STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

(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 10/13/20 The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS Focused Infection Control Survey was conducted on 10/13/20. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. The facility had 21 positive COVID-19 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	F 886		11/17/20

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

Electronically Signed | 11/05/2020

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F 886	Continued From page 1	F 886		

this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(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,

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F 886	Continued From page 2 contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or 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 test documentation for 3 of 3 sampled residents (#1, #2, and #3) and failed to provide a policy/procedure required for resident and staff test refusals. Failure to document COVID 19 testing and results and failure to have a process in place for testing refusal may lead to a lack of further required interventions. Findings include: Review of medical records occurred on 10/13/20 and showed Resident #1, #2, and #3's records failed to contain documentation of COVID-19 testing offered and completed and interventions implemented to prevent the transmission of COVID-19. The facility failed to provide a policy/procedure for refusal of testing for staff and residents when requested. During an interview on 10/13/2020 at 11:35 a.m., an administrative staff member (#1) confirmed the facility failed to have a policy/procedure in place for staff and/or residents who refuse COVID-19 testing.	F 886	1. There has been no resident COVID-19 testing done since survey was complete, so no charts to document in. Policy was implemented regarding staff and residents refusing testing. Lab results for COVID testing will be placed on resident's chart as soon as received from lab. 2. All residents have the potential to be affected by the facilities failure to place COVID testing lab results on residents charts and document any refusals as well as the facilities failure to have a policy in place for resident and staff refusal of testing. 3. All admits and current residents past 90 days of positive results will be tested according to NDDOH testing guidelines at that time example twice weekly, weekly, monthly, etc. Test results will be placed on each residents chart. Documentation on the residents chart will be done for all positive residents or residents that refuse testing to show what interventions were put into place. Nursing staff were educated in proper interventions and documentation of interventions of refusals as well as when to move a resident into COVID isolation whether a positive result or refusals. All staff educated in refusal of COVID-19 testing according to the policy. Due to COVID, an all-staff was not held;	

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F 886	Continued From page 3	F 886	email was sent out to all staff on 11-5-2020 of the changes as well as a memo placed in paychecks 11-17-2020. Nursing staff education was emailed 11-11-2020 to LTC nurses. 4. QI Director or designee will do QA on resident charts that are COVID-19 tested to ensure that each resident's lab results are placed on the chart. QA will be done on any positive residents or refusals to ensure resident was placed in COVID isolation to ensure problem does not recur and solutions are sustained. QA will be done on all charts for the first 2 testing events, and then will do 3 random charts for each testing done for 6 months. All residents and staff that refuse testing will be noted and tracked on a refusal log by the QI Director or designee for compliance. 5. 11-17-2020	