

North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/07/2025
NAME OF PROVIDER OR SUPPLIER TOUCHMARK AT HARWOOD GROVES			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HARWOOD DR S FARGO, ND 58104		
(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) COMPLETE DATE	
B 000	INITIAL COMMENTS An unannounced onsite complaint investigation occurred on April 7, 2025 and included two resident records for review. The facility was found in compliance with the licensing requirements under our jurisdiction.	B 000			

Health Repsonse and Licensure			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE	