

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

PRINTED: 03/26/2025
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 03/10/2025	
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 A recertification survey conducted on 03/10/2025 found Garrison Memorial Hospital Nursing Facility in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.			E 000			

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

TITLE

(X6) DATE

Electronically Signed

03/21/2025

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: 03/26/2025
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 03/10/2025	
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 This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type II (000) construction with a basement. The building had a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. An occupancy separation wall constructed to have a two-hour fire resistance rating separated a clinic building to the east from the hospital. The nursing facility occupied the second floor of the hospital.			K 000			
K 271 SS=D	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 be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: 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. 19.2.1 The facility failed to maintain the means of			K 271	K271 Egress pathway on the west side of the building does not meet the provisions for means of egress		4/24/25

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

TITLE

(X6) DATE

Electronically Signed

03/21/2025

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: 03/26/2025
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 03/10/2025
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 1 egress as required. Walking surfaces in the means of egress shall comply with the following: 1) Walking surfaces shall be nominally level. 2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. 3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. Every ramp used as a component in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.5. 7.1.6.3 New ramps shall be in accordance with the following: 1) Minimum width of 44 in. (1120 mm). 2) Maximum slope of 1 in 12. 3) Maximum cross slope of 1 in 48. 4) Maximum rise for a single ramp run of 30 in. (760 mm). 7.2.5.1, 7.2.5.2(1), Table 7.2.5.2(a) Ramp landings shall be as follows: 1) Ramps shall have landings located at the top, at the bottom, and at door leaves opening onto the ramp. 2) The slope of the landing shall be not steeper than 1 in 48. 3) Every landing shall have a width not less than the width of the ramp. 4) Every landing shall be not less than 60 in. (1525 mm) long in the direction of travel, unless the landing is an approved existing landing. 5) Where the ramp is not part of an accessible route, the ramp landings shall not be required to	K 271	The corrective action will be accomplished by hiring an architect or a competent contractor to design and install a compliant egress route. The other egress routes will be assessed by the architect or contractor to ensure that similar issues do not exist. (4 other exits) The annual PM to inspect exterior grounds updated to include additional language pertaining to egress route surface condition, gaps, and tripping hazards. Monitoring is through the Preventive Maintenance program Expected completion of the identified work is estimated to be completed on 4/24/25		

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

PRINTED: 03/26/2025
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 03/10/2025
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 2 exceed 48 in. (1220 mm) in the direction of travel, provided that the ramp has a straight run. 6) Any changes in travel direction shall be made only at landings. 7) Ramps and intermediate landings shall continue with no decrease in width along the direction of egress travel. 7.2.5.3.2 Handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 in. (150 mm). 7.2.5.4.2 Observation determined the concrete sidewalk near the west exterior exit from the west stair enclosure to the public way had a slope of approximately 1 in 10 exceeding the maximum walking surface slope of 1 in 20 and did not meet the following requirements for ramps: 1) The sidewalk exceeded the maximum ramp slope of 1 in 12. 2) The sidewalk exceeded the maximum slope perpendicular to the direction of travel of 1 in 48. 3) The sidewalk exceeded the maximum rise for a single ramp run of 30 in. (760 mm) and did not have intermediate landings. 4) The sidewalk run had a rise greater than 6 in. and did not have handrails along both sides. Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected exit discharge from one (1) of five (5) exterior exits from the facility.	K 271			
K 918	Electrical Systems - Essential Electric Syste	K 918			3/21/25

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

PRINTED: 03/26/2025
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 03/10/2025
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 SS=F	Continued From page 3 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 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:	K 918			

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

PRINTED: 03/26/2025
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 03/10/2025
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 4 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Health Care Facilities Code and NFPA 110, Standard for Emergency and Standby Power Systems. 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. Diesel-powered EPS installations that do not meet the requirements 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. NFPA 99 6.4.4.1.1.4, NFPA 110 8.4.2, 8.4.2.3 Review of generator test records and interview with staff did not indicate the minimum exhaust temperature provided by the manufacturer was achieved and that the monthly exercise of the 200 kW diesel generator loaded the generator to at least 30% (60 kW) of the nameplate rating. The facility did not perform annual supplemental load exercises as required when diesel	K 918	K918 Emergency generator not annually load tested. The standby emergency generator will have an annual load bank performed on 3-21-25 There is only one emergency generator at this site so no other locations are affected. The old Annual Load test PM will be modified to the new date and equipment and will. This PM will serve as a reminder to evaluate whether a load test is necessary and to schedule the test. The facility will monitor the activity via the PM documentation and subsequent vendor reports. The date of the load test is 3-21-25		

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

PRINTED: 03/26/2025
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 03/10/2025
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 5 generators are not loaded to 30% of nameplate rating or manufacturer's recommended temperature during the required monthly exercises. Failure to inspect, test and maintain the emergency generator in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 918			