John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Health Standards Section

September 7, 2021

SENT VIA EMAIL AND BY CERTIFIED MAIL / RETURN RECEIPT REQUESTED
7014 2870 0001 3888 7105

Maison Orleans Healthcare of New Orleans
Torrel Bridges, Administrator
1420 General Taylor Street
New Orleans, LA 70115

email: admin@maisonorleansnola.com

Re: Maison Orleans Healthcare of New Orleans
License # 2203781847
License Revocation

Dear Mr. Bridges:

The Nursing Homes Minimum Licensing Standards codified in the Louisiana Administrative Code (LAC), Title 48, Chapter 97 govern the operation of nursing home facilities. Further, all nursing homes are placed under the jurisdiction of the Louisiana Department of Health (LDH or the department) by Louisiana Revised Statutes 40:2009.1 et seq, and those statutes also control nursing home licensing. Pursuant to La. R.S. 40:2009.11, no person shall operate a nursing home in violation of any provision of R.S. 40:2009.1 through 40:2009.11 or any other state or federal statute, regulation, or any department rule adopted pursuant to the Administrative Procedure Act which govern the administration of nursing home care.

Pursuant to La. R.S. 40:2009.6 (B), a license may be revoked for any of the following reasons:

1. Cruelty or indifference to the welfare of the residents
2. Misappropriation or conversion of the property of the residents
3. Violation of any provision of R.S. 40:2009.1 through 2009.11 or of minimum standards, rules and regulations, or order of the department promulgated thereunder
4. Any ground upon which an application for a license may be denied as prescribed in Subsection A of R.S. 40:2009.6. These grounds include the following:
    a. Failure to meet any of the minimum standards prescribed by the department under R.S. 40:2009.4(A)
    b. Conviction of a felony, as shown by a certified copy of the record of the court of conviction of the applicant, or, if the applicant is a firm or corporation, conviction of any of its members or officers of a felony, or conviction of the person designated to manage or supervise the home of a felony
    c. If the supervisor of the home is not reputable
    d. If the staff or a member of the staff is temperamentally or otherwise unsuited to for the care of the patients in the home.

Pursuant to Section 9717 of the above referenced Title and Chapter of the LAC, the department may also revoke a license where there has been substantial noncompliance with the LAC requirements in accordance with the nursing home licensing law. Specifically, in accordance with Section 9717 (E), a nursing facility license may be revoked for fourteen, non-exclusive, reasons set forth therein.

General Facts

Hurricane Ida (Ida) was approaching the State of Louisiana with imminent landfall around Port Fourchon, Louisiana, predicted on or about August 29, 2021. Due to this impending landfall, and the implications to the infrastructure of Southeast Louisiana as a result thereof, many nursing home facilities found it necessary to evacuate further inland to sheltering sites. The facts bear out that your facility did, in fact, evacuate to an evacuation site (hereinafter referred to as the "site") located at 129 Calhoun Street in Independence, Louisiana 70443.

On Friday, August 27, 2021, members of the Louisiana Department of Health, Office of Public Health (OPH), conducted an "Environmental Health Assessment" on the site. This document is attached as "Exhibit A" and is made a part of this correspondence. In noting some of the highlights of this assessment, it appeared that the current census was 23 residents, all over the age of 60, and an allowed capacity was self-stated as 600. The assessment indicated that masks were available and that a system for screening for COVID-19 was part of the process for occupancy of the site. The assessment noted adequate space per person, activated municipal power, with backup generator, adequate drinking water and food.

On Friday, August 27, 2021, well before landfall of Ida, Surveyor #1 with the LDH Health Standards Section (HSS) presented at the site to conduct a site visit to ensure regulatory compliance with the nursing home facility licensing regulations as a hurricane evacuation site. The surveyor notes worksheet is attached hereto as "Exhibit B" for reference. During this visit, Surveyor #1 was met by Ms. Donise Boscareno, who represented herself as an Administrator and Director of Operations. Ms. Boscareno represented that the owner of the seven nursing facilities, (1) South Lafourche Nursing and Rehabilitation Center (South Lafourche), (2) Maison De'Ville Nursing Home of Houma, (3) River Palms Nursing and Rehabilitation Center, (4) Maison Orleans Healthcare of New Orleans, (5) Maison De'Ville Nursing Home of Harvey, (6) West Jefferson Healthcare Center of Harvey, Louisiana, and (7) Park Place Healthcare, LLC of Gretna (Park Place) instructed her to evacuate all seven of the nursing home facilities through an "order of evacuation". The plan was to begin with three homes totaling approximately 365 residents. During the August 27, 2021 visit of the site, Surveyor #1 noted around 350 air mattresses ready for occupancy and was informed that over 700 mattresses and linens were available. Ms. Boscareno represented that the proposed "order of evacuation" ordered that there would be an initial evacuation of the first three homes of South Lafourche, Maison De'Ville Nursing Home of Houma, and River Palms Nursing and Rehabilitation Center, and then re-assess the need to evacuate the remaining homes. At that time, Ms. Boscareno represented that Park Place Healthcare, LLC of Gretna may not need to evacuate. Ms. Boscareno stated each facility was bringing their own staff and that administrative staff would serve as "back up" staffing. In regards to food, Ms. Boscareno informed Surveyor #1 that a local church was going to provide cooked food on-site and the church would provide storage as well. In regards to infection control, Ms. Boscareno represented that there were not any COVID-19 infections. It was stated that laundry would NOT be done on-site but that a contractor would provide such services. Allegedly, residents were told to pack for 5 days. In general, Surveyor #1 noted what appeared to be ample linens, diapers, and wipes. Surveyor #1 noted that there were

bathroom facilities onsite, including toilets and showers. Surveyor #1 also noted that portable toilets were also set up by the facilities for use by residents and staff. Ms. Boscareno represented to Surveyor #1 that supplies had been inventoried two weeks ago and there was enough to easily take care of 700 residents for seven days on hand. At the time of this LDH-HSS onsite survey, the site was operating under regular power, water and sewage. Surveyor #1 also observed that there were large quantities of bottled water available on-site. Surveyor #1 spoke with the Inspector of Services for the city who was ensuring that services were in working order at the site. Surveyor #1 also heard that the State Fire Marshal was at the site as well.

On Saturday, August 28, 2021, one day prior to landfall of Ida, Surveyor #2 with the LDH-HSS went to the site for a visit to ensure regulatory compliance with the nursing home facility licensing regulations. Surveyor #2 went to the site due to, among other issues, reports that a large number of individuals were appearing at the site. For reference, the Surveyor Notes Worksheet of Surveyor #2 as it relates to Maison Orleans Healthcare of New Orleans is attached as "Exhibit C" to this document. Upon arrival, Surveyor #2 held an entrance conference with Donise Boscareno, who represented as the Director of Operations at the site. At that time, it was determined that the number of residents transferred, or to be transferred, from Maison Orleans Healthcare of New Orleans to the site was 182 residents. During the onsite LDH-HSS Surveyor #2 again noted that Ms. Boscareno stated that there were no known COVID-19 positive residents or staff at the site visit, as Ms. Boscareno previously indicated to Surveyor #1 one day prior. Ms. Boscareno represented that personal protective equipment (PPE) supplies were readily available including masks, gloves, and hand sanitizer. Surveyor #2 noted that the site was operating on municipal power at the time but that a generator was available. The site still had access to city water and the sewer system was functioning. Also, it was noted that there was a water tank on the grounds. Surveyor #2 noted that she observed adequate food and supplies. She noted that each facility brought their own medication carts and appeared to have medical records of residents available. Surveyor #2 noted that there did not appear to be any staffing issues at the moment. During this visit, Surveyor #2 also observed residents and residents' "rooms" on the site. In pertinent part, Surveyor #2 noted that beds were placed in a large room and that staff and residents were wearing masks. Observation revealed a total of three buildings that were being utilized as shelter for residents. Interviews with residents and staff did not indicate any major issues at this time. Ms. Boscareno stated that the Fire Marshal had previously visited the site; the building was privately owned and did not have an occupancy capacity. However, the Louisiana State Fire Marshal report for the site, which is dated September 1, 2021 and discussed below, indicated that the site had a capacity of 1,665 persons. At this time, Surveyor #2 noted that Ms. Boscareno expected 843 residents to be housed at the site. Ms. Boscareno stated that staff of your facility visited the site two weeks prior to inventory food and supplies.

On Monday, August 30, 2021, Ida passed through the Baton Rouge area at around 1:00 a.m. At around 6:00 that morning a team member at the State Emergency Operations Center (EOC) was approached by a fellow EOC team member who reported that she had received a report from Tangipahoa Parish where the site was located, indicating that it had "taken on" 8 inches of water. This information immediately resulted in the LDH team initiating action to obtain proper situational awareness. After certain EOC team members were able to connect, a conference call was held with the "action items" that the EOC team should verify / validate the information received, identify potential mitigation, and determine what other "consequence management" activities may be needed. As indicated in text communication traffic (see "Exhibit D"), the LDH Region 9 Medical Director, was extremely concerned about the situation at the site. She made mention that over 800 residents were in the building and that 3-7 inches of water remained at the time of the message.

The Region 9 Medical Director noted that the generators that powered Oxygen (O2) concentrators were not working and that residents were sleeping on floor mattresses. However, as indicated in text messages sent later that morning, the site was apparently still communicating that the situation was "fine", and that some residents were moved to other buildings.

On that same day, LDH-HSS Section surveyor #3 made an onsite visit to the site to ensure regulatory compliance with the nursing home facility licensing regulations. This was the first LDH-HSS visit post-landfall of Ida. Surveyor #3 arrived at approximately 4:30 in the afternoon on August 30, 2021 due to receipt of a call from the LDH-HSS Field Office Manager indicating possible regulatory non-compliance at the site. The surveyor notes worksheet of Surveyor #3 is attached as "Exhibit E" to this correspondence and is made a part hereof. As referenced in "Exhibit E," upon arrival Surveyor #3 was met by a Certified Nurse Assistant (CNA) who stated that Surveyor #3 needed to go inside the site as this "was not right." The CNA indicated that residents should not be treated like this and that some residents had not been taken to their dialysis appointments. Upon entering the first building on site, Surveyor #3 was directed to Ms. Boscareno as the Director of Operations. Ms. Boscareno indicated to Surveyor #3 that the site had 838 residents currently. It was also indicated that 24 residents required dialysis, 3 residents were trach dependent, and 6-8 residents were bariatric patients (around 600 pounds and needing 3 staff to assist each bariatric patient). Ms. Boscareno confirmed that all seven facilities referenced above evacuated to this site. Ms. Boscareno again indicated that each resident had seven days' worth of medication, and that the site had transport vans to transport dialysis patients. Ms. Boscareno confirmed that trash had tripled since the arrival of the residents at the site, and they had no immediate plans to return to their home facilities. Ms. Boscareno confirmed that the facility had issues with water intrusion, claiming that the buildings only had approximately 1 inch of water, in contradiction to earlier reports of 3- 8 inches of water, during the storm and offered that the evacuation was set for a Category 2 hurricane. It appeared, that while onsite staff of the site became aware of the strengthening of Ida and a shift of Ida's track. At this time, the site was running on generator power, had shower access, and access to portable toilets. Ms. Boscareno stated that the site still had needed supplies for all residents, including food. Ms. Boscareno indicated that the site had some staffing issues during the night as staff transportation was blocked due to storm damage. In regards to infectious disease protection, Ms. Boscareno indicated that staff and residents could no longer properly social distance due to water intrusion into two of the three buildings. After this initial entrance discussion, Surveyor #3 "toured" the three buildings located at the site to make observations. A summary of Surveyor #3's observations are contained in "Exhibit E," but some observations are worth noting herein. In building #1, residents were observed in various states of clothing, one resident was on a cot with water close to intruding on his personal clothing. Nearby, one CNA was observed changing a resident's diaper without observing any privacy. Piles of dirty linens were observed in this room, residents were not wearing face masks, the building smelled strongly of urine and dampness, and was stuffy. In building #2, it was immediately clear that residents were overcrowded and not socially distanced (mattresses were placed less than a foot apart). Only 5 residents were wearing masks and residents were again in various states of dress. This building also smelled strongly of urine and was slightly warm and stuffy. Finally, in building #3, residents' bedding was again observed to be less than one foot apart with only 3 residents wearing masks, and overcrowding was apparent. Residents again were in various states of dress, the building smelled strongly of urine and was slightly warm and stuffy. During the rounds, Surveyor #3 stated that staff were overheard stating the situation was bad, staff were neglected, and residents were neglected. Based on the this onsite visit, a team of LDH employees were set to return the next day on August 31, 2021, at 9:00 a.m.

Also, on August 30, 2021, LDH-OPH conducted another "Environmental Health Assessment" at the site. As can be seen from the attached assessment in "Exhibit A", the situation at the site had clearly began to deteriorate in the opinion of the LDH-OPH sanitarian. The assessment indicated that the site no longer had adequate ventilation or adequate space per person. The municipal power supply was no longer operational. Although an electric generator was working, a backup power source was not available. The assessment indicated that there were not an adequate number of cots/beds/mats for the occupants nor was there an adequate supply of bedding. It is noted that the facility requested 500-600 additional cots to make it easier for residents as they recognized most were sleeping on the floor and the site acknowledged that laundry service was needed. However, the assessment still indicated adequate food and water. The assessment closed with a recognition that garbage and linens were piling up, acknowledgement that 3 patients were transported to the hospital via ambulance, and that the facility requested help in placing 15 trach patients and bariatric patients so they could receive better care.

On Tuesday morning, August 31, 2021, LDH-HSS Surveyor #4 arrived to the site for a visit as planned the previous day. The Surveyor Notes Worksheet from Surveyor #4 is attached as "Exhibit F" and made a part of this document. Upon arrival at the site, Surveyor #4 made contact with Ms. Boscareno, Director of Operations. Ms. Boscareno again confirmed that she was in charge of the operations, and that all seven nursing facilities had been evacuated to this site. After Ms. Boscareno was called away for an urgent need, Surveyor #4 conducted a tour of the site, which showed that the situation had continued to deteriorate. Surveyor #4 observed overcrowded conditions with bedding mere inches apart. Surveyor #4 observed pallets of supplies close to the area of water intrusion from Ida. The floor in that area was still puddled with water and smeared with dirt and mud. A smaller partitioned area of about 20 cots was for the locked unit for behavioral health residents. Surveyor #4 indicated that the smell of urine was now so strong it hit her sense of smell through her mask. Bedding in this area was placed in about a 40 foot by 60 foot area with aisles around the outside. The sheets of the bedding had visible signs of dirt from being walked on by residents / staff. Surveyor #4 indicated that the aisles were "grimey" and dirt scratched beneath her feet as she continued her tour. One resident indicated she had not had a shower or bath in 4 days and had not changed clothes since arrival. It was observed that portions of food were being underserved at this point. Surveyor #4 continued her tour into the largest area of the site where the smell of feces and urine was powerful even with a mask barrier. A female resident was sitting on the floor by the door with only a diaper and t-shirt. Again, overcrowding was observed with bedding mere inches away from each other. At this point, Surveyor #4 noticed a male resident in only a t-shirt and diaper full of feces. Another male resident was observed laying on his floor mattress with only a diaper on and without a sheet. Another male resident was observed laying on his floor mattress naked without any sheet for cover. Surveyor #4 observed a female resident softly calling for help in this large facility where staff could not hear her nor did she have any signaling mechanism. During this part of the tour, Surveyor #4 observed staff sitting out of view of residents while she could hear a patient calling out for help without any staff response whatsoever.

After completion of the tour, Surveyor #4 references in her notes worksheet a meeting conducted with the Fire Marshal and Office of Public Health Inspectors, whereby it is indicated that, certain "conditions" would have to be met for continued operations at the site. At the conclusion of this meeting, Surveyor #4 contacted her superiors at the LDH-HSS State Office in Baton Rouge. She relayed her observations and the meeting results. Surveyor #4 was instructed by her superiors to continue the site visit for all seven of the facilities at the site. As Surveyor #4 attempted to continue her site visit in order to assure the health and safety of these most fragile residents, the facility administrator approached Surveyor #4 informing her that Mr. Bob Dean, owner of all seven

facilities, wanted to speak with her. Surveyor #4 professionally greeted Mr. Dean and informed him of her credentials. At this point, the individual identified as Mr. Dean began aggressively asking Surveyor #4 questions. When Surveyor #4 responded that she did not know the answers to his questions, Mr. Dean started yelling over and over "Who sent you?" cutting her off from her attempts to answer. Even after telling Mr. Dean that he should contact LDH-HSS management, he continued to berate Surveyor #4 by continually yelling, "Who sent you?" When Surveyor #4 responded one last time that she would not answer that question, Mr. Dean informed her to "Get off my property! Now!" At that point, Surveyor #4 gathered her belongings and professionally exited the site.

It must also be noted that beginning on August 30, 2021, Mr. Bob Dean began a campaign of threats, intimidation and attempts at interfering with LDH's ability to properly assess the site and assure the safety of the residents at the site. This campaign included a phone call referenced above with Surveyor #4. In addition, Mr. Bob Dean sent threatening text messages to a recently retired LDH-HSS Deputy Assistant Secretary (see "Exhibit G"), who is still working with LDH assisting with emergency preparedness and response. This exhibit also contains text messages sent to another LDH employee who attempted to professionally respond to Mr. Bob Dean only to be met with nonsensical text messages devoid of any basis in reality or fact. It goes without saying that the content of the various text messages from Mr. Bob Dean was vile, repulsive and lacking any professionalism or basis in fact. Mr. Bob Dean also left a voicemail for another LDH employee, which indicated that if anyone from LDH stepped foot on his evacuation site in Independence, Louisiana, he would have him or her arrested for trespassing. Also, on August 30, 2021, LDH reached out to representatives of Mr. Bob Dean to discuss reports that were being received from the facility and the need for possible assistance. A representative of Mr. Bob Dean informed an LDH employee that needs were being met, residents were being cared for and there were adequate supplies on hand. Due to the conflicting reports from the staff on site at the shelter, and the representatives of Mr. Bob Dean, LDH sent team members to the shelter site to determine if the facility had addressed the needs of the residents.

On August 31, 2021, the LDH-OPH team conducted yet another "Environmental Health Assessment" at the site. This assessment is attached to this correspondence, and made a part thereof as "Exhibit A." Again, in looking at the highlights of the assessment, it underscores that conditions had continued to deteriorate at the site. For example, the assessment indicated that the site was crowded, not adhering to spacing requirements, smelled bad, and did not have adequate ventilation. It is also indicated that adequate PPE was available, including masks, although masking of residents was not consistently taking place at the site. The assessment again pointed out that laundry service had just started, garbage was still a problem, there was not an adequate number of cots/beds/mats/ bedding, and that overcrowding was an issue. Further, at this time, OPH participated in an inspection with State Fire Marshal Representatives as well as Surveyor #4 of LDH-HSS, prior to her being asked to leave the premises. It was during this inspection that notations were made that some patients had expired and that the coroner was onsite.

On the next day, September 1, 2021, the LDH entered the facility, with support from various state and local entities, to begin rescuing the residents by moving them to safe areas where their needs could be fully met. The vast majority of the residents immediately transitioned to other nursing homes or shelters in the Bossier and Alexandria areas. The rescued residents in Bossier and Alexandria immediately began receiving assessments upon their arrival and linkage to nursing homes most appropriate to meet their needs with the provision of freedom of choice.

On September 1, 2021, another "environmental health assessment" was conducted by LDH-OPH at the site. This assessment is attached as "Exhibit A", and is included and made a part of this correspondence. The highlights of this assessment were that, once again, the site was noted as not having adequate ventilation or adequate space per person, and smelled bad. The assessment noted that the laundry service was catching up on linens but garbage still needed to be emptied.

On September 1, 2021, Surveyor #3 again went onsite to the shelter location. The Surveyor Notes Worksheet from Surveyor #3 is attached as "Exhibit H" and made a part of this document. In building #1 there were 35 residents observed lying on mattresses on the floor. Residents were observed in various states of dress and some residents were wearing masks. In building #2, 95 residents were observed in the room. Residents were observed in various states of dress and no residents were wearing facemasks. Surveyor #3 also observed the behavior unit. The LPN in that unit stated that two residents had to be sent to the hospital related to behaviors, one resident got into a fight with staff and one resident got into a fight with another resident. Surveyor #3 stopped observing to assist with rescue of residents from the shelter site. On September 2, 2021, Surveyor #3 was at the shelter site to assist with the continued rescue of the residents of the seven nursing facilities.

On September 1, 2021, Surveyor #4 again went onsite to the shelter location. The Surveyor Worksheet from Surveyor #4 is attached as "Exhibit I" and made a part of this document. Surveyor #4 was told that LDH staff, the National Guard, and the local sheriff's office were forming a strike team to rescue and remove the residents from this shelter location. Surveyor #4 began a tour at 12:52 P.M. She observed the same layout of beds as she did on August 31, 2021. There was still a strong smell of urine. Surveyor #4 observed a female resident completely nude with no cover. The other residents were in various stages of undress. One resident was sweating and visibly struggling to breathe and hollering out for help. The staff did not acknowledge him. Surveyor #4 asked the staff who was this resident's nurse three times, before anyone admitted to being his nurse.

Finally, on September 1, 2021, the Office of State Fire Marshal issued an "inspection report", attached as "Exhibit H", in relation to the site. While the inspection report speaks for itself, some of the highlights are worth mentioning. The Fire Marshal reported that means of exits and egress were blocked throughout the facility, that the site was deficient in "fire watch", that pallets of flammable liquids were present in the area and close to administrative offices, propane tanks were present where residents were located, and the site was not adhering to minimum square footage per person with sleeping mattresses directly against adjacent mattresses. Upon reading the report in detail, it appears that plans to change parts of the site from a warehouse to an emergency evacuation shelter for a nursing home may have not been submitted to the Fire Marshal. The Fire Marshal also noted that some areas used for sleeping and housing of residents were not suitable due to missing drop ceiling tiles and rusted sprinkler system heads.

Application of Law

As mentioned above, pursuant to La. R.S. 40:2009.6, a nursing facility license may be revoked for cruelty or indifference to the welfare of the residents. Notwithstanding the decisions and plans for evacuation made by Maison Orleans Healthcare of New Orleans, and put into operation before the landfall of Hurricane Ida, the actions of this facility in the days following landfall, as mentioned above, clearly establish cruelty or indifference to the welfare of the residents. On Monday, August 30, 2021, it should have been clear to any reasonable individual that the conditions at the site were beginning to deteriorate. Allegedly, on August 30, 2021, the shelter site reached out to the EOC

for assistance with placing 15 trach patients and bariatric patients at another location; however, they never reached out for assistance for the hundreds of remaining vulnerable residents. Hurricane Ida caused damage to the power grid feeding the site and caused water intrusion; however, no request for assistance came from this facility or site. The Director of Operations at the site, Ms. Boscareno, had acknowledged that the amount of trash had tripled since their arrival and willingly admitted that there were no immediate plans for the residents to return to their home site. Upon arrival at the facility, the site's very own staff called into question the care the residents were receiving at that time. The Director of Operations admitted that their evacuation site was prepared to weather a strike from a Category 2 storm and it is noted that Ida was much stronger than a Category 2 storm. The Director of Operations knew that water intrusion was an issue, although she alleged that the site only took on 1 inch of water in direct contradiction to reports received at the State EOC of approximately 3-8 inches of water, that was leading to crowded, and potentially unsanitary, conditions. The Director of Operations conceded and pointed out that staffing was an issue on the previous night of August 29, 2021; however, the facility still continued on without notice to LDH or reaching out for support. In all three buildings housing residents, residents were in various states of dress and piled close together on cots or floor mattresses. The buildings were beginning to smell strongly of urine and dampness, masking was all but eliminated among the residents, and temperatures were beginning to rise; however, still no request for help came from the facility or site. The facility's very own staff even understood the gravity of the situation and felt that staff and residents were being neglected.

If the message was not clear on Monday, August 30, 2021, it should have been clear on Tuesday, August 31, 2021. Without restating what is mentioned in the fact section above, the situation at the site was clearly and rapidly deteriorating. While this was going on, the facility's owner, rather than reaching out for help in regards to the situation from state regulators, was orchestrating a campaign with the goal of preventing a proper assessment of what the situation was at the site via threats, harassment and intimidation. This type of conduct, while also possibly violating the right of the resident to receive adequate and appropriate health care and protective and support services, is clearly demonstrative of indifference to the welfare of the residents.

Finally, even as late as the date of the LDH beginning rescue efforts on September 1, 2021, the "Environmental Health Assessment" ("Exhibit A") noted that the site was not adhering to the directives of the State Fire Marshal regarding resident spacing, and other Fire Marshal Requirements described above.

According to LAC Tit. 48.I. 9717, a nursing facility license may also be revoked for failure to be in substantial compliance with the nursing facility licensing laws, rules, and regulations or for failure to be in substantial compliance with other required statutes, law, ordinances, rules, or regulations. At the time of a natural disaster or emergency, nursing facilities are expected to adhere to its individualized emergency preparedness policies and procedures to ensure the health, safety, and welfare of all residents. This is memorialized in the Residents "Bill of Rights" which states that residents have the right to receive adequate and appropriate health care and protective and support services and is one of the many reasons an emergency preparedness plan must be activated and implemented properly. An emergency preparedness plan is more than just a form of paper compliance. The implementation must accomplish the goals it is designed to meet. Some of those goals include the delivery of essential care and services to residents, the procedures for ensuring that all residents have access to licensed nursing staff, and that services are provided, during all phases of the evacuation, including transporting of residents. As evidenced by the narrative above and the attachments, it is clear that the facility failed in this regard. Again, instead of reaching out

for help and collaborating with LDH for assistance in rescuing the vast majority of residents, the owner thwarted all LDH efforts to assist. The failure to reach out for total help in rescuing the residents from this site, as well as demanding that LDH assistance leave the site, demonstrates failure to maintain substantial compliance with the nursing facility licensing regulations referenced above. The site managers knew that help was available as noted in one "Environmental Health Assessment" report (See "Exhibit A"). Site manager staff asked LDH-OPH for assistance with cots and with the trach and bariatric patients on site.

According to LAC Tit. 48. I. 9717, a nursing facility license may be revoked for failure to protect a resident from a harmful act of an employee. This can include abuse, neglect, exploitation, etc. While some of the employees of this facility may have tried to assist residents in these conditions, based on the narrative above, and the statements/admissions against interest by the staff residents of this facility were not protected from neglect at this site. It is clear that the situation post-landfall was quickly deteriorating from one day to the other, and drastic measures, as undertaken and attempted by LDH, needed to be done. Your facility failed to recognize the warning signs, notify LDH of this neglectful situation (or high likelihood of neglect), and work with LDH to remedy the situation collaboratively.

According to LAC Tit. 48.I. 9717, a nursing facility license may be revoked for failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof. While the management team of the facility at the site may have notified the EOC of concerns with 15 residents, it should have notified LDH of suspected neglect of the hundreds of remaining residents. On August 30-31, 2021, post-landfall, the situation was clearly deteriorating to the point where surveyors could smell feces and urine, residents were in various states of dress, some even lacking clothing, with diapers full of feces, and general overcrowding. Some residents implored staff for help to no avail. At that stage, any reasonable person would have reached out for help with a simple call. The facility had a duty, under penalty of license revocation in accordance with the LAC, to make that contact for help.

According to LAC Tit. 48.I. 9717, a nursing facility license may be revoked for knowingly making a false statement, or providing false, forged, or altered information or documentation to LDH employees or to law enforcement in matters under investigation by the department. As can be seen from the text messages shown in "Exhibit G", an individual representing / identifying himself as Mr. Bob Dean appears to be providing false statements and information to various LDH employees as they were trying to conduct an investigation into the conditions at the site. These text messages, while being harassing, threatening and unprofessional, were also not true.

According to LAC Tit. 48.I. 9717, a nursing facility license may be revoked for failure to comply with all reporting requirements in a timely manner as required by the Department. After LDH took steps to rescue the residents of this facility, and others, from the site and gain control of the situation, LDH representatives requested various pieces of information from the facility, including census and evacuation data. The facility was given a reasonable time by which to respond and, to the best of LDH's knowledge, they have failed to respond.

According to LAC Tit. 48. I. 9717, a nursing facility license may be revoked for failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview facility staff or residents individually as necessary to conduct a survey. The owner of the facility, Mr. Bob Dean was on the telephone with his representatives at the site and asked to speak to the LDH-HSS Surveyor #4 on Tuesday, August 31, 2021. This surveyor was attempting to fully investigate the

conditions at the site by conducting observations and interviews. A phone was handed to Surveyor #4 with Mr. Bob Dean on the other end. The specifics of the conversation is referenced above but Mr. Dean unequivocally ordered this LDH-HSS surveyor to immediately leave the site. Because of this, the LDH-HSS on-site investigation was terminated. While such conduct is in violation of applicable regulations, it is simply inexcusable in a situation involving a hurricane evacuation where neglect is apparent, deaths have happened, and residents desperately need 24 hour per day medical care. This action, in and of itself, along with the other text messages in "Exhibit G", are enough to warrant revocation in this matter.

According to LAC Tit. 48.I. 9717, a nursing facility license may be revoked for failure to allow, or refusal to allow, access to records by personnel authorized by LDH. As mentioned above, the termination of the LDH-HSS investigation prevented LDH to access records that it may have determined necessary for even swifter action than that taken by LDH in rescuing the residents from the site. Further, in the aftermath of the rescue, LDH has requested additional documents from the facility that it has not received.

For all the reasons stated in this letter, LDH is revoking the license to operate Maison Orleans Healthcare of New Orleans.

In accordance with LAC Tit. 48. I. 9719 C.3.a. the secretary of the department has determined that the violations of the nursing facility pose an imminent or immediate threat to the health, welfare or safety of a participant; as such, the imposition of the license revocation is hereby **IMMEDIATE** and shall be enforced during the pendency of the administrative appeal. Please see administrative appeal rights below.

LDH is also reserving its right to supplement this license revocation letter as more information becomes available.

Right to Appeal

You may request an Administrative Reconsideration of this decision to revoke your facility's license. The request for Administrative Reconsideration must be in writing and must be forwarded to the following address:

IDR Program Manager
Health Standards Section
P. O. Box 3767
Baton Rouge, LA 70821-3767

Your request for Administrative Reconsideration must be received by this office within ten (10) calendar days from receipt of this notice letter and must include any documentation that you think demonstrates this determination was made in error. If a timely request for the Administrative Reconsideration is received by his office, an Administrative Reconsideration will be scheduled and you will be notified of the time and place. The reconsideration decision shall be made on the basis of documents and shall include the statement of deficiencies and all documentation the facility submits to the department at the time of its request for reconsideration. Further, oral presentations can be made by the department spokesmen and facility spokesmen at the time of the Administrative Reconsideration. The department shall notify the facility, in writing, of the results of the Administrative Reconsideration.

You also have the right to an Administrative Appeal regarding this decision. If you wish to request an appeal of the administrative decision to revoke the nursing home license, please send a written appeal request within thirty (30) calendar days of receipt of the results of the Administrative Reconsideration.

Your request for an Administrative Appeal must be sent to:

Division of Administrative Law
P. O. Box 4189
Baton Rouge, LA 70821
1020 Florida St.
Baton Rouge, La 70802

A copy of your request for an Administrative Appeal should be sent to:

LDH Bureau of Legal Service
P.O. Box 3836
Baton Rouge, LA 70821-3836
Phone (225)342-1128
Fax (225)342-2232

You may choose to waive or forego the right to an Administrative Reconsideration and proceed directly to an Administrative Appeal. If you choose this option, you must file a written request for an Administrative Appeal within thirty (30) calendar days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the Division of Administrative Law at the address cited above.

Your request for an administrative appeal must specify in detail reasons why the appeal is lodged and why the nursing home feels aggrieved by the action of the Department. **Correction of the violations shall not be a basis for the administrative appeal.**

Failure to submit a timely request for an Administrative Appeal will result in the Department's determination being final, without further administrative or judicial recourse.

If you choose not to appeal this determination, this letter is your notification to surrender the nursing home license to the Department. If your plan is to surrender the nursing home license, you must provide written notification of such to the Department and include a plan for the safe and orderly relocation of residents. You must contact Catherine Williams, LTC Supervisor at 225-342-2795 to obtain the elements which shall be contained in the relocation plan.

You will also need to inform the Department of who will be custodian of medical records and provide a plan for the disposition and storage of medical records of your nursing home facility. The custodian of medical records must provide physical and environmental security that protects the medical records against fire, water, intrusion, unauthorized access, loss and destruction as well as notification of the address of where the medical records will be stored.

Sincerely,

Tasheka Dukes, R.N.
Deputy Assistant Secretary Health Standards

Cc: Medicaid Director