STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 10/28/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 10/28/20. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F886. The facility had 24 COVID-19 positive residents at the time of the survey.	F 000		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §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: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (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;	F 886		11/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/17/2020

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F 886	Continued From page 1 (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (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. §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. §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. §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	F 886		

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F 886	Continued From page 2 processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to take actions necessary to prevent the transmission of COVID-19 on 1 of 1 days of survey (10/28/20). Failure to screen visitors upon entry to the facility and effectively cohort COVID-19 positive residents may result in further transmission of the virus within the facility. Findings include: Review of the facility policy titled "Visitor Guidance" occurred on 10/28/20. This policy, updated 09/28/20, stated, ". . . The facility needs to follow the core principles and best practices that reduce the risk of COVID-19 transmission: Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs and symptoms), and denial of entry of those with signs or symptoms . . . Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care) . . ." Observation on 10/28/20 at 1:30 p.m. showed the facility's front door was unlocked, and no staff available to screen visitors. Upon entering the facility, the staff failed to screen (i.e. temperature checks and symptom questions) the survey team until approximately 3:30 p.m. Review of the facility map showed a double room occupied by one COVID-19 positive resident (Resident #2) and one COVID-19 negative resident (Resident #1). A staff member (#1)	F 886	1. Adm/DON will complete a daily audit of a door screening process with COVID symptom questionnaire completed daily for x 2 weeks. Weekly audits will be completed x4 weeks and then quarterly. Audit results will be submitted to the QAPI committee monthly for review and further recommendation as indicated. Staff were educated on door screening process. 2. These deficiencies were corrected by 11/25/2020. 3. MDS revised the care plans for Resident #1 and Resident #2 for accuracy regarding the education for COVID-19, the risks of remaining in a room shared with a COVID-19 positive resident. Families that were notified regarding the decisions to remain in the room were updated. 4. Adm/DON/MDS educated family and residents on cohorting with covid symptoms. Residents were encouraged to move rooms as to prevent cohorting and all refusals were care planned. Family was educated on resident refusals and covid 19 symptoms. 5. No future residents will be allowed to cohort. 6. Other Residents care plans were audited to ensure documentation of	

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F 886	Continued From page 3 identified the residents did not want to change rooms. Resident #1's medical record failed to include information regarding the room change, such as education regarding COVID-19, the risks of remaining in a room shared with a COVID-19 positive resident, and notification of family/resident representative regarding Resident #1's decision to remain in her room.	F 886	COVID-19 education and family awareness notification. 7. Care plan review audits will be performed by the DON/ or designee weekly x 4 weeks, monthly x2 and then quarterly x 3. Audit results will be submitted to the QAPI committee quarterly for review and further recommendation as indicated. 8. These deficiencies were corrected by 11/25/2020.	