STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garrison Mem Hosp Nsg Fac	407 3rd Ave SE Garrison, ND 58540

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 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

45873

46964

Based on record review, review of facility policies, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 4 of 12 sampled residents (Residents #1, #4, #5, and #7). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care.

Findings include:

Review of the facility policy titled Interdisciplinary Care Plan and Care Plan Meeting occurred on 02/26/25. This policy, dated December 2023, stated, . C. Develop a care plan based upon information from the Interdisciplinary Team.

Review of the facility policy titled Care Conference and Resident Centered Care Plan occurred on 02/26/25. This policy, dated June 1985, stated, . 2. The care plan will include . b) Physician orders . c) Dietary orders . 3. The . care plan will be . b. Developed by an interdisciplinary team, that includes . i. the attending physician . iv. dietary staff member . c. Reviewed and revised . by each member . 5. A comprehensive resident-centered care plan will be developed and implemented for . a) Services . furnished to the resident to attain or maintain their highest practicable . well-being . 8. Care plans will . be reviewed . as needed.

- Review of Resident #1's medical record occurred on all days of survey. Current physician's orders included verify monthly weight on the first Wednesday of the month.

Review of Resident #1's current care plan stated, . Admission Care Assist Task: 06/07/23-Monthly weight once a day on 1st Wed [Wednesday] of the month . Resident has kidney disease and neuropathy, related to diabetes mellitus . 10/22/2020-Monitor weight weekly .

The facility failed to remove contradicting orders from Resident #1's care plan.

- Review of Resident #4's medical record occurred on all days of survey. Current physician's orders included restorative nursing ambulation program with a platform walker and assistance of 2 with a wheelchair to follow 3-5 days a week.

(continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's current care plan stated, . 02/06/25 Restorative Nursing Ambulation Program-Ambulation with platform [NAME] with assist of 2 with wheelchair to follow 3-5 days a week . ADLs [activities of daily living] 01/27/2021 Ambulate with assist of one and front wheeled walker, 1x/d [one time per day], 3-5x's/week, [three to five times a week] . The facility failed to remove contradicting orders from Resident #4's care plan. - Review of Resident #5's medical record occurred on all days of survey. Current physician's orders included verify monthly weight completed once a day on the 1st Tuesday of the month. Review of Resident #5's current care plan stated, . Admission Care Assist Task 05/02/2023 Monthly weight-Once A Day on 1st Tue [Tuesday] of the Month . 04/21/2017 Vital signs and weight weekly and PRN [as needed] . The facility failed to remove contradicting orders from Resident #5's care plan. - Review of Resident #7's medical record occurred on all days of survey. Current physician's order included monthly weights on the first of the month, and a diet order for a diabetic/regular consistency, low potassium diet. Resident #7's current care plan failed to identify orders for monthly weights and type of diet. During an interview on 02/25/25 at 4:45 p.m., an administrative nurse (#2) agreed staff failed to update the residents' care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39685 Based on observation, policy review, and staff interview, the facility failed to follow professional standards of practice for medication administration for 2 of 13 sampled residents (Residents #1 and #15) and one supplemental resident (Resident #14). Failure to follow a physician's order, document medications after administration, properly prime insulin pens, and provide privacy during insulin administration, may impede the therapeutic effectiveness of the medications, cause adverse events such as medication errors and low blood sugar, and infringes upon the residents right to privacy. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, . Carrying Out a Physician's Orders . Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Review of the facility policy titled Medication Administration occurred on 02/27/25. This policy, dated February 2008, stated, . All medications should be charted immediately after they are given . Insulin, accuchecks . will not be given in the dining room. This will be done to assure the right of personal privacy and confidentiality of all residents. Review of the facility policy titled Insulin Pen Use occurred on 02/27/25. This policy dated 2010, stated, . prime safety needle with 2 units prior to each administration . hold pen with needle pointing up . - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included polyneuropathy (nerve damage causing numbness and pain). A physician's order, dated 01/29/25, stated, Hydrocodone-APAP [an opioid pain medication] 5-325 milligrams (mg) QAC [before every meal] and QHS [bedtime]. Resident #1's nursing progress note, dated 01/31/25 at 4:04 p.m., stated, [Resident] has been confused today and whiney. [Resident] sleeping frequently today. Provider on call notified . and scheduled hydrocodone order was changed from QID [4 times a day] to BID [twice a day]. Resident #1's medication administration record (MAR) identified the resident received hydrocodone at 8:00 a.m. and 12:00 p.m. and showed the resident received a third dose of hydrocodone at 8:00 p.m. During an interview on 02/25/25 at 5:20 p.m. an administrative nurse (#2) confirmed Resident #1 received a third dose of hydrocodone after the physician changed the order to twice a day. - Observation on 02/25/25 at 11:58 a.m. showed a nurse (#13) documented Resident #14's blood sugar and insulin administration on the medication administration record (MAR) at 12:00 p.m. The nurse then prepared a Humalog Kwikpen (insulin) and primed the pen holding the pen downward. The nurse (#13) documented medication administration prior to administration and failed to prime the insulin pen pointing upward per facility policy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Observation on 02/25/25 at 12:10 p.m. showed a nurse (#13) documented Resident #15's blood sugar and insulin administration on the (MAR) at 12:00 p.m. The nurse prepared a Fiasp FlexTouch (Insulin) pen and primed the pen holding the pen downward. The nurse (#13) brought Resident #15 to the dining room table where three residents were seated, pulled up the resident's shirt, and injected the insulin in the abdomen. The nurse (#13) documented medication administration prior to administration, failed to prime the insulin pen pointing upward per facility policy and failed to provide privacy for the resident. During an interview on 02/25/25 at 1:33 p.m., an administrative nurse (#2) stated she expected nurses to document medications after they are administered, follow facility policy for priming of insulin pens, and provide privacy when administering insulin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39685 Based on observation, record review, and staff interviews, the facility failed to provide assistive devices necessary to prevent accidents for 2 of 4 sampled residents (Residents #1 and #13) observed without wheelchair foot pedals. Failure to use wheelchair foot pedals while transporting residents, places all residents at risk for falls and/or injury. Findings include: The facility failed to provide a policy for foot pedal use upon request. - Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated [DATE], identified functional limitations in range of motion with lower extremity impairment on both sides and dependance on staff for wheelchair transfers. The current care plan stated, . Self-Care Deficit R/T [related to] old hip fracture . Locomotion is total assistance of one staff once in wheelchair. During an observation on 02/24/25 at 1:04 p.m., a certified nurse aide (CNA) (#7) wheeled Resident #1 to the activity room. The resident's left foot dragged on the floor and became twisted under the wheelchair. The CNA stopped the wheelchair, straightened the resident's leg and proceeded down the hall. The CNA (#7) stated the left foot pedal was missing and she does not know where it is. During an interview on 02/27/25 at 12:00 p.m., an administrative nurse (#2) stated she expected staff to apply foot pedals on a wheelchair when the resident cannot lift their feet. - Review of Resident #13's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], identified dependence on staff for wheelchair transfers. The current care plan stated, . is total assistance of one staff once in wheelchair. During an observation on 02/24/25 at 3:50 p.m., two CNAs (#7 and #8) transferred Resident #13 from the recliner to another resident's wheelchair without foot pedals on it. The CNA (#7) pushed the resident down the hallway. The resident put his legs out and then bent them so they were under the wheelchair. The CNA (#7) stopped, straightened the resident's legs, and proceeded down the hallway. The CNA stated she did not know the location of Resident #13's wheelchair. The CNA (#7) failed to use Resident #13's wheelchair with foot pedals during locomotion. During an interview on 02/27/25 at 12:10 p.m., an administrative nurse (#2) stated she expected staff to apply foot pedals on Resident #13's wheelchair. 45873

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45873 Based on record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 2 of 2 sampled residents (Residents #1 and #5) with documented weight variances. Failure to obtain weights and reassess weight variances may delay needed treatment for weight loss/gain and alter the resident's ability to maintain a sufficient health/nutritional status. Findings include: Review of the facility policy titled Weighing Residents occurred on 02/27/25. This policy, reviewed February 2023, stated, . It is important to maintain adequate nutritional status . The early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. Monthly weights will be completed by the second week of the month. Weights will be recorded in the EMR [electronic medical record]. Residents will have a consistent method for being weighed . Nurses are responsible for making sure aides get and document those weights. A weight variance report will be completed the third week of each month. Any resident with a loss of 5% or greater will be re-weighed that week to validate that month's weight. Review of the facility policy titled Vital Signs Routine occurred on 02/27/25. This policy, dated March 2015, stated, . Any time that you observe anything abnormal, make sure that you report this to the Charge Nurse. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic kidney disease with congestive heart failure. The current care plan stated, . 06/07/23 . Monthly weight Once A Day on 1st Wed [Wednesday] of the Month . Physician's orders included Furosemide (a diuretic) 40 milligrams (mg) daily and monthly weights on the first Wednesday of the month Resident #1's monthly weight record dentified the following: 02/10/25 167.8 pounds 01/08/25 172.4 pounds 12/02/24 175.8 pounds 11/05/24 158.8 pounds (17 pound weight loss in 1 month) 10/03/24 180.7 pounds 09/04/24 181.6 pounds (18.4 pound weight loss in less than 1 week) 09/02/24 200 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/07/24 to 09/01/24 Not Taken 05/06/24 190 pounds Facility staff failed to obtain Resident #1's weight for three months (June-August 2025), failed to identify weight variances or weight loss, and assess any related causes for Resident #1's weight fluctuations. - Review of Resident # 5's medical record occurred on all days of survey. Diagnoses included hypertension. Physician's orders included Furosemide) 20 mg twice a day and weight on the first Tuesday of the month. Resident #5's monthly weight record identified the following: 02/10/25 147.1 pounds (7 pounds in 1 month) 01/08/25 154.8 pounds 01/03/25 148.3 pounds No weight recorded in December 11/05/24 150.9 pounds 10/30/24 150.9 pounds 10/01/24 152.4 pounds 08/06/24 153 pounds Facility staff failed to weigh Resident #5 as ordered in September and December 2024. During an interview on 02/27/25 at 12:00 p.m., an administrative staff nurse (#2) expected the charge nurse to monitor weights and confirmed they failed to run monthly weight variance reports per their policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39685 Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of 3 of 3 insulin pens observed during review of medication storage. Failure to obtain a label for an insulin pen and identify the resident's name and date opened may result in a resident receiving another resident's insulin or outdated insulin. Findings include: Review of the facility policy titled Insulin pen use occurred on 02/27/25. This policy, revised in 2010, stated, . All Insulin pens must have patient identification label and date opened . Review of the facility policy titled Storage of Insulin occurred on 02/27/25. This policy, revised May 2015 stated, . Insulin pens, stored in cart, once they are used, must have [resident's] name and date on the pen . - Observation on 02/26/25 at 10:00 a.m. showed an administrative nurse (#2) obtained three insulin pens from the medication cart. All three pens lacked a resident's name and an opened date. During an interview on 02/26/25 at 10:14 a.m., an administrative nurse (#2) confirmed she expected staff to follow facility policy and ensure staff label insulin pens with the correct identifying information, and expected the pens to include dosing information.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 45873 Based on review of the State Agency (SA) facility files, survey findings, and staff interview, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements. Findings include: Review of the state agency files indicated the facility failed to maintain compliance at F658 as indicated by a deficiency cited during the last standard survey on 12/20/23. Refer to F658. During an interview on 02/27/25 at 11:53 a.m., an administrative staff member (#1) stated, We work with quality on the hospital side, we do QA [quality assurance] audits here [for the nursing home] and bring those results to the hospital meeting. When asked what the facility did to develop the plan of correction and conduct audits following the federal survey, an administrative nurse (#2) stated she thought staff completed audits for a year. The administrative staff members (#1 and #2) listed two issues the facility currently audited and neither issue reflected any of the last standard survey's citations. Failure of the facility to establish a separate nursing home QA committee and effectively utilize QA resulted in continued noncompliance at F658.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39685 Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 8 sampled residents (Resident #5 and #13) and 1 supplemental resident (Resident #6) requiring stand lift transfers. Failure to practice infection control standards related to disinfection of equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Patient Multi-Use Devices, occurred on 02/27/25. This policy, dated February 2011, stated, . As part of the infection control prevention program, all patient/resident multi-use medical devices must be disinfected between patient/resident uses. These include but are not limited to . Mechanical lift devices . - Observation on 02/24/25 at 1:40 p.m. showed a certified nurse aide (CNA) (#8) transferred Resident #6 from the toilet to a wheelchair using a stand lift. After completing the transfer, the CNA failed to sanitize the lift. When asked if there was a policy for sanitizing the lifts, the CNA (#8) replied, housekeeping does that. - Observation on 02/24/25 at 3:58 p.m. showed two CNAs (#7 and #8) transferred Resident #13 from the toilet to a wheelchair using a stand lift. After completing the transfer, the CNAs failed to sanitize the lift and pushed it to another resident's room. - Observation on 02/24/25 at 4:10 p.m. showed a CNA (#7) and a nurse (#6) transferred Resident #5 from the toilet to a wheelchair using a stand lift. After completing the transfer, the nurse (#6) failed to sanitize the lift and pushed it to a storage room. During an interview on the afternoon of 02/25/25, an administrative staff member (#11) provided a Lifts and Stands Maintenance Record showing housekeeping cleans the lifts twice a month and stated, But staff clean them after each use. During an interview on 02/27/25 at 12:00 p.m., an administrative nurse (#2) stated she expected staff to sanitize the lift between resident use. 45873