

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355037</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/11/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST ALOISIUS MEDICAL CENTER NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 E BREWSTER ST<br/>HARVEY, ND 58341</b>                                   |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| E 000                                                                              | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | E 000                                                                      |                                                                                                                          |                            |                                                        |
| F 000                                                                              | <p>A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 11/11/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).</p> <p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted on 11/11/20. 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 for COVID-19. The facility had eight positive COVID-19 residents in the facility and one who transferred to the hospital.</p> | F 000                                                                      |                                                                                                                          |                            |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/30/2020

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.