

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 02/20/23</p> <p>Facility Number: 000180 Provider Number: 155282 AIM Number: 100274190</p> <p>At this Emergency Preparedness survey, Good Samaritan Society Northwood Retirement Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 107 certified beds. At the time of the survey, the census was 56.</p> <p>Quality Review completed on 02/27/23</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:</p>			E 0000	<p>K0000 Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed solely because it is required by the provisions of the Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. Completed 03/08/23</p>		
E 0004 SS=C Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Edwin Onwukegwu

Administrator

03/13/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>§494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was 12/15/21. Based on interview at the time of review, the Maintenance Director said the Disaster Plan has not been reviewed and updated within the past twelve months.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p>			E 0004	<p><b>E0004 Emergency Preparedness Plan, Reviewed and Updated Annually CFR 483.73a</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) Emergency Management Preparedness (Manual) was reviewed and <b>updated on 03/02/23</b></p> <p>2) Maintenance Director and or designee will schedule annual reviews of the Emergency Preparedness Plans (Manual), with the next annual review scheduled <b>to begin on 01/02/24</b></p> <p><b>Assurance of On-Going Compliance</b></p> <p>1) Facility administrator and maintenance director will ensure that emergency preparedness gets updated annually. <b>Beginning 01/02/24</b></p> <p>2) Audits will be conducted quarterly by the Maintenance Director or designee; all findings will be discussed in QAPI meeting to assure compliance <b>Beginning 06/02/23</b></p>		03/08/2023
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)</p> <p>Plan Based on All Hazards Risk Assessment</p> <p>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing</p>			E 0006	<p><b>E0006 AHRA – All Hazard Risk Assessment – EMP Drills CFR 483.73 (a) (1)-(2)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73</p>		03/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
E 0009 SS=F Bldg. --	<p>emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, facility-based and community-based risk hazards were addressed in the plan, however, there was no facility-based and community-based risk assessment utilizing an all-hazards approach available. Based on interview at the time of record review, the Maintenance Director said he knows the facility has a risk assessment for the Disaster Plan but it could not be found.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4) Local, State, Tribal Collaboration Process §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4),</p>		<p>standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility AHRA (All Hazard Risk Assessment) was <b>updated on 0/03/2023</b></p> <p>2) The administrator updated the Emergency Preparedness Plan (manual) to include any combination of (2) Community Base Drills or (2) two Facility Based Drills and (1) one Tabletop exercise and training annually <b>Completed on 03/03/2023</b></p> <p>3) The administrator, Maintenance Director and or designee will conduct drills throughout the year <b>beginning 03/03/2023</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Audits will be conducted quarterly by the Maintenance Director or designee, all findings will be reviewed and discussed in QAPI meetings to assure compliance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>§494.62(a)(4)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]</p> <p>(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. *</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.</p> <p>Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants.</p>		E 0009	<p><b>E0009 Local, State, Tribal Collaboration Process CFR 483.73 (a) (4)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility updated the emergency preparedness to</p>		03/08/2023	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0013 SS=C Bldg. --	<p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, no documentation was available which included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of review, the Maintenance Director acknowledged there was no cooperation and collaboration process in the Disaster Plan available.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p>				<p>include documentation that will include cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness official's efforts to maintain an integrated response during a disaster or emergency situation <b>On 03/02/23</b></p> <p>2) Facility administrator and maintenance director will ensure that emergency preparedness gets updated annually to incorporate documentation to reflect corporation and collaboration of facility with external emergency preparedness official which will help integrate quick response during a disaster.</p> <p><b>Beginning 01/02/24</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>Audits will be conducted quarterly by the Maintenance Director or designee, all findings will be reviewed and discussed in QAPI meetings to assure compliance.</p>		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was 12/15/21. Based on interview at the time of review, the Maintenance Director said the Disaster Plan's policies and procedures has not been reviewed</p>			E 0013	<p><b>E0013 Development of EP Policies and Procedures CFR 483.73 (b)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility updated facility policies and procedures emergency preparedness <b>On 03/03/23</b></p> <p>2) Facility administrator and maintenance director will ensure that facility policy and procedure for emergency preparedness is updated annually. <b>Beginning 01/02/24</b></p>		03/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 0018 SS=C Bldg. --	<p>and updated within the past twelve months.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility]</p>		<p><b>Assurance of On-Going Compliance</b></p> <p>1) Audits will be conducted quarterly by the Maintenance Director or designee, all findings will be reviewed and discussed in QAPI meetings to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Maintenance Director confirmed there was no system to track the location of on-duty staff and</p>	E 0018	<p><b>E0018 Procedure for Tracking of Staff and Patients CFR 483.73 (b) (2)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility updated emergency preparedness to reflect procedure for Tracking of Staff and Residents <b>On 03/03/23</b></p> <p>2) Facility administrator and maintenance director developed a system to track staff on duty and resident in-shelter in place during a disaster or emergency situation. <b>On 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Audits will be conducted</p>		03/08/2023		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0023 SS=C Bldg. --	<p>sheltered residents in the event of an emergency in the available plan.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4)</p> <p>Policies/Procedures for Medical Documentation</p> <p>§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.</p>				<p>quarterly by the Maintenance Director or designee, any findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:</p> <ul style="list-style-type: none"> <li>(i) Preserves patient information.</li> <li>(ii) Protects confidentiality of patient information.</li> <li>(iii) Secures and maintains the availability of records.</li> </ul> <p>*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review. Based on interview at the time of record review, the Maintenance Director confirmed the facility's Disaster Plan does not include a system</p>			E 0023	<p><b>E023 Policies/Procedures for Medical Documentation CFR 483.73(b) (5)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <ul style="list-style-type: none"> <li>1) The facility added existing system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability to the EMP On 03/03/23</li> <li>2) Facility administrator and maintenance director will ensure that the system of medical documentation that preserves</li> </ul>		03/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E 0025 SS=C Bldg. --	<p>of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must</p>			<p>resident information, protects confidentiality of resident information, and secures and maintains the availability are always available to all staff/residents for when needed</p> <p><b>Beginning 03/03/23</b></p> <p>3) Maintenance director educated on the already existing system of medical documentation back-up EMAR for emergency use</p> <p><b>On 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Administrator or designee will audit EMP every 6monthx2 to ensure that medical system EMAR remain in the emergency binder, findings will be discussed in QAPI meeting to assure compliance.</p>			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCl patients.</p> <p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This</p>	E 0025	<p><b>E0025 Arrangement with Other Facilities CFR 483.73 (b) (7)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible</p>		03/08/2023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0029 SS=F Bldg. --	<p>deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation of arrangements with other facilities was not available for review at the time of the survey.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain</p>				<p>allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) Facility added existing policy and procedures for transfer of residents to other LTC facilities in EMP on 03/03/23</p> <p>2) Facility administrator, maintenance or designee will continue to ensure that facility policy and procedure for residents transfers to other LTC facilities in case of facility cessation remains in the binder for easy access to all that needs it <b>Beginning 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Administrator, maintenance or designee will audit EMP every 6monthx2 to ensure that the policy for resident's transfers to other LTC facilities in case of facility cessation remains in the emergency binder, findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, the facility's emergency preparedness plan provided did not include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws.</p> <p>Based on interview at the time of the record review, the Maintenance Director acknowledged the facility's emergency preparedness plan provided did not include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p>			E 0029	<p><b>E0029 Development of Communication Plan CFR 483.73 (C)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility updated emergency communication plan that complies with Federal, state, and local laws <b>On 03/03/23</b></p> <p>2) Facility administrator, maintenance or designee will continue to ensure that facility Maintains communication plan in the emergency binder <b>Beginning 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Administrator, maintenance or designee will audit EMP every 6monthx2 to ensure that facility maintains communication plan in the emergency binder and any findings will be discussed in QAPI meeting to assure compliance.</p>		03/08/2023
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d),						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23</p>			E 0036	<p><b>E0036 EP Training and Testing CFR 483.73 (d)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p>		03/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0037 SS=F Bldg. --	<p>between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, there was no documentation available to show the facility had an emergency preparedness training and testing program available. Based on interview at the time of record review, the Maintenance Director confirmed there is no training and testing program available within the Disaster Plan.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do</p>				<p>1) The facility completed an emergency preparedness training and testing program with facility staff <b>On 03/03/23</b></p> <p>2) Facility completed all staff in-service by completing a Tornado drill, called code green, brought all residents to designated area, staff completed resident head counts, and code green called off <b>On 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Administrator, maintenance or designee will audit EMP and ensure that staff training and testing are conducted quarterly x 3 and any findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> <li>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</li> <li>(ii) After initial training, provide emergency preparedness training every 2 years.</li> <li>(iii) Demonstrate staff knowledge of emergency procedures.</li> <li>(iv) Maintain documentation of all emergency preparedness training.</li> <li>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</li> </ul> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <ul style="list-style-type: none"> <li>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</li> <li>(ii) Provide emergency preparedness training at least every 2 years.</li> <li>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</li> <li>(iv) Maintain documentation of all training.</li> <li>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</li> </ul>						



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and</p>			E 0037	<p><b>E0037 EP Training Program CFR 483.73 (d) (1)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in</p>		03/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0039 SS=F Bldg. --	<p>procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, no documentation of annual Disaster Plan training and no documentation to show staff could demonstrate knowledge of the Disaster Plan was available for review. Based on an interview at the time of record review, the Maintenance Director confirmed there was no documentation of annual Disaster Plan training and no documentation to show staff could demonstrate knowledge of the Disaster Plan was available for review.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2),</p>				<p>accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility completed an emergency preparedness training and testing program with facility staff <b>On 03/03/23</b></p> <p>2) Facility completed all staff in-service by completing a Tornado drill, called code green, brought all residents to designated area, staff completed resident head counts, and code green called off <b>On 03/03/23</b></p> <p>3) Facility will ensure that all new hire undergo emergency preparedness training during their orientation such as what to do during emergencies, where to find EMP, and location of emergency accessories <b>Beginning 03/03/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Administrator, maintenance or designee will audit EMP and ensure that new and old staff training and testing are conducted quarterly x 3 and any findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>§460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>§482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility,</p>						



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt</p>	E 0039	<p><b>E0039 EP Testing Requirement CFR 483.73(d) (2)</b></p> <p>It is the policy of the facility to maintain up to date Emergency Preparedness Plans in accordance with CFR 483.73 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) The facility completed a stimulated community based exercise with the Fire Chief and code enforcement officer with staff</p>	03/08/2023			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</li> <li>b. A mock disaster drill; or</li> <li>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> </ul> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2).</p> <p>This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Disaster Plan on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a community based exercise during the past 12 months, and was further unable to provide documentation of a second exercise conducted during the past twelve months. The Maintenance Director said the facility has not taken part in a community based exercise during the past 12 months, or conducted a second exercise during the past 12 month period.</p> <p>This finding was reviewed with the Maintenance</p>				<p>during table top exercise <b>On 03/03/23</b></p> <p><b>2)</b> Facility will conduct community-based table top exercise with Fire Marshall annually <b>Beginning 01/02/24 Assurance of On-Going Compliance:</b></p> <p>1) Administrator, maintenance or designee will audit EMP and ensure that community-based exercise is conducted annually and any findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0000  Bldg. 01	<p>Director and Maintenance Assistant #1 during the exit conference.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 02/20/23</p> <p>Facility Number: 000180 Provider Number: 155282 AIM Number: 100274190</p> <p>At this Life Safety Code survey, Good Samaritan Society Northwood Retirement Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 107 and had a census of 56 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except a detached garage used for facility storage.</p>			K 0000	<p>K0000 Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed solely because it is required by the provisions of the Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. Completed 03/08/23</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0222 SS=F Bldg. 01	<p>Quality Review completed on 02/27/23</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p><b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 13 of 15 delayed egress locks were readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11</p>	K 0222	<p><b>K0222 Egress Doors CFR: NFPA 101</b> It is the policy of the facility to maintain a Life Safety Code in accordance with CFR 483.90 standards and requirements, and accept this facilities, credible allocation of compliance. <b>Corrective Action will include:</b> 1) The facility will post on all the identified exit doors with delayed egress signage that reads "PUSH UNTILL ALARM SOUNDS</p>		03/09/2023		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/20/23 between 12:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, Maintenance Assistant #1, and Director of Transportation, all exit doors from the facility, except two in the memory care unit, were equipped with magnetic locks with 15 second delayed egress. None of the exit doors were provided with signage that read, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. Furthermore, none of the exit doors had the code posted near the keypad to exit. When tested by maintenance, the doors did release from the magnetic holders when pushing on the panic bars and activating the 15 second delayed egress. Based on interview at the time of each observation, the Maintenance Director acknowledged all exit doors were not equipped with the proper signage or had the code posted near the keypad.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>3.1-19(b)</p>				<p>DOOR CAN BE OPENED IN 15 SECONDS" By 03/09/23</p> <p>2) All staff will be in-service on ability to push the door for 15 seconds in case there is emergency to use the door exits By 03/09/23</p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Facility maintenance director or designee will round weekly x 4 weeks, monthly x 3months ensuring that the signage remains intact and any findings will be discussed in QAPI meeting to assure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	<p><b>NFPA 101</b> Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook tops in 2 of 2 rooms was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met.</p>			K 0324	<p><b>K0324 Cooking Facilities CFR: NFPA 101</b> It is the policy of the facility to maintain a Life Safety Code in accordance with CFR 483.90 standards and requirements, and accept this facilities, credible allocation of compliance. <b>Corrective Action will include:</b> 1) The facility contacted electrical company to install a breaker switch in the physical therapy and activity rooms that will deactivate the stove when not in use. <b>Will be completed by</b></p>		03/09/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0711 SS=F Bldg. 01	<p>19.3.2.5.3(9) states A switch meeting all the following is provided:</p> <p>(a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range.</p> <p>(b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision.</p> <p>This deficient practice could affect all residents while in the Physical Therapy Room and Activity Room.</p> <p>Findings include:</p> <p>Based on observations on 02/20/23 between 12:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, Maintenance Assistant #1, and Director of Transportation, there were cooktop stoves in the Physical Therapy and Activity rooms. When checked, and not in use, these stove top appliances were not deactivated from the individual cooktop power sources. Based on interview at the time of observation, the Maintenance Director confirmed both cooktop stoves were not deactivated when not in use.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan,</p>				<p><b>03/09/23</b></p> <p>2) Therapy and Activity staff will be educated on how to turn on breaker switch when using the stove and turn off the breaker switch when not in use of the stove <b>By 03/09/23</b></p> <p><b>Assurance of On-Going Compliance:</b></p> <p>1) Facility maintenance director or designee will round weekly x 4 weeks, monthly x 3months to ensure that therapy and activity staff are compliance and any findings will be discussed in QAPI meeting to assure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.</p> <p>18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3</p> <p>Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to fire department</li> <li>(3) Emergency phone call to fire department</li> <li>(4) Response to alarms</li> <li>(5) Isolation of fire</li> <li>(6) Evacuation of immediate area</li> <li>(7) Evacuation of smoke compartment</li> <li>(8) Preparation of floors and building for evacuation</li> <li>(9) Extinguishment of fire</li> </ol> <p>Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:</p> <ol style="list-style-type: none"> <li>i. Equipment in use and carts in use</li> <li>ii. Medical emergency equipment not in use</li> </ol>			K 0711	<p><b>K711 Evacuation and Relocation Plan CFR: NFPA 101</b></p> <p>It is the policy of the facility to maintain a Life Safety Code in accordance with CFR 483.90 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <ol style="list-style-type: none"> <li>1) The facility updated the EMP to address the use of K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, the removal of wheeled equipment from the corridor in event of an emergency, the transmission of the alarm to the fire department, and emergency phone call to the fire department <b>On 03/03/23</b></li> <li>2) Facility will ensure that EMP is updated annually for compliance <b>Beginning 01/02/24</b></li> <li>3) Kitchen staff will be in-service on K-class fire extinguisher usage <b>By 03/09/23</b></li> <li>4) All staff in-services on ensuring that all wheeled equipment are removed in event of an emergency <b>On 03/03/23</b></li> </ol>		03/09/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 0920 SS=E Bldg. 01	<p>iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the facility's "Fire Emergency Management Plan" on 02/20/23 between 9:15 a.m. and 12:45 p.m. with the Maintenance Director present, the plan did not address the following items:</p> <ul style="list-style-type: none"> <li>a. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system.</li> <li>b. The removal of wheeled equipment from the corridor in the event of an emergency.</li> <li>c. The transmission of the alarm to the fire department.</li> <li>d. An emergency phone call to the fire department.</li> </ul> <p>Based on interview at the time of record review, the Maintenance Director acknowledged and agreed that the fire safety plan did not address the previously mentioned items.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been</p>			<p><b>Assurance of On-Going Compliance:</b></p> <p>1) Facility maintenance director or designee will complete Kitchen and nursing staff interview/audit monthly x 3months, quarterlyx2 to ensure that the respective staff are knowledgeable on what to do in event of an emergency, and any findings will be discussed in QAPI meeting to assure compliance.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 3 dining rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 10 resident and staff.</p> <p>Findings include:</p> <p>Based on observations on 02/20/23 between 12:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, Maintenance Assistant #1, and Director of Transportation, there was a toaster and microwave oven plugged into a power strip on the counter in the Cedar Dining Room.</p>		K 0920	<p><b>K920 Electrical Equipment-Power Cords and Extension CFR: NFPA 101</b></p> <p>It is the policy of the facility to maintain a Life Safety Code in accordance with CFR 483.90 standards and requirements, and accept this facilities, credible allocation of compliance.</p> <p><b>Corrective Action will include:</b></p> <p>1) Facility immediately removed the toaster and microwave oven from that were plugged into power strip on the counter in the Cedar Dining Room <b>On 02/20/23</b></p> <p>2) Facility completed staff in-service to ensure that no one plugs in any equipment on a power strip in Cedar dining room and anywhere else in the facility</p>		03/08/2023	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Based on interview at the time of observation, the Maintenance Director acknowledged the use of the power strip in the Cedar Dining Room.</p> <p>This finding was reviewed with the Maintenance Director and Maintenance Assistant #1 during the exit conference.</p> <p>3.1-19(b)</p>				<p><b>On 03/03/23</b> <b>Assurance of On-Going Compliance:</b> 1) Facility maintenance director or designee will complete daily rounding x 4weeks, then monthly x 3 months, then quarterly x 2, and any findings will be discussed in QAPI meeting to assure compliance.</p>		