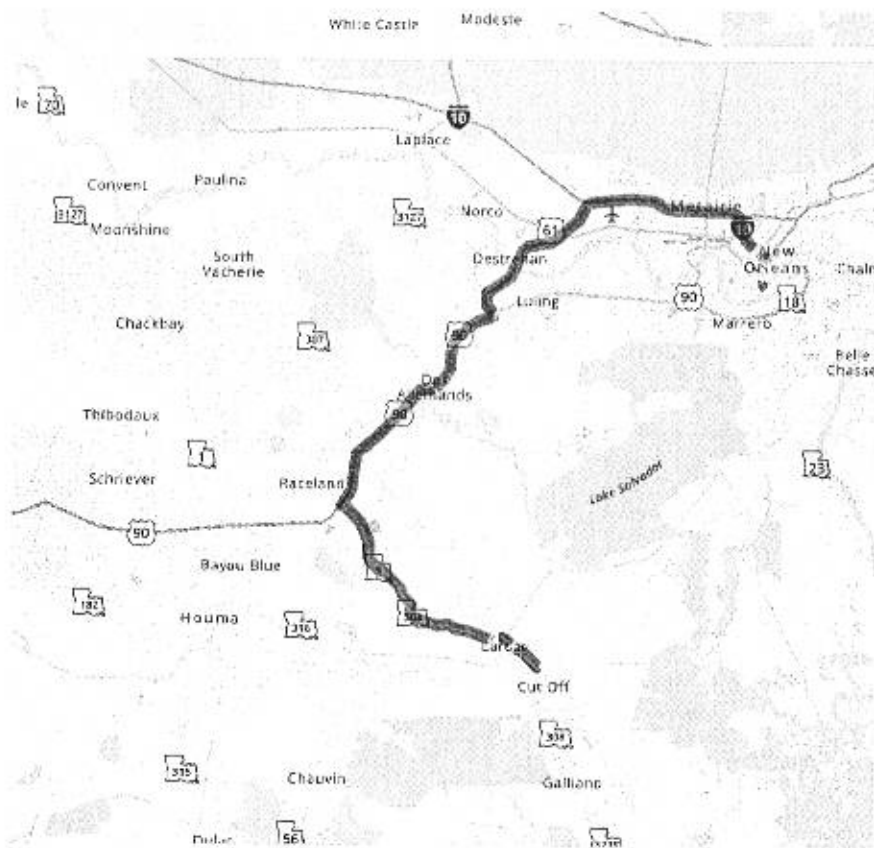
14. 1420 General Taylor St, New Orleans, LA 70115-3718, 1420 GENERAL

TAYLOR ST is on the left.

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

Then 0.04 miles 65.79 total miles





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)?
Maison Deville of Houma
- ii. What is the physical address of each **alternate/secondary** host site(s)?
107 S. Hollywood rd
Houma, LA
70360
- iii. What is the distance, in miles, to each **alternate/secondary** host site(s)?
28.8 Miles
- iv. Is the host site(s) located outside of the parishes identified as hurricane risk areas?
☒ Yes
☐ No
- v. Does plan include map of route to be taken and written directions to host site?
☒ Yes. If No - obtain and mark Yes.
- vi. Who is the contact person at each **alternate/secondary** host site(s)?
Name: William Dukes
Phone: 985-876-3250
Email: wdaigre@devillehouma.com
Fax: 985-873-0046
- vii. What is the capacity (number of residents allowed) of each **alternate/secondary** host site(s)?
 - Capacity that will be allowed at each **alternate/secondary** site:
75
 - 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?

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 Hrs
☐ No.

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

১৯৮৫



MAISON DE'VILLE of HOUMA

Nursing Home & Rehabilitation

107 South Hollywood Rd
Houma, LA 70360

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

January 1, 2019

RE: Emergency Evacuation for 2019

To Whom It May Concern:

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

Sincerely,

William Daigre

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, Water, and Paper Goods

Name of Supplier:

Reinhardt/ DBA Reyes

Contact Person: Adrienne Huffman

Phone # of Contact Person: 225-715-8227

FAX#: 504-734-5270

E-Mail Address: addmonique@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 supplier can be contacted according to agreement?

72 Hrs

How long will it take to receive the delivery?

72 Hrs

Date of agreement/contract/verification: 1/18/2019

Date agreement/contract ends: Renews Annually



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

Bd-Raceland Manor
Hwy 1 Hospital Drive
Raceland, LA 70394

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

REINHART FOODSERVICE OF LOUISIANA EMERGENCY CALL LIST

New Orleans Division			
Toll Free Phone Number	800-488-3988	Fax	504-734-5270
Local Phone Number	504-733-5200		
HEALTHCARE SALES TEAM - NEW ORLEANS DIVISION			
Shannon Hayes, RD, LDN	Regional Manager Healthcare	527339	225-288-1279
Adrienne Uffman, RD, LDN	Southeast Louisiana	527302	225-715-8227
Dawn Arceneaux, RD, LDN	South Central Louisiana	527320	337-344-9767
Candice Faler, RD, LDN	New Orleans/North Shore	527353	985-778-8449
Angel Schlotterbeck, CDM, CFPP	Southwest/Central Louisiana	528319	318-230-1341
Customer Service Team - New Orleans Division			
Lori Nunez	Manager/Healthcare Customer Svc	527736	
Jeannette Lemoine	Inside Sales-Healthcare	527703	
Dawn Sisung	Inside Sales	527743	
Senior Management - New Orleans Division			
Gil Tynes	Vice President of Sales	527336	228-861-9730
Steve Mills	Director of Operations	527794	602-616-6947
Steven Wood	Division President	527707	504-202-7276
Reinhart Foodservice Corporate Healthcare Team			
Lydia Hampton, RD, LDN	Corporate Regional Director of Healthcare - Southern Region		
Dawn LeBlanc, RD, LDN	Corporate Regional Healthcare Menu Systems Coordinator		

Revised: 1/09/2017

Shreveport Division			
Toll Free Phone Number	800-256-1336	Fax	318-213-5105
Local Phone Number	318-869-3061		
HEALTHCARE SALES TEAM - SHREVEPORT DIVISION			
Tiffany Wenzel, RD/LD	Director of Healthcare-Texas	528322	817-320-4614
Kim Branch, RD, LDN	North Louisiana	528316	318-518-3721
Angel Schlotterbeck, CDM, CFPP	Southwest/Central Louisiana	528319	318-230-1341
Jennifer Hoffman, RD/LD	Northeast Texas	528317	713-301-6360
Jimmy Yen	Southeast Texas	528335	381-745-7858
Elsie Sielen	Central Texas	528320	214-507-9229
Customer Service Team - Shreveport Division			
Tami Rutten, CDM, CFPP	Healthcare Specialist/Inside Sales	528224	
Regina Ross	Healthcare Customer Service	528227	
Senior Management - Shreveport Division			
Jay Tynes	Vice President of Sales	528202	228-860-9894
Ken Elkins	Director of Operations	528209	318-393-7780
Steven Wood	Division President	527707	504-202-7276
Reinhart Foodservice Corporate Healthcare Team			
Lydia Hampton, RD, LDN	Corporate Regional Director of Healthcare - Southern Region		318-344-7358
Dawn LeBlanc, RD, LDN	Corporate Regional Healthcare Menu Systems Coordinator		528318

EMERGENCY DIRECTIVES AND ACKNOWLEDGEMENTS

Reinhart strongly urges all of its customers to purchase its emergency food and disposable supplies at the beginning of each hurricane season.

Facilities are expected to have on hand enough supplies to maintain meal service for 48 hours without outside assistance.

An emergency supply order may be kept on file and can be discussed with your healthcare consultant. Or, an emergency supply template can be built in TRACS Direct. For more information on building an emergency supply template, contact TRACS Support or the Customer Service department at 1-800-256-1336 ext. 1320 (SHR) or 1-800-488-3988 ext. 527736 (NOR).

Please note:

- 1) Reinhart will make every attempt to deliver goods upon approach of storms; however, civil authority as well as Mother Nature will control our abilities to service your needs.
- 2) Inventory levels will be depleted during emergencies with no guarantee of stock.

* Evacuation Information (Please supply the location of your evacuation site, if any)

Name of Site

Raceland Manor

Municipal:

4302 Hwy 1 Raceland LA 70394

Municipal address

city

state

zip

Contacts:

Bob J. Duet Krystal Ciccarelli

Phone:

985 856 8005 or 985 414 4336 Fax: 985 537 3020

Email:

mbergeron@racelandmanor.com
kciccarelli@racelandmanor.com

Directions:

I, Bob Duet, administrator for Raceland Manor nursing facility acknowledge receipt and review of Reinhart's disaster procedure manual.

Administrator

Date

Jan 27, 2016

I, Mallorie Bergeron, dietary manager for Raceland Manor nursing facility acknowledge receipt and review of Reinhart's disaster procedure manual.

Dietary Manager

Date

Jan 27, 2016

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: Pharmacy

Name of Supplier:

Peoples Pharmacy

Contact Person: Susan Brunet, Andre Brunet

Phone # of Contact Person: 985-873-8526

FAX#: 985-873-8541

E-Mail Address: jacesjaces@bellsouth.net

Indicate where the supplies are to be delivered to;

☒ Evacuation host site

☐ Nursing home's licensed facility

☐ determined upon decision of sheltering or evacuating

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

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

4hrs

How long will it take to receive the delivery?

2hrs

Date of agreement/contract/verification: 01/15/2019

Date agreement/contract ends: Renews Annually

Pharmacy Service Agreement

This agreement is entered into the 15 day of Jan, 2019 between Peoples Drug Store, hereinafter referred to as Pharmacy and South Lafourche Nursing and Rehab, permit _____ hereinafter referred to as Facility. Whereas the facility desires to employ the services of a pharmacy, and whereas the Pharmacy is desirous of offering pharmacy services, it is therefore mutually agreed that the facility does employ the pharmacy and he agrees to provide pharmacy services to all residents without regard to race, color, national origin, age, gender, religion, or disability under the following terms and conditions:

Pharmacy responsibilities:

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

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

10. Provide written, dated, and signed reports of each consultation visit to the administrator. Such reports shall contain at least the consultants:
 - a. Findings
 - b. Recommendations
 - c. Plans for implementation; and
 - d. Plans for continued assessments.
 - e. The pharmacy will provide the facility with a consultant to provide these reports.
11. Provide written reports, at least quarterly, to the Administrator and Director of Nursing on the status of the facility's pharmaceutical service and performance.
12. Provide continuous services to the facility during the term of this agreement and, in accordance therewith, to provide services of another licensed pharmacist during an absence, vacation, period of illness, or limited period when the consultant is not available.
13. Obtain and maintain during the term of this agreement a suitable professional liability and malpractice insurance policy.
14. Serve the facility as an independent contractor. Our facility has full control over the acts of all our employees and agencies supplying or administering drugs within the facility, and in accordance herewith, the pharmacy shall not be responsible to the facility for any losses or liabilities sustained as a result of their independent malfeasance or negligence.
15. Maintain the confidentiality of resident information as established by our facility's policies and procedures.
16. Stay abreast of all other responsibilities required of a consultant as set forth in any federal or state laws, statutes, or regulations as enacted or may be enacted or amended.
17. Follow the duties and responsibilities as outlined in the pharmacy's position description and our established policies and procedures.

Qualifications:

The pharmacy/pharmacist certifies that he/she is:

1. Is licensed to practice pharmacy in the State of Louisiana.
2. Has at least a Bachelor of Science degree from a college of pharmacy accredited by the American Council of Pharmaceutical Education.
3. Meets the requirements as set forth by current state, federal, and local laws, guidelines and regulations governing pharmaceutical services in a long term care facility.
4. Meets the qualifications standards in our pharmacy's position description.
5. Maintains the required continuing education hours (annually) relative to the practice of a pharmacist to assure continued competence.

Duration of this Agreement

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

Time Commitment

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

The Facility shall be responsible for:

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

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




Susan Brunet
Pharmacy Owner

Signature/ Title Facility Official
License _____

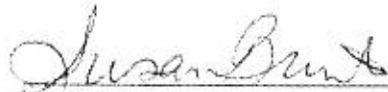
Peoples DRUG STORE, INC.

Emergency Medications Agreement

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



South Lafourche Nursing and Rehab
146 East 28th Street
Cutoff, LA 70345
Date _____



Peoples Drug Store
7869 Main Street
Houma, LA 70360
Date 4/15/19

2019 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

Type of Supply: Diesel

Name of Supplier:

Louisiana Gas Association Hotline

Contact Person: Randy Hayden

Phone # of Contact Person: 225-763-8922 or 1-800- pgasos

FAX#: 225-763-8989

E-Mail Address: www.lapropane.org OR www.louisianapropane.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?

24hrs

How long will it take to receive the delivery?

24hrs

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

Date agreement/contract ends: Continuing Since 2010

Louisiana Propane Gas Association
HotLine
1-888-LPGA-SOS

To: All Nursing Home Administrators
From: Randy Hayden, Executive Director, La. Propane Gas Association
Date: June 10, 2010
RE: La. Awarded Emergency Grant for Nursing Homes

The Hurricane season of 2005 was a learning experience for everyone in Louisiana. As the Executive Director of the La. Propane Gas Association, we learned how important it is to be prepared for emergencies. One of the lessons learned was that emergency personnel did not know how to (or could not) get in touch with propane suppliers to fuel emergency generators for power, communications towers, etc. We saw improvements during Hurricanes Gustav and Ike in 2008, but we know more can be done.

As a result of these traumatic events, the Propane Education and Research Council awarded a grant to our association to devise a communications plan for emergency response in the event of similar tragedies in the future.

We have established a toll-free, 24-hour-a-day, 7-day-a-week Hotline Number (1-888-LPGA SOS) for use by all emergency units including every hospital and nursing home in the state. Please add this number to your emergency response files and call us immediately if your facility has the need for emergency propane for cooking, heating, lighting, refrigeration, hot water heaters, emergency generators, etc. Your call will be directed to the association headquarters where we will immediately begin addressing your emergency concerns.

Again, this is a program funded by a national grant from PERC and administered by the La. Propane Gas Association in Baton Rouge. If you have any questions, please call us on our office phone at 225-763-8922 or visit our website: www.LaPropane.org.

Randy Hayden



Executive Director
La. Propane Gas Association

**Yes, I would like to participate in the
LPGA SOS Emergency Response Program!
I give permission for my company to be contacted in the
event of an emergency.**

Name Bob J. Duet

Company Name Raceland Manor NH

Date Jan 1st, 2019

Location Raceland, LA

Emergency After-Hours Numbers You May Call: (if Applicable)

Name of Contact Bob J. Duet

Home Phone (985) 856-8005

Cell Phone (985) 537-3569

Pager N/A

Name of Secondary Contact Krystal Ciccarelli

Home Phone (985) 537-3569

Cell Phone (985) 414-4336

Pager N/A

Please fax this form to (225) 763-8989.

2019 Nursing Home Emergency Preparedness Plan Survey

SUPPLY CONTRACTS COVER SHEET

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

Type of Supply: Linen

Name of Supplier:

West Port Linen

Contact Person: Eddie Lafeaux

Phone # of Contact Person: 225-268-3393, (cell) 225-218-8875

FAX#: 225-218-8885

E-Mail Address: elefeaux@westportlinen.net

Indicate where the supplies are to be delivered to;

☒ Evacuation host site

☐ Nursing home's licensed facility

☐ determined upon decision of sheltering or evacuating

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

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

24hrs

How long will it take to receive the delivery?

24hrs

Date of agreement/contract/verification: 01/22/2019

Date agreement/contract ends: Renews Annually

**WESTPORT LINEN SERVICES
EMERGENCY LINEN ADDENDUM**

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

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

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

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

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

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

West Jefferson Healthcare Center
1020 Manhattan Blvd
Harvey, LA 70058

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

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

If activated the Evacuation site addresses are as follows:

59355 River West Dr
Plaquemine, LA 70764

24320 Ferdinand St
Plaquemine LA 70769

129 Calhoun St
Independence, LA 70764

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

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

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

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

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


Signature

Westport Linen Services, LLC.

CEO
Title

1/31/19
Date


Signature

Plaza Holdings LLC.

COO
Title

1/31/2019
Date

Renewal 2020:

Signature _____ Date _____

Title _____

Signature _____ Date _____

Title _____

Renewal 2021:

Signature _____ Date _____

Title _____

Signature _____ Date _____


Title _____

Westport Linen Services
EMERGENCY LINEN SERVICE
AGREEMENT

1. This agreement is between Plaquemine Plaza Holding, 343 Third Street, Baton Rouge, La 70801 ("Facility") and Westport Linen Services, ("Westport"), a Louisiana corporation. Westport will launder linen used by Facility; Westport will launder linen subject to the following terms and conditions.
2. The term of this agreement is for an undetermined time and will not be activated until an emergency is declared. Price for washing and drying is .65 cents per soiled pound as received by Westport. Linen will be shipped back to the Facility to fold. These prices will be honored until November 2019.
3. Deliveries will be made at \$1.75 per mile driven by Westport or Facility can transport linen to and from Westport at its own cost.
4. Westport's a fuel surcharge is (5%) five percent of the weekly invoice amount.
5. Bulk carts owned by Westport are expected to be returned at end of service. Each cart will be barcoded and tracked by the Westport Tracking System and noted on each delivery's shipping manifest.
6. The first invoice will include a \$250 cart deposit for carts supplied by Westport during this emergency. This deposit is refundable after all carts have been returned. If carts are not returned to Westport, Facility will pay a replacement cost of \$600 per missing cart.
7. Invoices will be submitted weekly to Facility with payments due net 14 days from the invoice date. Facility will have 10 days from the invoice date to object to incorrect billings. If objection is made, payment for the disputed portion of the statement may be held pending a resolution. Late charges will apply 1% per unpaid invoice after 30 days from the invoice date.
8. Facility will be responsible that trash, dietary waste, needles, blades, plastic, paper, and other non-linen items are not sent to Westport. Isolation and infectious linen will be handled by Facility as required by current regulations.
9. Westport will maintain as a minimum the current standards set by The Hospital Laundry Accreditation Council, The Joint Commission and the HIPAA Act of 1996 and the security and confidentiality of any individually identifiable health information received ("Protected Health Information" or "PHI" as required by applicable laws and regulations.
10. Contact information will be maintained and updated each year on June 1st of each year by Facility and Westport. See Attachment A.


For Westport Linen Services
Co-Owner
Title

Date _____


For Plaquemine Plaza Holding, LLC
COO
Title

2/29/2016
Date

Attachment A

PLANT

510 Kornmeyer Plaza Drive

Baton Rouge, La 70806

(225) 218-8878

(225) 218-8885 FAX

Monday – Saturday 6:00AM – 5:30PM

Eddie Lefaux

(225) 268-3393 (Cell Phone)

Josh Landry

(225) 324-2209 (Cell Phone)

Brandon Harvey

(225) 788-4136 (Cell Phone)

2019 Nursing Home Emergency Preparedness Plan Survey

AUTHENTICATION

Facility Name (Print):

South Lafourche Nursing and Rehab

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

Date: 02/28/2019

Facility Administrator Name (PRINT): Bob Duet, NFA

Facility Administrator Signature: _____



Comments:
