

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments 42 CFR 483.73 K6 PLAN APPROVAL: 1954 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A three (3) story with partial basement, 1954, Type II (111), protected noncombustible construction, with a total of three (3) smoke compartments and a complete automatic (wet) sprinkler system. Additions of the same building construction were completed in 2000 which consisted of the addition of bedrooms on the third (3rd) floor and an elevator on the south end of the facility. The LTC facility is located on the third (3rd) floor. A Comparative Federal Monitoring Survey was conducted on 1/31/23, following a State Agency Annual Survey on 12/20/22 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Garrison Memorial Hospital Nursing Facility was found to not be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.73 et seq. (Emergency Preparedness).			E 000			
E 009	Local, State, Tribal Collaboration Process			E 009			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 009 SS=F	Continued From page 1 CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal Emergency Preparedness (EP) officials' efforts to maintain an integrated	E 009			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 009	Continued From page 2 response during a disaster or emergency situation, including documentation of the Long-Term Care (LTC) facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Records review of the facility's EP plan on 1/31/23 at 1:50 p.m. revealed the facility failed to document the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Interview on 1/31/23 at 1:50 p.m. with the Quality and Patient Safety Manager (via conference call) revealed that the facility had not contacted the local Emergency Management officials and did not have any documentation to indicate that anyone at the facility had identified or contacted the local, Emergency Management officials and shared the EP plan with them or planned any activities relative to the EP plan with any local, tribal, regional, state, or federal EP officials. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m.	E 009			
E 018	Procedures for Tracking of Staff and Patients	E 018			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 018 SS=F	Continued From page 3 CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 018	Continued From page 4 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			E 018			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 018	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to develop a procedure for tracking staff and residents in an emergency. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Records review of the facility's EP plan on 1/31/23 at 2:07 p.m. revealed the facility had no system for tracking staff or residents in an emergency. Interview on 1/31/23 at 2:07 p.m. with the Interim President revealed the facility did not have a system that tracks movement and locations of both staff and residents during an emergency evacuation. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m.			E 018			
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must			E 025			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 025	Continued From page 6 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced	E 025			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 025	Continued From page 7 by: Based on records review and interview, the facility failed to develop arrangements with other facilities. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Records review of the facilities' EP plan on 1/31/23 at 2:00 p.m. revealed the facility had no written agreements with any other Long Term Care facilities or other providers in the event residents had to be evacuated from the facility. Interview with the Interim President on 1/31/23 at 2:00 p.m. revealed that she could not locate any agreements with any other facility within the EP plan and that there were no such agreements. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m.			E 025			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1954 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A three (3) story with partial basement, 1954, Type II (111), protected noncombustible construction, with a total of three (3) smoke compartments and a complete automatic (wet) sprinkler system. Additions of the same building construction were completed in 2000 which consisted of the addition of bedrooms on the third (3rd) floor and an elevator on the south end of the facility. The LTC facility is located on the third (3rd) floor. A Comparative Federal Monitoring Survey was conducted on 1/31/23, following a State Agency Annual Survey on 12/20/22 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Garrison Memorial Hospital Nursing Facility was found to not be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from			K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 1	K 000			
K 225 SS=E	Fire). Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress in accordance with the code. The deficient practice affected one (1) of three (3) smoke compartments, staff, and 11 residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Observation during the building tour on 1/31/23 at 1:17 p.m. revealed that the landing located between the first (1st) and second (2nd) floor in the exit stair enclosure located at the West end of the facility was not provided with an interruption that would prevent accidental travel to the story beyond the level of exit discharge such as a partition, door, gate, or other effective means, as required by section 7.7.3.4 of NFPA 101, Life Safety Code. Additional observation revealed that the exit stair served as a required exit for the first (1st), second (2nd) and third (3rd) floors of the building. The level of exit discharge was between the first (1st) and second (2nd) floor at	K 225			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 225	Continued From page 2 the landing and the distance from landing to the first (1st) floor was greater than one-half story below the level of exit discharge. Interview on 1/31/23 at 1:17 p.m. with the Facilities Manager from Bismarck revealed the facility was aware of the interruption requirement for exit stair. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101 (2012) Life Safety Code 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.7.3.4* Stairs and ramps that continue more than one-half story beyond the level of discharge shall be provided with an approved means to prevent or dissuade occupants from traveling past the level of discharge during emergency building evacuation.			K 225			
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall			K 271			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 271	Continued From page 3 be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a hard packed all-weather travel surface to the public way for all marked Exits. The deficient practice affected one (1) of three (3) smoke compartments, staff, and 11 residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Observation during the building inspection tour on 1/31/23 at 1:15 p.m. revealed the door leading out of the corridor into the stairwell on the West side of the Nursing Unit on the third (3rd) floor was marked as an exit. The exit stair enclosure traveled down to an exit. The exit opened to a set of outside steps that lead to a sidewalk that extended approximately three (3) feet from the building and terminated in a grassy area. Additional observation revealed there was no hard packed, all-weather surface path of egress to the public way, as required by sections 19.2.7 and 7.7 of NFPA 101, Life Safety Code and CMS Survey & Certification Letter 05-38. Interview with the Maintenance Technician on 1/31/23 at 1:15 p.m. revealed the facility was aware of the requirements for exit discharges to terminate at the public way and that the facility has a proposal for providing a proper walking surface at this exit discharge. The census of 22 was verified by the Interim President on 1/31/23. The findings were	K 271			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 271	Continued From page 4 acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7. 7.7 Discharge from Exits. 7.7.1* Exit Termination. Exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4. 7.7.1.1 Yards, courts, open spaces, or other portions of the exit discharge shall be of the required width and size to provide all occupants with a safe access to a public way. 7.7.1.2 The requirement of 7.7.1 shall not apply to interior exit discharge as otherwise provided in 7.7.2. 7.7.1.3 The requirement of 7.7.1 shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. 7.7.1.4 Means of egress shall be permitted to terminate in an exterior area for detention and correctional occupancies as otherwise provided in Chapters 22 and 23.	K 271			
K 321 SS=D	S &C Letter 05-38-Clarification of Life Safety Code Survey Issues in Nursing Homes Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 321	Continued From page 5 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect hazardous areas. The deficient practice affected one (1) of three (3) smoke compartments, staff, and no residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Observation during the building inspection tour	K 321			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	Continued From page 6 on 1/31/23 at 1:00 p.m. revealed the door to the dry goods storage room off the kitchen was not equipped with a self-closing device. The room was over 50 square feet and filled with cardboard boxes, plastic bags, plastic-wrapped condiments, food items, and other combustible storage. Additional observation revealed the door was not self-closing or auto-closing, as required by section 19.3.2.1.3 of NFPA 101, Life Safety Code. Interview with the Facilities Manager from Bismarck on 1/31/23 at 1:00 p.m. revealed that the facility was not aware this storage room was a hazardous area. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. 19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4.	K 321			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	Continued From page 7 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.4 Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (1220 mm) above the bottom of the door. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3.	K 321			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control	K 324			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 8 and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on records review, observation and interview, the facility failed to install the kitchen hood extinguishing system and maintain the kitchen cooking hood ventilation system in accordance with the code. The deficient practice affected one (1) of three (3) smoke compartments, staff, and no residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: 1. Records review on 1/31/23 at 10:42 a.m. of the	K 324			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 9 kitchen hood extinguishing inspection reports for the 12-month period prior to the survey revealed there was no documentation to indicate that the gas shut-off valve for the gas appliances under the cooking hood was functioning properly, as required by section 10.4 of NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations. Additional records review of the report dated 1/20/23 revealed "gas valve shut down doesn't work". Interview with the Maintenance Technician on 1/31/23 at 10:42 a.m. revealed the facility was aware that the gas valve shut down does not work and continues to use the appliances. 2. Records review on 1/31/23 at 10:42 a.m. of the kitchen hood extinguishing inspection reports for the 12-month period prior to the survey revealed there was no documentation to indicate that the wet agent cylinders for the cooking hood extinguishing system were hydrostatically tested every 12 years, as required by section 7.5 of NFPA 17A, Standard for Wet Chemical Extinguishing Systems. Additional records review of the report dated 1/20/23 revealed "system was last hydrotested in 1998". Interview with the Maintenance Technician on 1/31/23 at 10:42 a.m. revealed the facility was aware that the cylinders were out of date and believes the system is due to be replaced. 3. Observation during the building inspection tour on 1/31/23 at 12:56 p.m. revealed that the grease filters installed within the cooking hood were not installed and used in their correct orientation, as required by section 6.2.5 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.	K 324			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 10 Additional observation revealed the filters were installed horizontally where the directional arrows indicate vertical installation. Interview with the Facilities Manager from Bismarck on 1/31/23 at 12:56 p.m. revealed that the facility was aware that the filters were installed incorrectly because the new hood contractor informed him of the violation. 4. Observation during the building inspection tour on 1/31/23 at 12:57 p.m. revealed that the kitchen hood extinguishing system was not interconnected with the building's fire alarm system, as required by section 10.6.2 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Additional observation on 1/31/23 at 12:57 p.m. revealed that there were no "dry contacts" or any fire alarm conduit in the area where the system was installed. Interview with the Facilities Manager from Bismarck on 1/31/23 at 12:56 p.m. revealed the facility was aware that the kitchen hood extinguishing system was not connected to the building's fire alarm system and is planning to replace the system. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise	K 324			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 324	Continued From page 11 permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 19.3.2.5.2* Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011) 6.2.5 Grease Filter Orientation. Grease filters that require a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so that filters cannot be installed in the wrong orientation. 10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (1) NFPA 12 (2) NFPA 13 (3) NFPA 17 (4) NFPA 17A 10.4 Fuel and Electric Power Shutoff. 10.4.1 Upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electrical power that produce heat to all equipment requiring protection by that system shall automatically shut off.			K 324			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 324	Continued From page 12 10.4.2 Steam supplied from an external source shall not be required to automatically shut off. 10.4.3 Any gas appliance not requiring protection but located under ventilating equipment where protected appliances are located shall be automatically shut off upon activation of the extinguishing system. 10.4.4 Shutoff devices shall require manual reset. 10.6 System Annunciation. 10.6.1 Upon activation of an automatic fire-extinguishing system, an audible alarm or visual indicator shall be provided to show that the system has activated. 10.6.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system. 12.1.2 Installation. 12.1.2.1 All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions.	K 324			
K 345 SS=F	Actual NFPA Standard: NFPA 17A, Standard for Wet Chemical Extinguishing Systems (2009) 7.5 Hydrostatic Testing Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 345	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to inspect the Fire Alarm System in accordance with the code. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Records review on 1/31/23 at 11:30 a.m. of the fire alarm inspection reports for the 12-month period prior to the survey revealed there was no documentation of a semi-annual visual inspection of the smoke detectors, as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. The last inspections of the smoke detectors were on 1/18/22 and in 1/23. Interview with the with the Facilities Manager from Bismarck on 1/31/23 at 2:15 p.m. revealed the facility was not aware of the requirements for semi-annual visual inspections for the smoke detectors and that only annual inspections are taking place at the facility. The facility is aware of semi-annual testing of the batteries in the fire alarm. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101, Life Safety	K 345			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 345	Continued From page 14 Code (2012) 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1* General. 9.6.1.1 The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. 9.6.1.2 Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.4 All systems and components shall be approved for the purpose for which they are installed. Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010) 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1 Visual Inspection Frequencies	K 345			
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 712	Continued From page 15 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: 1. Records review on 1/31/23 at 10:55 a.m. revealed the facility had conducted a fire drill on the third (3rd) shift, 12/28/22 at 6:50 a.m. without sounding the facility fire alarm, as required by section 19.7.1.4 of NFPA 101, Life Safety Code. Additional record review revealed no other third (3rd) shift fire drills were conducted in this quarter. Interview with the Maintenance Technician on 1/31/23 at 10:55 a.m. revealed the facility was not aware that the fire alarm had to be used during fire drills after 6:00 a.m. 2. Records review on 1/31/23 at 11:03 a.m. revealed that no documentation was present that	K 712			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 712	Continued From page 16 indicated the facility had conducted a fire drill on the third (3rd) shift during the third (3rd) quarter of 2022, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. Interview with the Maintenance Technician on 1/31/23 at 11:03 a.m. revealed the facility was not aware that that a fire drill was missing. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101 (2012) Life Safety Code 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.	K 712			
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing	K 914			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 914	Continued From page 17 Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview the facility failed to maintain the electrical receptacles in patient care areas. The deficient practice affected one (1) of three (3) smoke compartments, staff, and 11 residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: Record review on 1/31/23 at 11:31 a.m. revealed non-hospital grade electrical receptacles located in patient bed locations at the facility did not have annual physical integrity, continuity, polarity, or retention testing documentation as required by	K 914			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 914	Continued From page 18 sections 6.3.3.2 through 6.3.4.2.1.2 of NFPA 99, Health Care Facilities Code. Interview on 1/31/23 at 11:31 a.m. with the Maintenance Technician revealed the facility was familiar with receptacle testing requirements and that he believes all the non-hospital grade electrical receptacles located in patient bed locations throughout the facility have been replaced with hospital grade units. There are no testing logs for the non-hospital grade electrical receptacles and no testing has been conducted. Observation during the building inspection tour on 1/31/23 from 11:35 a.m. to 1:23 p.m. revealed that resident bedrooms in the West part of the Nursing Unit had non-hospital grade electrical receptacles located in patient bedrooms and the South part of the Nursing Unit had hospital grade electrical receptacles located in patient bedrooms. Interview on 1/31/23 at 11:54 a.m. with the Maintenance Technician revealed the facility was not aware that any of the non-hospital grade receptacles were still in use. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard NFPA 99, Health Care Facilities Code (2012) 6.3.3.2 Receptacle Testing in Patient Care Rooms			K 914			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 914	Continued From page 19 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). 6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.4.1.4 The LIM circuit shall be tested at intervals of not more than 1 month by actuating the LIM test switch (see 6.3.2.6.3.6). For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more than 12 months. Actuation of the test switch shall activate both visual and audible alarm indicators.	K 914			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 914	Continued From page 20 6.3.4.1.5 After any repair or renovation to an electrical distribution system, the LIM circuit shall be tested in accordance with 6.3.3.3.2.	K 914			
K 918 SS=F	6.3.4.2 Record Keeping. 6.3.4.2.1* General. 6.3.4.2.1.1 A record shall be maintained of the tests required by this chapter and associated repairs or modification. 6.3.4.2.1.2 At a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023	
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 918	Continued From page 21 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to inspect and test the emergency generator in accordance with the code. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 26 beds with a census of 22 on the day of the survey. The findings include: 1. Records review on 1/31/23 at 11:10 a.m. of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview on 1/31/23 at 11:10 a.m. with the Maintenance Technician confirmed the batteries on the generator were lead-acid and revealed the facility was aware of the monthly generator battery testing requirements.			K 918			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	Continued From page 22 2. Records review on 1/31/23 at 11:19 a.m. of the generator inspection, testing, and maintenance records for the prior year revealed during the monthly load test the load handled by the generator did not list or document the percent of the nameplate kW rating and it is unknown if the generator reached the 30 percent threshold required by section 8.4.2 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional records review revealed there was no annual load bank test in 12-months prior to the survey as required by section 8.4.2.3 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview with the Facilities Manager from Bismarck on 1/31/23 at 2:15 p.m. revealed the information should be recorded on the computerized work order system and when he shared his screen shot of the template, there was no requirement to list the percent of the nameplate kW rating during the monthly load test of the generator. The census of 22 was verified by the Interim President on 1/31/23. The findings were acknowledged by the Interim President and verified by the Maintenance Technician and the Facilities Manager from Bismarck during the exit interview on 1/31/23 at 2:15 p.m. Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3 Emergency Generators and Standby Power Systems.	K 918			

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

PRINTED: 08/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER GARRISON MEM HOSP NSG FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 407 3RD AVE SE GARRISON, ND 58540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	Continued From page 23 Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010) 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.	K 918			