STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 01/04/22. 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 01/04/22. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F886. The facility currently had no COVID-19 positive residents.	F 000		
F 886 SS=E	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		1/18/22

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

Electronically Signed | 01/19/2022

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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 record review and staff interview, the facility failed to document required COVID-19 testing documentation for 3 of 3 sampled residents (Residents #1, #2, and #3), failed to obtain a physician's order for COVID-19 testing for 1 of 3 sampled residents (Resident #1), and failed to provide a policy/procedure required for staff COVID-19 testing refusals. Failure to document COVID-19 testing and results, follow professional standards of practice for testing, and failure to have a process in place for testing refusal may lead to a lack of further required interventions and/or incomplete medical records. Findings include: The facility failed to provide a policy/procedure for staff refusal of COVID-19 testing. - Review of Resident #1's medical record occurred on 01/04/21. The medical record lacked a physician's order for COVID-19 testing. - Review of Resident #1, #2 and #3's medical records occurred on 01/04/21 and lacked test results for completed COVID-19 testing. During an interview on 01/04/21 at 2:45 p.m., an administrative nurse (#1) confirmed Resident #1's medical record lacked a physician's order for COVID-19 testing, and Resident #1, #2, and #3's medical records lacked COVID-19 test results, and stated the facility failed to establish a policy for staff refusal of COVID-19 testing.	F 886	1. No physician's order for COVID-19 testing for Resident #1. a. Physician's order obtained for COVID-19 testing as per NDDoH state guidelines on 1/17/22 and entered into Resident #1's EHR chart. b. Reviewed all other resident's charts to verify if they have COVID-19 testing orders. Orders received on 1/18/2022 for those residents who did not have the order and entered into their EHR chart. c. COVID-19 testing orders have been added to our facility's standing orders and our new admission physician's order form has been updated to ensure any new residents will have these orders upon admission. d. This will be monitored by nursing staff and QA/Infection Control with all new admissions and reviewed monthly for 3 months, then quarterly for 1 year and as needed. 2. Staff refusal of COVID-19 testing policy and procedure. a. Policy and procedure for staff refusal of COVID-19 testing developed and added to our COVID-19 policy and procedure manual. This will be reviewed yearly and PRN.	

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F 886	Continued From page 3	F 886	3. Lack of test results for completed COVID-19 testing. a. Staff will enter a progress note into each resident's EHR chart after each COVID-19 testing event. Information included will be: type of test performed, the route used, and the results. If result is positive, the progress note will also include resident's current status, signs and symptoms, and when isolation began. b. This will be monitored by nursing staff and QA/Infection Control after each testing event and reviewed monthly for 3 months, then quarterly for 1 year and as needed. 4. Documentation of individual staff COVID-19 results. a. Starting on 1/7/22 each individual staff will have their own log for COVID-19 test results. This will be kept confidential in a binder and will be available upon request. Log includes staff name, department, testing dates, type of test performed and results. b. This will be monitored by nursing staff and QA/Infection Control after each testing event, reviewed monthly for 3 months, then quarterly for 1 year and as needed.	