

PRINTED: 05/10/2012
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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If continuation sheet Page 1 of 2

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2009
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(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	
K 038	Continued From page 1 must be of required width and size to provide all occupants with safe access to a public way. 7.7.1 To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. Observation determined the west exterior exit discharge traversed the lawn to get to a public way.	K 038	allow the exit to public ways to traverse grassy surfaces. The facility passes the FSES.		