

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

PRINTED: 10/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355124		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2023	
NAME OF PROVIDER OR SUPPLIER SHEYENNE CROSSINGS CARE CENTER/TCU				STREET ADDRESS, CITY, STATE, ZIP CODE 125 13TH AVENUE WEST WEST FARGO, ND 58078			
(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			E 000			
F 000	A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 06/28/23. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6). INITIAL COMMENTS The COVID 19 Focused Infection Control Survey was conducted on June 28, 2023. The facility was found to be in compliance with 42 CFR 482.80 infection control regulations and has implemented the Centers of Medicare and Medicaid Services (CMS) and Centers of Disease Control (CDC) recommended practices to prepare for COVID 19. The facility had no positive COVID 19 resident(s) in the facility at this time. An unannounced onsite complaint investigation survey was completed on June 28, 2023. The concerns identified by the complainant were found in compliance with the regulatory requirements.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

08/28/2023

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.