STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. Building B. Wing	04/08/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and staff interview the facility failed to fully inform the resident or resident representative regarding treatment with psychotropic medications for 5 of 5 sampled residents (#2, #4, #5, #9, and #16) reviewed for unnecessary medications. Failure to fully inform the resident or the resident's representative of the risks, benefits, alternatives and obtain consent for psychotropic medications does not allow the right to choose treatment options. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Physician's orders included Buspirone (antianxiety), Duloxetine (antidepressant), Lorazepam (antianxiety), Mirtazapine (antidepressant), and Risperidone (antipsychotic). The medical record lacked documentation the facility informed the resident and/or their representatives of treatment risks, benefits, options, or obtain their consent to the treatment prescribed. - Review of Resident #4's medical record occurred on all days of survey. Physician's orders included Citalopram (antidepressant) and Quetiapine (antipsychotic). The medical record lacked documentation the facility informed the resident and/or their representatives of treatment risks, benefits, options, or obtain their consent to the treatment prescribed. - Review of Resident #5's medical record occurred on all days of survey. Physician's orders included Quetiapine (antipsychotic) and Lorazepam (antianxiety). The medical record lacked documentation the facility informed the resident and/or their representatives of treatment risks, benefits, options, or obtain their consent to the treatment prescribed. - Review of Resident #9's medical record occurred on all days of survey. Physician's orders included Lorazepam (antianxiety) and Bupropion (antidepressant). The medical record lacked documentation the facility informed the resident and/or their representatives of treatment risks, benefits, options, or obtain their consent to the treatment prescribed. - Review of Resident #16's medical record occurred on all days of survey. Physician's orders included Seroquel (antipsychotic), and Memantine (psychotropic). The medical record lacked documentation the facility informed the resident and/or their representatives of treatment risks, benefits, options, or obtained their consent to the treatment prescribed. During an interview on 04/08/26 at 12:15 p.m., an administrative staff member (#1) confirmed the facility failed to fully inform the resident and/or their representatives of psychotropic medication treatment for Residents #2, #4, #5, #9, and #16.

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	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the resident's current status for 6 of 12 sampled residents (Resident #2, #3, #4, #8, #16, and #21). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care for each resident.Findings include: Review of the facility policy titled Care Conference and Resident Centered Care Plan occurred on 04/08/26. This undated policy stated, . A comprehensive resident-centered care plan will be developed and implemented for each resident, consistent with their resident rights, that include measurable goals and timeframes to meet the resident's medical, nursing, mental and psychosocial needs, and will contain the following: Services to be furnished to the resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being . Care plans will then be reviewed a minimum of quarterly, as the resident/representative requests, or as needed. Care plans will be reviewed by the team at regularly scheduled care conferences . Care plans must be kept current . - Review of Resident #2's medical record occurred on all days of survey. Physician's orders identified Oxycodone (opioid pain medication) and Risperidone (antipsychotic medication). Resident #2's care plan failed to identify problems and interventions for the use of opioid and antipsychotic medications. -Review of Resident #3's medical record occurred on all days of survey. Physician's orders identified Spironolactone (diuretic), Furosemide (diuretic), Tramadol (opioid pain medication) as needed, and Xarelto (anticoagulant). Resident #3's care plan failed to identify problems and interventions for the use of diuretic and opioid pain medication and goals or interventions for anticoagulation therapy. - Review of Resident #4's medical record occurred on all days of survey. Physician's orders identified Hydrochlorothiazide (diuretic medication) and Xarelto (anticoagulant-blood thinner). Observation on 04/07/26 at 8:48 a.m., showed Resident #4 in the hallway holding a roll of toilet paper in her hand and speaking Spanish to an unidentified housekeeping staff member. The staff member responded, I don't speak Spanish. During an interview on 04/07/26 at 11:50 a.m. an administrative staff member stated, There are translating ear buds at the nurse's station for staff and resident to use. Resident #4's care plan failed to identify problems and interventions for the use of diuretic and anticoagulant medication and translation devices for resident communication. -Review of Resident #8's medical record occurred on all days of survey and identified an indwelling urinary catheter. Resident #8's care plan failed to identify problems, goals, and interventions related to indwelling urinary catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #16's medical record occurred on all days of survey. Physician's orders identified Lasix (diuretic), and Tramadol (opioid pain medication). Resident #16's care plan failed to identify problems and interventions for the use of diuretic and opioid pain medication. - Review of Resident #21's medical record occurred on all days of survey. Physician's orders identified Lasix (diuretic) and Seroquel (antipsychotic medication). The progress notes identified the resident has fallen from his chair. Observation on 04/06/26 at 2:29 p.m. showed Resident #21 asleep at a dining room table. A nursing staff member (#10) indicated he had been there since noon lunch and stated He has a recliner in his room and he won't sit in it. He is ambulatory and he goes back to his table. They had tried a recliner in the corner by his table, but he did not sit in that either. Resident #21's care plan failed to identify problems and interventions for the use of diuretic and antipsychotic medications and the resident's preference for spending most of the day at the dining room table.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of the dishwasher temperature and chemical concentration logs, review of the manufacturers' guidelines, and vendor and staff interview, the facility failed to ensure the low temperature dishwasher provided adequate heat and sanitization for dishes and utensils washed in 1 of 1 kitchen (main kitchen). Failure to ensure the appropriate wash temperature for the dishwash cycle may result in inadequate cleaning and sanitation of dishware. Findings include:Review of manufacturer specifications for Energy Series 'Green' Machine American Dish Service, Edwardsville, Kansas identified Water Temperature - 120 degrees [Fahrenheit] F.Product specifications for Ultra San Liquid Sanitizer, Ecolab, 2023 Ecolab USA, stated, For Sanitizing Tableware in low-temperature warewashing machines, inject Ultra San into the final rinse water at concentration of 100 ppm available chlorine. Do not exceed 200 ppm .Observation in the main kitchen on 04/08/26 at 8:15 a.m. showed a low temperature chemical sanitizing dishwasher in use. A dietary aide checked the temperature of the wash cycle and obtained a measurement of 99 degrees Fahrenheit (F) stating, It doesn't always get to 120 degrees until later in the morning because they [other departments] are giving baths and doing laundry and using up the hot water. When asked if management or maintenance are aware of the low measurement, a dietary supervisor (#7) stated, Yes, administration and maintenance are aware, but we haven't heard anything. They have been working on the boilers. When asked if anyone had looked at the dishwasher, she said, No Review of the dishwasher temperature and chlorine level logs from March 20 through April 6, 2026, showed the temperature of the dishwasher water failed to reach 120 degrees F per manufacturers guidelines. The chlorine log identified the level at 100-200 parts per million (ppm) on those days.During an interview the morning of 04/08/26, an administrative staff member (#6) stated maintenance was aware of the dishwasher concerns.During a telephone interview on 04/08/2026 at 12:34 p.m., a dishwasher Service Representative (#8) confirmed a low temperature sanitizer is, Always known to require a minimum wash temp [temperature] of 120 degrees. A facility can turn up the water heater or attach a booster heater. But again, from a sanitizing standpoint the Ultra San will complete the sanitization process. The facility failed to address and correct the inadequate dishwasher temperature for 18 days.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 1 sampled resident (Resident #2) reviewed for a fall with injury. Failure to notify the physician of the fall, potential fracture, and pain prevented the physician from altering the treatment and care for the resident. Findings include:Review of the facility policy titled Fall Protocol occurred on April 7, 2026. This policy dated June 2023 stated, . Post-Fall Management . Immediately perform and document complete head-to-toe assessment. including assessment for possible injuries. Notification. 1. Notify the LP [Licensed Practitioner] immediately at the time of the fall; provide the following: . b. Injury or complaint of pain . d. Obtain order for medical interventions/diagnostic procedures . 3. Patient's representative, as appropriate. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a right femur fracture. The current care plan stated, . Resident is at risk for falls due to cognitive loss . A progress note, dated 02/03/2026 at 8:15 a.m., stated, . At 0130 [1:30 a.m.] . nurse heard injured resident yelling. Bathroom door was shut. Resident was found on the floor on her back at 0135 [1:35 a.m.] . had no s/s [signs or symptoms] of head injury, all limbs palpated, and resident voiced increased pain in her right leg above her knee. resident was hoyer [mechanical lift] lifted to her bed. Large blanket in her room was rolled up and placed under her knee to help immobilize and stabilize her leg. Nurse contacted ER [emergency room] . and asked for provider on calls number. Noc [night] nurse gave ER staff nurse sit rep [situation report]. ER nurse stated to residents noc nurse that if it didn't appear to be emergent at the time to give tylenol [pain medication] and ice extremity, and to wait to call provider and obtain x-rays at 0800 [8:00 a.m.] this morning. Prn [as needed] tylenol was given around 0200 [2:00 a.m.] . providing non-pharmacological care using conversation to try to keep her mind off the pain. Resident complained of pain at first on her outer right hip and upper right leg. ice pack was applied . Throughout the night she [Resident #2] would say pain was one place and not in others, and other times would say pain was present in areas where she said she didn't have pain prior. Provider on call and family notified of resident condition. X-rays taken around 0815 [8:15 a.m.], and resident transported to the ER at 0900 [9:00 a.m.] .A progress note dated 02/03/26 at 9:38 a.m. stated, . Pain reported by resident to R [right] leg. Leg is swollen and slightly rotated. Femur fracture reported to RN [registered nurse] per [provider name].During an interview on 04/8/26 at 12:15 p.m., an administrative nurse (#1) confirmed staff failed to notify the physician about Resident #2's potential fracture.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents remained free of chemical restraints for 1 of 5 residents (Resident #2) reviewed for unnecessary medications. Failure to document an assessment and appropriate diagnosis for the use of an antipsychotic medication does not allow the resident to attain and/or maintain his/her highest level of practicable well-being.Findings include:Review of the facility policy titled Antipsychotic Drugs occurred on 04/08/26. This policy, dated September 2022 stated, . Based on a comprehensive assessment of a resident, the facility must ensure that: A. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. Medications included Risperidone (antipsychotic medication).Resident #2's admission Minimum Data Set (MDS), dated [DATE], identified no behaviors and the use of antipsychotic medication. A quarterly MDS, dated [DATE], identified physical behaviors and the use of antipsychotic medication.During an interview on the afternoon of 04/08/26, an administrative nurse (#1) confirmed the facility received an order for the antipsychotic medication after a psychiatric consultation however the order lacked a diagnosis or progress note from the physician.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #5) observed to self-administer medications (SAM). Failure to assist/observe residents who are not SAM take their medications may result in adverse health consequences.Findings include:Review of the facility policy Self-Administration of Medication occurred on 04/08/26. This policy, dated January 2024, stated, . Drugs can be left at the bedside and self-administered by the resident only if ordered by the physician. nursing will assess resident/patient for appropriateness of self-administering, this form will be kept in the MAR [medication administration record] . Observation on 04/06/26 at 5:00 p.m. showed Resident #5 seated in the dining room and a medication cup containing several pills on the meal tray in front of the resident. The nurse (#2) administered medications to other residents in the dining room. Resident #5 picked up the medication cup and consumed the pills. When asked if Resident #5 is capable to self-administer medications, the nurse (#2) stated, Yes, I believe so. Review of #5's medical record occurred on all days of survey. The record lacked a physician order for SAM and the care plan identified the following, . I am unable to self-administer my own medications due to dementia history of CVA [cerebrovascular accident] (stroke) . The nurse (#2) failed to assist/observe Resident #5 with her medications.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure appropriate care and services for 1 of 1 sampled resident (Resident #8) with an indwelling urinary catheter. Failure to obtain a physician's order for an indwelling catheter and catheter cares may result in urinary tract infections (UTIs), discomfort, skin issues, and sepsis.Findings include: Review of Resident #8's medical record occurred on all days of survey and identified an indwelling urinary catheter since admission on [DATE]. The physician's orders failed to include an order for an indwelling urinary catheter or how often to replace the catheter. The record showed facility staff changed the catheter 01/18/26, 15 weeks after admission. Review of Resident #8's progress note, dated 01/18/26 at 5:19 p.m., stated . resident reported severe pain to his catheter insertion site. Urine in tubing noted to be puss [sic] like with some blood noted. Catheter was irrigated with approx [sic] 40 cc [cubic centimeter a unit of measure] of normal saline. Small clot noted to tubing post irrigation, minimal urine return. Resident reported minimal relief post irrigation . Old foley removed. insertion of new 16 fr [French] foley catheter. Approx 30 ml [milliliters] of cloudy yellow urine returned. Site secured. Resident reported relief from pain. During an interview on 04/08/26 at 4:07 p.m., an administrative staff member (#1) confirmed Resident #8's physician's orders failed to include an indwelling foley catheter and how often to change the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, professional reference review, and staff interview, the facility failed to obtain an order for oxygen for 1 of 1 sampled resident (Resident #12) observed with oxygen. Failure to obtain a physician's order for oxygen use may result in complications and compromise the residents' respiratory status.Findings include: Kozier &ˆErb'sˆFundamentals of Nursing, Concepts, Process and Practice, 11th Editionˆ eText, 2021, Pearson, Boston, Massachusetts, page 1292,ˆstated, . Oxygen Therapy . The medical administration of supplemental oxygen is considered to be a process similar to that of administering medications and requires similar nursing actions. Oxygen therapy is prescribed by the healthcare provider, who orders the concentration, method of delivery, and depending on the method, liter flow per minute .Review of Resident #12's medical record occurred on April 7-8, 2026, and identified the resident returned to the facility the afternoon of 04/06/26 following an acute hospital stay for pneumonia and exacerbation (flare up) of congestive heart failure. Observation on April 7-8, 2026 showed Resident #12 wearing oxygen via a nasal cannula at 2 liters per minute. The physician's orders failed to include an order for oxygen.During an interview on 04/08/2026 at 4:40 p.m., an administrative staff member (#1) confirmed Resident #12 did not have an order for oxygen.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 6 sampled residents (Resident #5, #6, and #8) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), personal protective equipment (PPE), hand hygiene, and surface disinfection has the potential to spread infection throughout the facility. Findings include: Review of the facility policy Enhanced Barrier Precautions occurred on 04/08/26. This policy, revised March 2026, stated, . Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing .Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting . Wound care: any skin opening requiring a dressing . All residents with any of the following: Infection or colonization with an MDRO [multidrug-resistant organisms] . Review of the untitled facility policy regarding hand hygiene occurred on 04/08/26. This policy, dated 04/2023, stated, . team members should use an alcohol-based hand rub for routinely decontaminating hands in these situations: . Before and after donning clean or sterile gloves. Review of the facility policy titled Urinary catheter: Indwelling (Foley) Catheter Care occurred on 04/08/26. This policy, dated 04/07/26, stated, . Emptying Urine Drainage Bag. Clean hands and put on gloves. - Review of Resident #6's medical record occurred on all days of survey identified a history of a MDRO. Observation on 04/06/26 at 3:20 p.m. showed an EBP sign, and PPE supplies on Resident #6's door. A certified nurse aide (CNA) (#5) wearing gloves, assisted the resident with a brief change, adjusted the top sheet, and placed the overbed table next to the bed. The CNA failed to apply a gown prior to completing high contact cares. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a non-pressure chronic ulcer of left lower leg. Observation on 04/07/26 showed an EBP sign and PPE on Resident #5's door. * At 9:59 a.m. two CNAs (#3 and #4) applied gloves, entered the room, and assisted the resident to the bathroom. The CNAs removed their gloves, completed hand hygiene and exited the room. The CNAs failed to apply a gown prior to completing high contact cares. * At 10:02 a.m. Resident #5 activated the call light. Two CNAs (#3 and #4) applied gloves, entered the resident's room and bathroom, assisted the resident with toileting hygiene, a brief change, and transferred the resident back into the wheelchair. The CNAs failed to apply gowns prior to completing high contact cares. During an interview 04/08/26 at 2:40 p.m., an administrative nurse (#9) confirmed she expected staff to wear the required PPE when performing high contact resident care tasks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Observation on 04/08/26 at 10:15 a.m. showed a CNA (#3) apply PPE without performing hand hygiene. As the CNA emptied Resident #8's urine collection bag into a graduated cylinder, urine dripped onto a paper towel underneath the cylinder and soaked through to the floor. The CNA (#3) failed to perform hand hygiene before applying PPE and failed to disinfect the floor where urine dripped. During an interview on 04/08/26 at 10:49 p.m., an administrative nurse (#9) confirmed she expected staff to perform hand hygiene before applying PPE and to disinfect the floor after a urine spill.