North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1076	A. BUILDING: _____ B. WING _____	C 02/27/2025

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

(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) COMPLETE DATE
L1617	33-07-03.2-16,1b DIETARY SERVICES If the director of dietary services is not a licensed and registered dietitian, regularly scheduled consultation from a consultant licensed and registered dietitian must be obtained at least monthly. This State Licensing Rule is not met as evidenced by: Based on review of facility policy and staff interview, the facility failed to ensure monthly oversight by a licensed registered dietitian. Failure to provide a dietitian's oversight of long-term care residents and the certified food manager (CFM) placed the residents at risk for adverse nutritional events. Findings include: Review of the facility policy titled "Dietary Implications for Nursing Service" occurred on 02/26/25. This undated policy stated, "A consultant dietitian visits the facility monthly and is available for diet instructions or dietary consultation for residents. . . ." During an interview the morning of 02/25/25, an administrative staff member (#1) stated our dietitians are hospital employees and work remotely. During an interview on 02/25/25 at 12:50 p.m., when asked about dietitian support and visits, the dietary supervisor (#10) stated, "They [hospital dietitians] only come when there is an admission or at least once per year," and confirmed she does not complete dietary assessments/progress notes. During an interview on 02/26/25 at 10:20 a.m., a	L1617	L1617 1.Dietician through CHI Bismarck, will assist the facility in bridging the gaps until dietary manager assumes her role in further encompassing the nutritional care of the residents. Dietitians will continue to complete annuals, initials, and significant changes assessments(including weight changes) as notified, by facility this was confirmed through email on 3/27/25. 2. All residents have the potential to be affected by this deficient practices of no dietitian oversight of long term care residents. 3. MDS coordinator completed an audit matrix care (EHR) to ensure that quarterly and annual dietician nutritional assessments were completed on 3/25/25. Facility Dietary policy was reviewed and revised to reflect current regulatory compliance, a licensed or registered dietitian occurs monthly for dietary instruction as needed. Education provided by March 25, 2025 to all staff, on the updated Dietary policy. 4.MDS coordinator will audit matrix care (EHR) to ensure that quarterly and annual nutritional assessments are being completed. Audit will be conducted	3/28/25

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/24/25

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L1617	Continued From page 1 hospital administrative dietitian (#12) stated dietitians do not visit the facility in person, the facility consults with concerns and/or if a resident needs a reassessment, and the facility's dietary supervisor (#10) writes monthly dietary progress notes.	L1617	randomly 2 times a month for 6 months. The MDS coordinator is responsible for compliance. The results of the audits will be reported to and reviewed by the quality council, by the MDS coordinator. If concerns are identified immediate corrective action of monitoring will be implemented	

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 02/24/25 and concluded 02/27/25. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F 000		
F 657 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:	F 657		3/28/25

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F 657	Continued From page 1 Based on record review, review of facility policies, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 4 of 12 sampled residents (Residents #1, #4, #5, and #7). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Interdisciplinary Care Plan and Care Plan Meeting" occurred on 02/26/25. This policy, dated December 2023, stated, ". . . C. Develop a care plan based upon information from the Interdisciplinary Team. . . ." Review of the facility policy titled "Care Conference and Resident Centered Care Plan" occurred on 02/26/25. This policy, dated June 1985, stated, ". . . 2. . . . The care plan will include . . . b) Physician orders . . . c) Dietary orders . . . 3. The . . . care plan will be . . . b. Developed by an interdisciplinary team, that includes . . . i. the attending physician . . . iv. dietary staff member . . . c. Reviewed and revised . . . by each member . . . 5. A comprehensive resident-centered care plan will be developed and implemented for . . . a) Services . . . furnished to the resident to attain or maintain their highest practicable . . . well-being . . . 8. Care plans will . . . be reviewed . . . as needed. . ." - Review of Resident #1's medical record occurred on all days of survey. Current physician's orders included verify monthly weight on the first Wednesday of the month.	F 657	F657 1. Resident #1□s No longer resides in the facility Resident #4□s care plan was updated to reflect the current orders for Restorative Care and Ambulation status under ADL□s, to reflect current recommendations on 3/20/25 Resident #5□s care plan was updated to reflect current orders for weekly weights and vital signs on 3/20/25 Resident #7 Care plan was updated to reflect current orders for weekly weights and correct diet, on 3/20/25 2.All the residents that have a care plan have the potential to be affected by this deficient practice. 3. All Residents care plans have had an initial audit completed, to ensure no contradictory orders exist by the DON, on 3/20/25 and 3/21/25. The current policy on Care Conference and Resident Centered Care Plan was reviewed and revised. Education/Training provided by March 25th, 2025 to all licensed staff and interdisciplinary team members on the Care planning for residents related to individualized resident orders. As well as reviewing the Care Conference and Resident Centered Care Plan policy 4. The DON is responsible for compliance. Audits on care plans to ensuring care plans are individualized to meet the residents diets, restorative care and weight needs conducted by DON and/or	

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F 657	Continued From page 2 Review of Resident #1's current care plan stated, ". . . Admission Care Assist Task: 06/07/23-Monthly weight once a day on 1st Wed [Wednesday] of the month . . . Resident has kidney disease and neuropathy, related to diabetes mellitus . . . 10/22/2020-Monitor weight weekly . . ." The facility failed to remove contradicting orders from Resident #1's care plan. - Review of Resident #4's medical record occurred on all days of survey. Current physician's orders included restorative nursing ambulation program with a platform walker and assistance of 2 with a wheelchair to follow 3-5 days a week. Review of Resident #4's current care plan stated, ". . . 02/06/25 Restorative Nursing Ambulation Program-Ambulation with platform Walker with assist of 2 with wheelchair to follow 3-5 days a week . . . ADLs [activities of daily living] 01/27/2021 Ambulate with assist of one and front wheeled walker, 1x/d [one time per day], 3-5x's/week, [three to five times a week] . . ." The facility failed to remove contradicting orders from Resident #4's care plan. - Review of Resident #5's medical record occurred on all days of survey. Current physician's orders included verify monthly weight completed once a day on the 1st Tuesday of the month. Review of Resident #5's current care plan stated,	F 657	designee at random of 4x a week x 4 weeks and 3 x week for three months The results of the audits will be reported to and reviewed by the quality council, by the Director of Nursing If concerns are identified immediate corrective action of monitoring will be implemented	

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F 657	Continued From page 3 ". . . Admission Care Assist Task 05/02/2023 Monthly weight-Once A Day on 1st Tue [Tuesday] of the Month . . . 04/21/2017 Vital signs and weight weekly and PRN [as needed] . . ." The facility failed to remove contradicting orders from Resident #5's care plan. - Review of Resident #7's medical record occurred on all days of survey. Current physician's order included monthly weights on the first of the month, and a diet order for a diabetic/regular consistency, low potassium diet. Resident #7's current care plan failed to identify orders for monthly weights and type of diet. During an interview on 02/25/25 at 4:45 p.m., an administrative nurse (#2) agreed staff failed to update the residents' care plans.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to follow professional standards of practice for medication administration for 2 of 13 sampled residents (Residents #1 and #15) and one supplemental resident (Resident #14). Failure to follow a physician's order, document medications after administration, properly prime insulin pens, and provide privacy during insulin administration, may	F 658	F658 1.Resident #1- no longer resides at the facility- order was verified and discontinued on 2/19/2025 Resident #15's- Provided individual education to nurse #13 and direction on Insulin pen use along with policy and medication administration policy and discussing privacy to the residents when	3/28/25

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F 658	Continued From page 4 impede the therapeutic effectiveness of the medications, cause adverse events such as medication errors and low blood sugar, and infringes upon the residents right to privacy. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, ". . . Carrying Out a Physician's Orders . . . Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . ." Review of the facility policy titled "Medication Administration" occurred on 02/27/25. This policy, dated February 2008, stated, ". . . All medications should be charted immediately after they are given . . . Insulin, accuchecks . . . will not be given in the dining room. This will be done to assure the right of personal privacy and confidentiality of all residents." Review of the facility policy titled "Insulin Pen Use" occurred on 02/27/25. This policy dated 2010, stated, ". . . prime safety needle with 2 units prior to each administration . . . hold pen with needle pointing up . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included polyneuropathy (nerve damage causing numbness and pain). A physician's order, dated 01/29/25, stated, "Hydrocodone-APAP [an opioid	F 658	given insulin on 3/10/25 Resident #14-Provided individual education to nurse #13 and direction on Insulin pen use along with policy and medication administration policy and discussing privacy to the residents when given insulin. 3/10/25 2. All the residents that receive medications have the potential to be affected by the deficient practice. 3. All licensed nursing staff were educated one on one, on the insulin use policy it was reviewed and revised, adding an Insulin Pen Instruction sheet to the policy. Discussed giving insulin to resident in a private area. All licensed nursing staff have been educated on medication orders and medication administration to follow the five elements of a drug order as stated in the policy was completed by the DON on 3/24/25. Education/Training will be completed with all licensed nursing staff by March 25, 2025 on the insulin pen use policy, along with the step by step instruction sheet and the medication administration policy. 4. Audits on priming insulin pen correctly, Insulin signed off prior to administration, was privacy provided to the resident. And Auditing Medication orders for correct transcription of the order from written order to EHR, to assure the freq of the order is correct, conducted by DON and/or designee at random of 5x a week x 4 weeks and 3x week for three months	

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F 658	Continued From page 5 pain medication] 5-325 milligrams (mg) QAC [before every meal] and QHS [bedtime]. Resident #1's nursing progress note, dated 01/31/25 at 4:04 p.m., stated, "[Resident] has been confused today and whiney. [Resident] sleeping frequently today. Provider on call notified . . . and scheduled hydrocodone order was changed from QID [4 times a day] to BID [twice a day]. Resident #1's medication administration record (MAR) identified the resident received hydrocodone at 8:00 a.m. and 12:00 p.m. and showed the resident received a third dose of hydrocodone at 8:00 p.m. During an interview on 02/25/25 at 5:20 p.m. an administrative nurse (#2) confirmed Resident #1 received a third dose of hydrocodone after the physician changed the order to twice a day. - Observation on 02/25/25 at 11:58 a.m. showed a nurse (#13) documented Resident #14's blood sugar and insulin administration on the medication administration record (MAR) at 12:00 p.m. The nurse then prepared a Humalog Kwikpen (insulin) and primed the pen holding the pen downward. The nurse (#13) documented medication administration prior to administration and failed to prime the insulin pen pointing upward per facility policy. - Observation on 02/25/25 at 12:10 p.m. showed a nurse (#13) documented Resident #15's blood sugar and insulin administration on the (MAR) at 12:00 p.m. The nurse prepared a Fiasp FlexTouch (Insulin) pen and primed the pen holding the pen downward. The nurse (#13) brought Resident #15 to the dining room table	F 658	The results of the audits will be reported to and reviewed by the quality council, by the Director of Nursing If concerns are identified immediate corrective action of monitoring will be implemented	

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F 658	Continued From page 6 where three residents were seated, pulled up the resident's shirt, and injected the insulin in the abdomen. The nurse (#13) documented medication administration prior to administration, failed to prime the insulin pen pointing upward per facility policy and failed to provide privacy for the resident. During an interview on 02/25/25 at 1:33 p.m., an administrative nurse (#2) stated she expected nurses to document medications after they are administered, follow facility policy for priming of insulin pens, and provide privacy when administering insulin.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide assistive devices necessary to prevent accidents for 2 of 4 sampled residents (Residents #1 and #13) observed without wheelchair foot pedals. Failure to use wheelchair foot pedals while transporting residents, places all residents at risk for falls and/or injury. Findings include:	F 689	F689 1.Resident #1's- no longer resides in the facility. The wheel chair was assessed and replaced immediately on 2/27/2025 Resident #13- wheel chair was labeled with the resident's name and foot pedals have been attached to the wheelchair. And a pedal bag was placed on the back of the wheelchair on 3/10/25. 2. All the residents that use a wheelchairs have the potential to be affected by this	3/28/25

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F 689	Continued From page 7 The facility failed to provide a policy for foot pedal use upon request. - Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 01/05/25, identified functional limitations in range of motion with lower extremity impairment on both sides and dependance on staff for wheelchair transfers. The current care plan stated, ". . . Self-Care Deficit R/T [related to] old hip fracture . . . Locomotion is total assistance of one staff once in wheelchair. . ." During an observation on 02/24/25 at 1:04 p.m., a certified nurse aide (CNA) (#7) wheeled Resident #1 to the activity room. The resident's left foot dragged on the floor and became twisted under the wheelchair. The CNA stopped the wheelchair, straightened the resident's leg and proceeded down the hall. The CNA (#7) stated the left foot pedal "was missing" and she does not know where it is. During an interview on 02/27/25 at 12:00 p.m., an administrative nurse (#2) stated she expected staff to apply foot pedals on a wheelchair when the resident cannot lift their feet. - Review of Resident #13's medical record occurred on all days of survey. The quarterly MDS, dated 12/16/24, identified dependence on staff for wheelchair transfers. The current care plan stated, ". . . is total assistance of one staff once in wheelchair. . ." During an observation on 02/24/25 at 3:50 p.m., two CNAs (#7 and #8) transferred Resident #13	F 689	deficient practice. 3.An audit of all residents that use wheelchairs and foot pedals was completed on 3/10/25, to determine if all wheelchairs have appropriate foot pedals. Wheelchairs without foot pedals now have foot pedals in place. A foot pedal bag is in place on the back of all wheelchairs for staff to have access to foot pedals. This was completed on 3/10/25. Education/Training will be completed with all staff by March 25th, 2025, on the newly developed policies on Hospital patient Transport safety process and wheelchair mobility policy. 4. Audits will be conducted on foot pedals on wheelchairs when in motion and foot pedals in bags when not in motion. Wheelchairs labeled with appropriate resident in right wheelchair by DON and/or designee at random of 5x a week x 4 weeks, then 3x week for three months The DON is responsible for compliance. The results of the audits will be reported to and reviewed by the quality council, by the Director of Nursing If concerns are identified immediate corrective action of monitoring will be implemented	

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F 689	Continued From page 8 from the recliner to another resident's wheelchair without foot pedals on it. The CNA (#7) pushed the resident down the hallway. The resident put his legs out and then bent them so they were under the wheelchair. The CNA (#7) stopped, straightened the resident's legs, and proceeded down the hallway. The CNA stated she did not know the location of Resident #13's wheelchair. The CNA (#7) failed to use Resident #13's wheelchair with foot pedals during locomotion. During an interview on 02/27/25 at 12:10 p.m., an administrative nurse (#2) stated she expected staff to apply foot pedals on Resident #13's wheelchair.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		3/28/25

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F 692	Continued From page 9 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 2 of 2 sampled residents (Residents #1 and #5) with documented weight variances. Failure to obtain weights and reassess weight variances may delay needed treatment for weight loss/gain and alter the resident's ability to maintain a sufficient health/nutritional status. Findings include: Review of the facility policy titled "Weighing Residents" occurred on 02/27/25. This policy, reviewed February 2023, stated, ". . . It is important to maintain adequate nutritional status . . . The early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. . . . Monthly weights will be completed by the second week of the month. Weights will be recorded in the EMR [electronic medical record]. Residents will have a consistent method for being weighed . . . Nurses are responsible for making sure aides get and document those weights. A weight variance report will be completed the third week of each month. Any resident with a loss of 5% or greater will be re-weighed that week to validate that month's weight. . ." Review of the facility policy titled "Vital Signs Routine" occurred on 02/27/25. This policy, dated	F 692	F692 1.Resident #1's no longer reside at the facility. Resident #5's-the facility updated the policy (Weighing Resident) to weekly weights, to be able to identify weight variances when they occur 3/18/25. 2. All the residents have the ability to be affected by this deficient practice of not being weighed in an appropriate time frame. 3. All residents have been weighed for a baseline weight with a monthly weight variance report completed on 3/18/25. The policy weighing residents has been updated and revised to read weigh resident weekly. Education/Training will be completed with all licensed staff by March 25th, 2025. On the weighing residents policy and how to run a weight variance report on the third week of the month. 4. Audits will be conducted on Weekly weights done on each resident, was doctor informed of any changes if needed by DON and/or designee at random of 4x a week x 4 weeks and 3 x week for three months The DON is responsible for compliance. The results of the audits will be reported to and reviewed by the quality council, by	

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F 692	Continued From page 10 March 2015, stated, ". . . Any time that you observe anything abnormal, make sure that you report this to the Charge Nurse. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic kidney disease with congestive heart failure. The current care plan stated, ". . . 06/07/23 . . . Monthly weight Once A Day on 1st Wed [Wednesday] of the Month . . ." Physician's orders included Furosemide (a diuretic) 40 milligrams (mg) daily and monthly weights on the first Wednesday of the month Resident #1's monthly weight record dentified the following: 02/10/25 167.8 pounds 01/08/25 172.4 pounds 12/02/24 175.8 pounds 11/05/24 158.8 pounds (17 pound weight loss in 1 month) 10/03/24 180.7 pounds 09/04/24 181.6 pounds (18.4 pound weight loss in less than 1 week) 09/02/24 200 pounds 05/07/24 to 09/01/24 Not Taken 05/06/24 190 pounds Facility staff failed to obtain Resident #1's weight for three months (June-August 2025), failed to identify weight variances or weight loss, and assess any related causes for Resident #1's weight fluctuations. - Review of Resident # 5's medical record occurred on all days of survey. Diagnoses included hypertension. Physician's orders	F 692	the Director of Nursing If concerns are identified immediate corrective action of monitoring will be implemented	

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F 692	Continued From page 11 included Furosemide) 20 mg twice a day and weight on the first Tuesday of the month. Resident #5's monthly weight record identified the following: 02/10/25 147.1 pounds (7 pounds in 1 month) 01/08/25 154.8 pounds 01/03/25 148.3 pounds No weight recorded in December 11/05/24 150.9 pounds 10/30/24 150.9 pounds 10/01/24 152.4 pounds 08/06/24 153 pounds Facility staff failed to weigh Resident #5 as ordered in September and December 2024. During an interview on 02/27/25 at 12:00 p.m., an administrative staff nurse (#2) expected the charge nurse to monitor weights and confirmed they failed to run monthly weight variance reports per their policy.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		3/28/25

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F 761	Continued From page 12 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of 3 of 3 insulin pens observed during review of medication storage. Failure to obtain a label for an insulin pen and identify the resident's name and date opened may result in a resident receiving another resident's insulin or outdated insulin. Findings include: Review of the facility policy titled "Insulin pen use" occurred on 02/27/25. This policy, revised in 2010, stated, ". . . All Insulin pens must have patient identification label and date opened . . ." Review of the facility policy titled "Storage of Insulin" occurred on 02/27/25. This policy, revised May 2015 stated, ". . . Insulin pens, stored in cart, once they are used, must have [resident's] name and date on the pen . . ." - Observation on 02/26/25 at 10:00 a.m. showed an administrative nurse (#2) obtained three	F 761	F761 1.All insulin pens were labeled with a marker on 02/27/25 by the DON, during the survey. 2. All residents that receive insulin pens have the Potential to be affected by this deficient practice. 3.All insulin pens have been audited to ensure they are labeled correctly with a name and date opened. March 2nd, 2025. The facility has made our own labels with resident name and Date opened on the label, the licensed nurse writes the open date on the label. The labels are located on top of the medication fridge in a binder labeled (Insulin Pen Labels) for easy access when a licensed nurse removes a new pen for the resident, from the Med fridge. Labels are applied to each Insulin Pen. Original Pharmacy labels are located on the insulin box and on each insulin pen plastic sleeve. Education/Training will be completed with all licensed staff by March 25, 2025 On	

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F 761	Continued From page 13 insulin pens from the medication cart. All three pens lacked a resident's name and an opened date. During an interview on 02/26/25 at 10:14 a.m., an administrative nurse (#2) confirmed she expected staff to follow facility policy and ensure staff label insulin pens with the correct identifying information, and expected the pens to include dosing information.	F 761	the insulin pen use policy in regards to labeling and where the binder is located in the nurse station with printed labels with residents name and open date on them. 4. Audits will be conducted on is label on insulin pen ensuring a label is in place with residents name and with open date, DON and/or designee will complete at random of 5x a week x 4 weeks and 3x week for three months The DON is responsible for compliance. The results of the audits will be reported to and reviewed by the quality council, by the Director of Nursing/Designee If concerns are identified immediate corrective action of monitoring will be implemented Substantial compliance is achieved 3/28/2025	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI	F 865		3/28/25

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F 865	Continued From page 14 program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence	F 865		

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F 865	Continued From page 15 to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around	F 865		

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F 865	Continued From page 16 safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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 review of the State Agency (SA) facility files, survey findings, and staff interview, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements. Findings include: Review of the state agency files indicated the facility failed to maintain compliance at F658 as indicated by a deficiency cited during the last standard survey on 12/20/23. Refer to F658. During an interview on 02/27/25 at 11:53 a.m., an administrative staff member (#1) stated, "We work with quality on the hospital side, we do QA [quality assurance] audits here [for the nursing	F 865	F865 1.The facility has formed an interdisciplinary QAPI committee for the nursing home, separate from the hospitals committee, to prevent further non-compliance with F658, which was affecting the residents in the facility; all staff will be educated on the facility's new policy for QAPI. 2. All residents have the potential to be affected by this deficient practice of not having a formal QAPI committee for this Facility 3. The facility has written and verified a new policy for this facility titled, “Quality assurance & performance improvement.” Meetings will be held monthly. Committee members will include: DON, Nursing leadership, Administrator, Quality & Patient Safety Program Manager. Medical director must attend at least quarterly.	

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F 865	Continued From page 17 home] and bring those results to the hospital meeting." When asked what the facility did to develop the plan of correction and conduct audits following the federal survey, an administrative nurse (#2) stated she thought staff completed audits for a year. The administrative staff members (#1 and #2) listed two issues the facility currently audited and neither issue reflected any of the last standard survey's citations. Failure of the facility to establish a separate nursing home QA committee and effectively utilize QA resulted in continued noncompliance at F658.	F 865	On 3/26/25 a QAPI meeting was held to introduce and review the new QAPI plan of action. Focusing on F658 as a quality improvement project. All committee members including the medical director were present. Education/Training will be completed with all staff by March 25, 2025 on the new developed policy Quality assurance and Performance Improvement Plan for the facility. 4. The Quality Manager is responsible for setting the date of QAPI meetings and monitoring audited data. A dated sign sheet that requires committee members to sign in. Quality manager will audit the sign in sheet for required QAPI meeting attendance. All audits to be conducted as part of a survey corrective action plan will be reported at this meeting. All audits that are not at 100% will require an action plan and for it to be presented at the QAPI Committee. If concerns are identified immediate corrective action of monitoring will be implemented	
F 880 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 help prevent the development and transmission of communicable diseases and infections.	F 880		3/28/25

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F 880	Continued From page 18 §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	F 880		

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F 880	Continued From page 19 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. §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, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 8 sampled residents (Resident #5 and #13) and 1 supplemental resident (Resident #6) requiring stand lift transfers. Failure to practice infection control standards related to disinfection of equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Patient Multi-Use Devices," occurred on 02/27/25. This policy, dated February 2011, stated, ". . . As part of the infection control prevention program, all patient/resident multi-use medical devices must	F 880	F880- 1.Education will be provided to all staff regarding lift/equipment cleaning for Resident #5, #6 and #13 2. All residents who use mechanical lift/equipment have the potential to be affected by this deficient practices . 3. The policies for the mechanical lift/EZ stand have been reviewed and revised to say this lift/stands needs to be disinfected between each resident use. Signage on step by step, how to clean/disinfect the mechanical lift/equipment, has been posted on doors where the mechanical lifts/equipment are stored along with small cards attached to each mechanical lift which gives step by step on how to	

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F 880	Continued From page 20 be disinfected between patient/resident uses. . . . These include but are not limited to . . . Mechanical lift devices . . ." - Observation on 02/24/25 at 1:40 p.m. showed a certified nurse aide (CNA) (#8) transferred Resident #6 from the toilet to a wheelchair using a stand lift. After completing the transfer, the CNA failed to sanitize the lift. When asked if there was a policy for sanitizing the lifts, the CNA (#8) replied, "housekeeping does that." - Observation on 02/24/25 at 3:58 p.m. showed two CNAs (#7 and #8) transferred Resident #13 from the toilet to a wheelchair using a stand lift. After completing the transfer, the CNAs failed to sanitize the lift and pushed it to another resident's room. - Observation on 02/24/25 at 4:10 p.m. showed a CNA (#7) and a nurse (#6) transferred Resident #5 from the toilet to a wheelchair using a stand lift. After completing the transfer, the nurse (#6) failed to sanitize the lift and pushed it to a storage room. During an interview on the afternoon of 02/25/25, an administrative staff member (#11) provided a "Lifts and Stands Maintenance Record" showing housekeeping cleans the lifts twice a month and stated, "But staff clean them after each use." During an interview on 02/27/25 at 12:00 p.m., an administrative nurse (#2) stated she expected staff to sanitize the lift between resident use.	F 880	clean/disinfect the lift. Education provided by March 25, 2025 to all staff, on the facility policies mechanical lift/EZ stand have been reviewed and revised to focus on Cleaning/disinfecting stands in between use. Provide education on new signage on stand/lift cleaning and signage posted on the doors where lifts/stands are stored. 4. Audits will be conducted on disinfecting/cleaning mechanical lifts between resident use completed by the Infection Control Nurse and/or designee. At random 5x a week x 4 weeks and 3x week for three months The Infection control nurse is responsible for compliance. The results of the audits will be reported to and reviewed by the quality council, by the Infection control nurse If concerns are identified immediate corrective action of monitoring will be implemented	