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 _____	10/28/2009

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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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint investigation, started on 10/26/09 and completed on 10/28/09, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	F tag 156 1. At the time that their Medicare coverage ended, Residents #6, #11 and #12 were given the option to appeal the decision to end coverage on the SNF Determination on Continued Stay notice and they all chose not to appeal. However, these residents were not given the CMS-10123 notice at that time. Since that time Resident #11 has died. We will meet this requirement by informing Residents #6 and # 12, or their legal representative, of the facility's error in not also giving the Medicare notice CMS-10123. 2. Any resident that qualifies for Medicare skilled services is affected by this notification process. 3. CMS form10123 is available for use on Garrison Memorial Hospital letterhead paper. This form will be given to residents or their legal representative at the same time as the SNF Determination on Continued Stay notice, informing	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Mathern	administrator	11/10/09

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.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156	them that their Medicare coverage is ending, the reason for their coverage ending, and their rights to appeal. These notices will be given by the facility's Utilization Review Coordinator or by the facility's social worker in her absence. 4. Nursing facility charts will be reviewed at the weekly utilization review meeting to ensure these notices are given to the residents as needed. As of 11-01-09 a monthly QA monitor of NF charts will be done by the facility's social worker to check for the presence of CMS-10123 notice for those residents whose Medicare skilled services have ended.	11/1/09

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to provide required notices for potential liability of payment for 3 of 3 Medicare billing records reviewed for Resident #6, #11, and #12. The facility must provide the beneficiary with a "Generic Notice/Notice of Medicare Provider Non-Coverage" (CMS- 10123) form, which informs the resident or their legal representative in writing why Medicare may not cover specific services, the right to appeal the decision, and the beneficiary's potential liability for payment of the	F 156		

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F 156	Continued From page 3 non-covered services. Failure to provide the correct notices of non-coverage of Medicare benefits is an infringement of resident rights. Findings include: Review of Medicare records for Resident #6, and supplemental Resident #11 and #12, occurred on the afternoon of 10/27/09. These reviews revealed the residents no longer received Medicare benefits as of the following dates: Resident #6: 09/26/09 Resident #11: 09/08/09 Resident #12: 01/22/09 The facility failed to provide the required CMS-10123 form to all three residents when the facility determined their Medicare coverage would cease. An interview with an administrative staff member (#1) occurred on 10/27/09 at 4:00 p.m. This staff member confirmed these three residents failed to receive the form CMS-10123 when their Medicare coverage ended.	F 156	F Tag 226 1. The Abuse policy will be updated with correct phone numbers and timing for reporting of suspected abuse. 2. All residents in the Hospital and Nursing Facility could be affected. 3. The policy will be updated with the correct phone number and timing for reporting abuse. Initial training and annual training will be held for employees regarding the abuse policy. The deficiency will be corrected by Nov. 30th, 2009.	
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and staff interview, the facility abuse policy lacked 1 of 7 required components (reporting requirements). Failure to adequately address all required	F 226	4. See attached updated policy and monitor. This policy will be reviewed and revised if needed, each year by the Social Worker. The result of this monitor will be presented to the QA committee.	11/30/09

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F 226	Continued From page 4 components increases the risk of staff to become unaware of how to properly address incidents of abuse and neglect. Findings include: Review of the facility policy titled "Abuse, Neglect or Misappropriation of Property" occurred on the morning of 10/27/09. This policy, revised 10/08, stated, ". . . V. Investigation: . . . 8. . . . The Administrator/designee by the fifth working day will notify the State Department of Health of the investigative results if allegations substantiated . . . VII. . . . 5. . . . All allegations must be reported to the department immediately by telephone [during business hours] followed by the report. . . ." The facility policy conflicts with regulatory requirements regarding immediate reporting of all allegations to the State survey and certification agency. Requirements also include reporting the outcome of the investigation (both substantiated and unsubstantiated) within five working days. The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding reporting of allegations. CMS has identified "Immediately" to mean as soon as possible, but ought not exceed 24 hours after discovery of the incident. Conformance with this definition requires that each State has a means to collect reports, even on off-duty hours [e.g., answering machine, voice mail, fax]. During an interview on 10/27/09 at 1:20 p.m., an administrative staff member (#3) confirmed the facility's abuse policy conflicted with regulatory requirements.	F 226		
F 323	483.25(h) ACCIDENTS AND SUPERVISION	F 323		

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F 323 SS=E	Continued From page 5 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide an environment free of accident hazards by failing to store hazardous chemicals in locked storage areas in 1 of 1 long term care unit during 3 of 3 days of survey. Failing to properly store hazardous chemicals has the potential to cause harm to cognitively impaired residents who may gain access to them. Findings include: Review of the facility policy titled "Hazardous Materials" occurred on the morning of 10/28/09 at 10:20 a.m. This policy, revised 10/03, stated, ". . . 8. CHEMICAL STORAGE 1. All Hazardous chemicals will be stored in a locked storage area . . ." During an initial tour of the environment on 10/26/09 at 8:20 p.m., observation in the Activity room identified two spray bottles of "Spic & Span" disinfectant all-purpose spray, two bottles of "Clean Erase" markerboard cleaner, and one bottle of "Woolite" fine fabric wash, located underneath the kitchen sink in an unlocked cupboard. The "Spic & Span" and "Woolite"	F 323	F Tag 323 1. Corrective action will be completed to protect residents from access to hazardous chemicals. 2. All residents in the Hospital and Nursing Facility could be affected. 3. Hazardous chemical policy (see attached) will be revised to include child safety locks as another method of securing chemicals. The facility will keep all hazardous chemicals secured/locked, so the residents do not have access to them. Child safety locks or locks will be put on all cupboards or areas where hazardous chemicals are stored. Chemicals will be removed from areas that are not secured. Staff education, including but not limited to housekeeping, nursing, activities, maintenance, and beauty shop employees, will also be a part of the process. This will be completed by Nov. 30th, 2009. 4. A monitor will be put in place (proper storage of chemicals), that will include the date, initials of	

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F 323	Continued From page 6 bottles contained the warning: "Keep out of reach of children", and the "Clean Erase" bottle contained the warning: "May be harmful if swallowed." On 10/27/09 at 7:40 a.m., random observation identified an unlocked storage room at the end of one of two hallways in the long term care unit. Observation of the unlocked storage room identified a pair of scissors and a spray bottle of "Space Age Spray Buff" maintenance and restorer. The "Space Age Spray Buff" bottle contained the warning: "Keep out of reach of children." In addition, observation of the Activity room identified chemicals found on 10/26/09 remained in the unlocked cupboard below the kitchen sink. During the environmental tour on 10/28/09 at 7:50 a.m. with an administrative maintenance staff member (#4), observation identified the chemicals found in the Activity room on 10/26/09 and 10/27/09 remained in the unlocked cupboard below the kitchen sink. Observation also showed the Barber Shop door unlocked and opened, and lights on in the room. A spray bottle of "Spic and Span" sat on the counter in the Barber Shop. Observation also identified an unlocked and opened Nursing Service room containing an unlocked housekeeping cart. The housekeeping cart contained the following chemicals: a container of "Comet" disinfectant cleaner with the warning: "keep out of reach of children", three spray bottles of "Crew Neutral NA" disinfectant cleaner with the warning: "keep out of reach of children", a spray bottle of "Vani-Sol" disinfectant cleaner with the warning: "avoid contact with eyes, may be harmful if swallowed", an unlabeled spray bottle containing a blue colored solution, a	F 323	person doing the monitor, area inspected, findings and actions taken. This monitor will be done on a weekly basis for 1 year. Findings will be reported to the QA committee at the quarterly meetings. This will be done by the housekeeping supervisor.	11/30/09

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F 323	Continued From page 7 container of "Ta-Poff" liquid tape remover containing the warning: "Danger Poison: may be harmful or fatal if swallowed", a container of "Super Odor Neutralizer" containing the warning: "caution: eye irritant", and a container of "Sursan 256" disinfectant with the warning: "keep out of reach of children, may irritate eyes, concentrated product may cause chemical burns." On 10/28/09 at 12:15 p.m., random observation identified the spray bottle of "Spic & Span" in the Barber Shop, and the previously identified bottles in the unlocked cupboard in the Activity room, remained accessible to residents. When asked, at the time of the environmental tour on 10/28/09 at 7:50 a.m., the administrative maintenance staff member (#4) did not disagree the chemicals are to be stored in locked storage areas.	F 323		
F 520 SS=C	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		

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F 520	Continued From page 8 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the designated physician actively participated as a member of the Quality Assurance (QA) Committee during 4 of 4 quarterly meetings held from October 2008 through July 2009. Findings include: During the entrance conference, on 10/26/09 at 7:15 p.m., an administrative nurse (#2) stated the physician attends quality assurance meetings "if he can." The nurse stated the physician is "always invited, but it doesn't always work out. The minutes are sent to him." The quality assessment and assurance review took place on 10/28/09 at 8:20 a.m. with an administrative nurse (#2). Review of QA Committee Meeting attendance rosters also occurred the morning of 10/28/09. These rosters, dated 10/21/08, 01/20/09, 04/21/09, and 07/21/09, confirmed the physician did not attend any of the meetings held between 10/21/08 - 07/21/09.	F 520	F tag 520 1. A provider will be present during the QA committee meetings either in person or by teleconference. 2. All residents of Garrison Memorial Hospital and Nursing Facility could be affected by not having a provider present during the meetings. 3. A monitor will be put in place to ensure that a provider will be present either in person or by teleconference at the QA committee meetings. This will be accomplished by Nov. 30th, 2009. 4. A monitor will be done every quarter to make sure a provider is present at the QA committee meeting, by the DON. Results will be reported at the quarterly QA committee meeting. See attached monitor.	11/30/09