STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375457	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETTY ANN NURSING CENTER	**1400 SOUTH MAIN STREET GROVE, OK 74344**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure outbreak testing was completed in accordance to CMS and CDC guidelines when the facility was made aware of one (#2) resident had tested positive for COVID-19. This had the potential to affect all 54 residents who resided in the facility. Findings: The CMS QSO 20-38-NH document, dated 08/26/20, documented, .Testing of Staff and Residents in Response to an Outbreak .An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further [MEDICAL CONDITION] transmission .Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested , and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result .The CDC guidance, Titled Testing Guidelines for Nursing Homes Interim [DIAGNOSES REDACTED]-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel, updated 07/21/20, documented, .After initially performing [MEDICAL CONDITION] testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department .Continue repeat [MEDICAL CONDITION] testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of [DIAGNOSES REDACTED]-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result .On 10/01/20 at 9:45 a.m., the DON identified the facility had one resident who had tested positive for COVID-19 at the hospital. She stated the hospital notified the facility resident #2 had tested positive for COVID-19 on 09/14/20. Resident #2 had [DIAGNOSES REDACTED]. Review of the resident's clinical record revealed the resident had been readmitted to the facility from a hospital stay on 09/04/20. Documentation revealed the resident was sent back to the hospital on [DATE] for respiratory distress. A laboratory report from the hospital, documented a nasopharyngeal test for COVID-19 was collected on 09/12/20. The laboratory report documented COVID-19 was detected on 09/14/20. Review of the facility's resident COVID-19 testing log revealed the residents were tested on [DATE] with all negative results. The documentation did not reveal further testing in response to the outbreak had been conducted for residents after 09/14/20. On 10/01/20 at 1:08 p.m., the DON was asked why residents had not been tested for COVID-19 following the testing on 09/14/20 in response to the outbreak. She stated she had discussed the outbreak testing protocol with corporate personnel and had been instructed to only conduct further testing if a resident became symptomatic. She stated they continued to test staff in accordance to the county positivity rate. At 3:27 p.m., the infection preventionist was asked what her role was during outbreak testing for COVID-19. She stated she had discussed the testing with the DON who talked to corporate personnel about testing the residents the week following 09/14/20. She was asked why residents were not tested after 09/14/20. She stated she was told the corporate personnel informed the facility one round of testing was sufficient for the residents. She stated they had been testing staff but should have tested the residents again to ensure there were no new positives for 14 days.

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

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.