STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

(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
F 884 SS=F	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(ix)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to- (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; (viii) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and (ix) Therapeutics administered to residents for treatment of COVID-19. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention ' s National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and	F 884		8/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/09/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 884	Continued From page 1 safety of residents, personnel, and the general public. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation. The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 08/02/2021 and 08/08/2021, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.	F 884		