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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE , GARRISON, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 04/06/26 and concluded 04/08/26.	F0000		05/04/2026
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: 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:	F0552	F0552- Right to be Informed/Make Treatment Decisions For Residents #2, #4, #5, #9, and #16, a new Psychotropic Medication Informed Consent Form was developed on 4/11/2026 and added to the facility's Psychotropic Drug Policy. The new consent form was mailed to each resident's Resident Representative, Power of Attorney, and/or Guardian on 4/11/2026. This mailing provided them with the opportunity to review the psychotropic medication, provide a signature to grant consent, and acknowledge notification of the psychotropic medication. All residents who are receiving psychotropic medication treatment have the potential to be affected. The current policy/procedure for Antipsychotic Drugs is being reviewed and revised on 4/28/2026 A new policy and procedure is being developed to include a Psychotropic Medication Informed Consent Form. The purpose of this form is to provide notification and obtain consent when a resident is either admitted while currently taking a psychotropic medication or is newly prescribed one. The form will be mailed to the resident's representative, Power of Attorney, or guardian for their review and signature, serving as their consent and acknowledgment of notification. All Licensed Nurses received in-service training from the Director of Nursing concerning the facility's revised policy, which now incorporates the Psychotropic Medication Informed Consent Form. The training covered the form's purpose and the	05/05/2026

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 reverse for further 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

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

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F0552 SS = E	Continued from page 1 - 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.	F0552	Continued from page 1 circumstances requiring its use, specifically for notifying and obtaining consent when a resident is admitted while currently taking a psychotropic medication or is newly prescribed one. The completed form will be dispatched to the resident's designated representative, Power of Attorney, or guardian for their review and signature, which constitutes their consent and acknowledgment of notification. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON), or an assigned representative, will monitor to assure residents with psychotropic medication orders to confirm that a Psychotropic Medication Informed Consent Form is on file. Quality Assurance monitoring will be implemented by 5/5/2026. DON or designee will monitor at random weekly for one month, monthly for three months, then quarterly thereafter for one year. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. Date of correction : 5-5-2026	05/05/2026

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

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F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: 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	F0657	F0657-Care Plan Timing and Revision For Resident #2, #3, #4, #8, #16, and # 21 Care plans for individual needs and conditions are in the process of being revised to be completed by 5/5/2026.. No residents were affected by the defiance practice. All residents who reside in the facility have the potential to be affected. The current policy/procedure for the Care Conference and Resident Center Care Plan was reviewed on 4/28/2026. No changes required. Prior to or by 5/5/2025, the Director of Nursing will provide in-service training to all Licensed Nurses. This training will cover the appropriate completion time and revisions of resident care plans. All Resident care plans will be assessed and updated to be resident-centered, based on a comprehensive individual evaluation. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON) or their designated representative will monitor to assure residents' care plans are resident-centered based on comprehensive assessment,updated timely to reflect changes in resident medications, and care needs. Quality Assurance monitoring will be implemented by 5/5/2026. DON or designee will monitor 3 random care plans weekly for one month, monthly for three months, then quarterly thereafter for one year. All results will be reported to the Director of Nursing (DON). If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each	05/05/2026

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F0657 SS = E	Continued from page 3 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.	F0657	Continued from page 3 scheduled meeting. Date of correction : 5/5/2026	05/05/2026

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F0657 SS = E	Continued from page 4 Resident #8's care plan failed to identify problems, goals, and interventions related to indwelling urinary catheter. -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.	F0657		05/05/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812	Tag 0812 Food Procurement, Store/Prepare/Serve-Sanitary Water temperatures were immediately monitored twice daily and now have been increased to three times daily with each use of a dishwasher. This will remain in effect until a new hot water heater is installed. All residents could be impacted by the dishwasher not maintaining the manufactured and recommended temperature. The current policy/procedure for FNS Department Standard Operating Procedure A-6004D, Operations will be reviewed and staff educated on policy. The Dietary Manager will monitor staff and verify that	05/05/2026

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F0812 SS = E	Continued from page 5 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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	F0812	Continued from page 5 policy is being followed prior to dishwasher being used to sanitize dishware. When a new hot water heater is installed by approx 5-8-2026 will continue to monitor temperatures 3x daily according to policy. The dietary manager or designee will monitor the temperature of the dishwasher prior to use everyday and if not within the temperature range will notify the manager and start the process to sanitize dishware according to policy. Date of Correction: 5-5-2026	05/05/2026

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F0812 SS = E	Continued from page 6 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.	F0812		05/05/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when	F0580	F0580- NOTIFICATION OF CHANGES For Resident #2, the provider and responsible party were notified immediately on 2/3/2026 regarding the specific resident's fall incident, ensuring all necessary assessments are completed. All residents have the potential to be affected. The current policy/procedure Notification of Change is being reviewed and/or revised to be completed by 5/52026. The new policy and procedure requires the following notification steps: Physician: The physician must be immediately contacted for any significant change, injury, or severe symptoms (e.g., unexpected death, incident involving injury, mental status change, chest pain, respiratory distress, or unspecified pain). Family/Representative: Nursing staff is responsible for immediately notifying the family or representative upon a significant change or need to alter treatment. Documentation and Care Plan: All assessments, notifications, and outcomes must be recorded in the resident's medical record (e.g., via the IRIS reporting tool). The resident's All Licensed Nurses received in-service training	05/05/2026

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F0580 SS = D	Continued from page 7 there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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 . . . "	F0580	Continued from page 7 from the Director of Nursing regarding a new policy and procedure that is being developed for Notification of Change. This will include the following notification steps: Physician: The physician must be immediately contacted for any significant change, injury, or severe symptoms (e.g., unexpected death, incident involving injury, mental status change, chest pain, respiratory distress, or unspecified pain). Family/Representative: Nursing staff is responsible for immediately notifying the family or representative upon a significant change or need to alter treatment. Documentation and Care Plan: All assessments, notifications, and outcomes must be recorded in the resident's medical record (e.g., via the IRIS reporting tool). The resident's care plan must be updated to reflect the new condition. All residents who experienced a significant change in condition within the last 30 days will have a chart assessment conducted to verify that providers and Family/Representative were notified of previous incidents.Any resident identified without appropriate provider and family/representative notification will be notified immediately and reflected in the residents' medical record.. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON), or a designated alternate, will monitor to assure the residents' electronic medical records that the provider and family/representative were notified of all significant changes in a resident's condition. 5.Quality Assurance monitoring will be implemented by 5/5/2026. DON or designee will monitor at random weekly for one month, monthly for three months, then quarterly thereafter for one year. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective	05/05/2026

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F0580 SS = D	Continued from page 8 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.	F0580	Continued from page 8 action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. Date of correction : 5/5/2026	05/05/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints	F0605	F0605 -RIGHT TO BE FREE OF CHEMICAL RESTRAINT 1. For Resident #2, On 4/9/2026, the resident's clinical record was reviewed to confirm if a medical symptom (e.g., delusional ideation, psychosis) was documented, even if not properly linked to the diagnosis. The psychiatric provider and attending provider was contacted. The purpose of this contact was to re-evaluate the need for the antipsychotic	05/05/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE , GARRISON, North Dakota, 58540**

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F0605 SS = D	Continued from page 9 imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or	F0605	Continued from page 9 medication and establish an appropriate diagnosis.Orders were received on 4/9/2026 to discontinue the patient's psychotropic medications. 2.All residents who are prescribed psychotropic medications have the potential to be affected. 3.The current policy/procedure for Antipsychotic Drugs is being reviewed and revised on 4/28/2026 A new policy and procedure is being developed to include a Psychotropic Medication Informed Consent Form. The purpose of this form is to provide notification and obtain consent when a resident is either admitted while currently taking a psychotropic medication or is newly prescribed one. The form will be mailed to the resident's representative, Power of Attorney, or guardian for their review and signature, serving as their consent and acknowledgment of notification. All Licensed Nurses received in-service training from the Director of Nursing regarding antipsychotic drug usage, documentation requirements, and dementia care, focusing on identifying behaviors as "unmet needs". 100% of licensed nurses are required nurses on antipsychotic usage, documentation requirements, and dementia care, focusing on identifying behaviors as "unmet needs" on 5/5/2026 All residents receiving medication treatment, will be reviewed for psychotropic medication orders and will be assessed to ensure they align with the appropriate psychological diagnosis. This assessment is required to confirm the correct diagnosis for psychotropic medication use. 4. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON) or their designated representative will monitor to assure residents' electronic medical records to review for psychotropic medication orders to ensure all psychotropic medication have the appropriate psychological diagnosis. Quality Assurance monitoring will be implemented	05/05/2026

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F0605 SS = D	Continued from page 10 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by:	F0605	Continued from page 10 by 5/5/2026. DON or designee will monitor at random weekly for one month, monthly for three months, then quarterly thereafter for one year. All results will be reported to the Director of Nursing (DON). If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. Date of correction : 5/5/2026	05/05/2026

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F0605 SS = D	Continued from page 11 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 12/18/25, identified no behaviors and the use of antipsychotic medication. A quarterly MDS, dated 02/15/26, 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.	F0605		05/05/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684	F0684-Quality of Care For Resident #5 was assessed by the Director of Nursing (DON) for any adverse effects and no negative outcomes were identified Completed self-administration of Medications assessment on 4/25/2026, Care plan was reviewed and updated as needed. The licensed nurse (#2) involved was immediately re-educated on the facility's Self Administration of Medication Policy, specifically regarding the requirement to observe the resident swallowing all medication before leaving the resident's side.	05/05/2026

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F0684 SS = D	Continued from page 12 This REQUIREMENT is NOT MET as evidenced by: 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.	F0684	Continued from page 12 All residents who receive medications in the facility have the potential to be affected. The current policy/procedure for the Self Administration of Medication was reviewed on 4/28/2026. No changes required. Prior to or on 5/5/2025, the Director of Nursing will provide in-service training to all Licensed Nurses and Medication Assistants on Self Administration Medications. This training will cover resident Self-administering medication assessment (SAMS), 5 Rights of Medication Administration, focusing on the “Right Route” and "Right Resident," and the requirement to witness the ingestion of medications. All Residents who receive medication in the facility will be assessed using SAM assessment to determine if the resident is fully independent , requires assistance or is unable to self-administer medications. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON) or their designated representative will monitor to assure residents' care plans are resident-centered based on comprehensive assessment,updated timely to reflect changes in resident medications, and care needs. Quality Assurance monitoring will be implemented by 5/5/2026. DON or designee will monitor random, unannounced, weekly medication pass audits on all shifts weekly for one month, monthly for three months, then quarterly thereafter for one year. All results will be reported to the Director of Nursing (DON). If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. Date of correction : 5/5/2026	05/05/2026

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F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: 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	F0690	F0690 Bowel/Bladder Incontinence, Catheter, UTI For Resident #8 was immediately assessed by the Registered Nurse (RN) for skin for signs of UTI or trauma. Physician/Provider was contacted to receive orders for catheter care, securement device and scheduled replacement intervals. The resident EMAR was updated to reflect these orders. Catheter care was provided by staff and a new catheter and bag was inserted if necessary. All residents with indwelling catheters have the potential to be affected. The current policy/procedure for Catheter Cares was reviewed on 4/28/2026. New changes required. A new policy/procedure for Indwelling/ Suprapubic Catheter Care/Replacement is being developed to reflect “. Verify that there is a physician's order for this procedure.:admission and readmission process if a resident has a catheter without an order, verify with the physician/provider to obtain an order to continue or discontinue catheter care. “General Guidelines to follow. Prior to or on 5/5/2025, the Director of Nursing will provide in-service training to all Licensed Nurses on Catheter Care/Replacement. This training will cover proper catheter care techniques. Documentation of care in the EMR, and The admission and readmission process updated to ensure that if a resident has a catheter,verification of orders is mandatory. All Residents who have an indwelling catheter will be assessed for catheter care orders. 4. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON) or their designated representative will monitor to assure residents' for presence of catheter care orders in the EMAR. Quality Assurance monitoring will be implemented by 5/5/2026.	05/05/2026

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F0690 SS = D	Continued from page 14 urinary catheter since admission on 10/06/25. 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.	F0690	Continued from page 14 DON or designee will monitor random, unannounced, weekly catheter audits on random shifts weekly for one month, monthly for three months, then quarterly thereafter for one year. All results will be reported to the Director of Nursing (DON). If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of correction : 5/5/2026	05/05/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: 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 & Erb's "Fundamentals of Nursing,	F0695	F0695 Respiratory/Tracheostomy Care and Suctioning For Resident #12 was immediately assessed by the Registered Nurse (RN) for respiratory status, checked oxygen saturation and adverse effects of oxygen use. Physician/Provider was contacted and an order for oxygen was obtained, including rate and method of delivery. Concentrator/tank settings were verified to match the new order. The Medication Administration Record was updated to reflect the new oxygen order. All residents currently utilizing supplemental oxygen have the potential to be affected. The current policy/procedure changes required. A new policy/procedure for Oxygen Administration is being developed to reflect “. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.”	05/05/2026

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F0695 SS = D	Continued from page 15 Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 1292, stated, ". . . 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.	F0695	Continued from page 15 Prior to or on 5/5/2025, the Director of Nursing will provide in-service training to all Licensed Nurses on New Oxygen Administration Policy. This training will be Respiratory Care, emphasizing that oxygen is a medication requiring a physician order including rate, duration, and method, and documentation in the EMAR. All Residents who are utilizing supplemental oxygen EMR will be assessed to verify the presence of a current physician order, and ensure the current settings match the physician/provider order, care plan, and MAR.. 4. The Director of Nursing (DON) or their designated representative will be responsible for monitoring /audit. The Director of Nursing (DON) or their designated representative will monitor to assure residents' utilizing supplemental oxygen has orders in the EMAR. Quality Assurance monitoring will be implemented by 5/5/2026. DON or designee will monitor random residents on oxygen weekly for one month, monthly for three months, then quarterly thereafter for one year. All results will be reported to the Director of Nursing (DON). If concerns are identified, immediate corrective action will be implemented. The Director of Nursing (DON) will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of correction : 5/5/2026	05/05/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to	F0880	Tag F0880 - Infection Control 1.For Resident #5, #6, #8 staff will be educated on the policy and procedure of proper PPE and how to care for a resident on Enhanced Barrier Precautions by 5-5-26. 1. For Resident #8, staff will be educated on policy and procedure of proper cleaning technique for	05/05/2026

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F0880 SS = D	Continued from page 16 help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 16 bodily fluid spills. Education on process to clean and disinfect area after a bodily fluid spill. 2. All residents who reside in the facility have the potential to be affected. 3. All direct care staff will be re-educated on the current policy/procedure for Enhanced Barrier Precautions, Hand Washing, and the Cleaning of bodily fluid when spilled on any surface on 5-5-26 by DON. Resident signage on doors will be updated to direct care providers on proper PPE needed to wear. Environmental Services Routine cleaning policy and procedure will be reviewed and updated to include Spills of blood or bodily fluids by 5-5-2026 4. The Director of Nursing (DON) or designated representative will be responsible for monitoring audits. The Director of Nursing (DON) or their designated representative will monitor to assure proper PPE and hand washing is being completed with direct care of residents in Enhanced Barrier Precautions. The Director of Nursing (DON) or their designated representative will monitor any spills of bodily fluids and/or any potential spills and audit that they are properly disinfected at time of any spills. DON or designee will monitor 3x per week x1 mth, 2x a week for a mth, then monthly x3 then quarterly and will adjust according to compliance. 5. Date of Correction: 5/5/2026	05/05/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE , GARRISON, North Dakota, 58540**

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F0880 SS = D	Continued from page 17 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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: . . .	F0880		05/05/2026

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F0880 SS = D	Continued from page 18 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. - Observation on 04/08/26 at 10:15 a.m. showed a	F0880		05/05/2026

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F0880 SS = D	Continued from page 19 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.	F0880		05/05/2026