

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

PRINTED: 01/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  |                                                                                       |                                                                                                                          |                                                        |                            |
|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355093</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/28/2020</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN SOCIETY - BOTTINEAU</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>725 E 10TH ST<br/>BOTTINEAU, ND 58318</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| F 000                                                                         | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |  | F 000                                                                                 |                                                                                                                          |                                                        |                            |
| F 886<br>SS=E                                                                 | <p>A COVID-19 Focused Infection Control Survey was conducted on 10/28/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations/COVID 19 Testing and will be cited at F886. The facility had no COVID-19 positive residents.</p> <p>COVID-19 Testing-Residents &amp; Staff CFR(s): 483.80 (h)(1)-(6)</p> <p>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:</p> <p>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:</p> <ul style="list-style-type: none"> <li>(i) Testing frequency;</li> <li>(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;</li> <li>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;</li> <li>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;</li> <li>(v) The response time for test results; and</li> <li>(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.</li> </ul> |                                                                            |  | F 886                                                                                 |                                                                                                                          |                                                        | 11/20/20                   |

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

TITLE

(X6) DATE

Electronically Signed

11/19/2020

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 90 days 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 14 days 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: 01/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                          |  |                                                        |
|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355093</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/28/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN SOCIETY - BOTTINEAU</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>725 E 10TH ST<br/>BOTTINEAU, ND 58318</b>                                                                                                                    |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                 |  | (X5)<br>COMPLETION<br>DATE                             |
| F 886                                                                         | <p>Continued From page 1</p> <p>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;</p> <p>§483.80 (h)((3) For each instance of testing:<br/>(i) Document that testing was completed and the results of each staff test; and<br/>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.</p> <p>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.</p> <p>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.</p> <p>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and staff interview, the facility failed to document required COVID-19 test documentation for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5, and #6), and failed to store COVID-19 test results for staff in a</p> | F 886                                                                      | <p>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</p> |  |                                                        |

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

PRINTED: 01/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355093</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/28/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN SOCIETY - BOTTINEAU</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>725 E 10TH ST<br/>BOTTINEAU, ND 58318</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 886                                                                         | <p>Continued From page 2</p> <p>secure manner. Failure to document COVID-19 testing and test results in each residents' medical record may lead to a lack of further required interventions and/or an incomplete medical record, and failure to store staff COVID-19 results in a secure maner does not ensure confidentiality of health information.</p> <p>Findings include:</p> <p>Review of resident medical records occurred on 10/28/20 and showed Resident #1, #2, #3, #4, #5, and #6 's records failed to contain documentation of COVID-19 testing completed and/or test results.</p> <p>During an interview on 10/28/20 at 1:00 p.m., an administrative staff member (#1) confirmed the resident medical records lacked documentation of COVID-19 testing completed and/or test results.</p> <p>During an interview the afternoon of 10/28/2020, an administrative staff member (#1) stated the staff COVID-19 test results were located on the desk in his/her unlocked office. Staff agreed the staff COVID-19 test results were not stored in a secure manner.</p> | F 886                                                                      | <p>statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>F- 886 – COVID -19 Testing Resident and Staff CFR(s): 483.80 (h)(1)-(6)</p> <p>1. Results have been scanned into the charts of residents #1, #2, #3, #4, #5 and #6.<br/>Staff test results will be stored in a locked file cabinet or electronically in a secured folder.</p> <p>2. Charts of all facility residents have been audited for results of previous COVID-19 tests and test results are present in EHR for all residents who were tested.<br/>All testing result documents for staff will be secured in a secured locked environment or scanned into a secure location.</p> <p>3. A procedure for scanning in of test results of all COVID-19 testing done on residents was developed and implemented. Staff involved in the process have been educated and trained on the process.<br/>All testing result documents for staff will</p> |                            |                                                        |

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

PRINTED: 01/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                                        |
|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355093</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/28/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN SOCIETY - BOTTINEAU</b> |                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>725 E 10TH ST<br/>BOTTINEAU, ND 58318</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 886                                                                         | Continued From page 3                                                                                                        | F 886                                                                      | <p>be secured in a secured locked environment or scanned into a secure location.</p> <p>4. Starting the week of 11-23-20<br/>QA audits will be done by HIM on 100% of residents tested in regard to test results being scanned into EHR for 2 weeks (4 testing events). Then on 50% of residents for 2 weeks. Then 10% or a minimum of 2 residents for 2 months. QA audits will be done by HIM on 100% of staff testing results security for 2 weeks (4 testing events). Then on 50% of staff testing results security for 1 month. Then 25% of staff testing results security Monthly for 2 months. Findings will be reported to QA committee for further recommendations</p> |                            |                                                        |

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

PRINTED: 01/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                                                                                                                                         |                                                                            |  |                                                                                       |                                                                                                                          |                                                        |                            |
|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355093</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/28/2020</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN SOCIETY - BOTTINEAU</b> |                                                                                                                                                                                                                                         |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>725 E 10TH ST<br/>BOTTINEAU, ND 58318</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                            |                                                                            |  | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| E 000                                                                         | Initial Comments<br><br>A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 10/28/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6). |                                                                            |  | E 000                                                                                 |                                                                                                                          |                                                        |                            |

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

TITLE

(X6) DATE

Electronically Signed

11/19/2020

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 90 days 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 14 days 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.