STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	10/31/2018

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 10/29/18 and concluded on 10/31/18.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a resident review (PASARR) for 1 of 1 sampled resident (Resident #17) with a recent diagnosis of major mental illness. Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services. Findings include: Review of Resident #17's medical record	F 644	1. It is the intent of CHI St. Alexius Garrison Hospital and Nursing Facility to assure that a PASSAR will be completed on all residents that receive a new diagnosis of a serious mental disorder. 2. A PASSAR was completed on resident #17 on Oct. 31st by our Social Service person. Resident #17 has been a resident of Dr. Capon who does our psychiatric services in Garrison since 3-6-	12/5/18

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

Electronically Signed | 11/15/2018

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F 644	Continued From page 1 occurred on all days of survey. The record identified the facility admitted Resident #17 in February 2017 with a diagnosis of dementia and received the psychotropic medication Risperdone (an anti-psychotic) for hallucinations. The record identified Resident #17 received a diagnosis of schizophrenia in March 2017 and lacked evidence facility staff completed a PASARR at the time of the diagnosis or any time thereafter. During an interview on 10/30/18 at 4:00 p.m., a social services staff member (#1) confirmed staff failed to complete a PASARR at the time Resident #17 received the diagnosis of schizophrenia or any time thereafter.	F 644	2017. 3. All residents who have or receive a new diagnosis of a serious mental disorder have the potential to be affected by this deficient practice. 4. The MDS coordinator who is responsible for coordinating teleconferences with Dr. Capon and our residents that have mental disorders will alert Social Services of new diagnosis of a mental disorder. At which time Social Services will complete a PASSAR if needed. 5. A review of this deficiency will be done on Nov. 26th at a floor in-service, to review this process. A QA study will be started on Nov. 1, 2018, and be completed by the MDS coordinator for a 4 month time frame then randomly for one year. All results will be reported to the Hospital QA Committee by Social Service on a monthly basis for further recommendations if needed	
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, review of facility policy,	F 658	1. It is the intent of CHI St. Alexius	12/5/18

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F 658	Continued From page 2 review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice to prime and administer an insulin pen for 1 of 1 sampled resident (Resident #8) observed receiving insulin. Failure to prime and administer an insulin pen as recommended has the potential for residents to receive an inaccurate dose of insulin. Findings include: Review of the NovoLog FlexPen manufacturer's guidelines occurred on 11/01/18. The guidelines stated, " . . . Prime your pen: Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. . . ." Review of the facility policy titled, "Insulin Pen Use - Nursing Guidelines" occurred on 10/31/18. This policy, dated January 2010, stated, " . . . hold the injection in place for 6 - 10 seconds . . ." Observation on 10/31/18 at 11:50 a.m. showed a licensed nurse (#2) prepared Resident #8's insulin pen for injection. After placing the needle on the insulin pen and with the shield in place, the nurse primed the insulin pen and was unable to visualize a drop of insulin from the needle. During an interview on 10/31/18 at 1:20 p.m. a supervisory nurse (#3) confirmed staff could not visualize the insulin with the shield on the needle and she expected staff to hold the needle in place for six seconds.	F 658	Garrison Hospital and Nursing Facility to ensure that services provided by the facility will meet professional standards of quality. 2. All diabetic residents that receive insulin have the potential to be affected by this deficient practice. 3. All residents that receive insulin have blood sugars done on a daily basis, whereby the nursing staff can monitor if the resident is receiving their insulin prescribed. 4. A policy review and education for all nursing staff on the appropriate procedure for priming an insulin pen will be conducted at an all staff in-service on Nov. 26th. 5. Our policy was revised to include the procedural steps on priming an insulin pen. A QA study will be started Nov. 1, 2018 and completed by the unit manager for a 3 month time frame (Dec. Jan Feb) in which direct observation of nursing staff will be conducted across the shifts that give insulin, for correct practice on priming an insulin pen, and monitoring of any abnormal blood sugars, then randomly for one year. Frequency of observations will be over all shifts that give insulin, 3 times per week times one month, weekly times one month, once every other week times one month, then	

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F 658	Continued From page 3	F 658	randomly for one year. All QA findings will be reported to the Hospital quarterly QA committee for further recommendations if appropriate.	
F 689 SS=E	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: RESIDENT TRANSFER 1. Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #8) observed during transfers utilizing a sit to stand lift. Failure to transfer Resident #8 safely placed the resident at risk of an accident and/or injury. Findings include: Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, " . . . needs extensive assistance with cares . . . Transfers - EZ stand assist of 1 . . ." Observation on 10/29/18 at 4:28 p.m. showed a certified nursing assistant (CNA) (#3) assisted Resident #8 on and off the toilet using the EZ	F 689	1. It is the intent of CHI St. Alexius Garrison Hospital and Nursing Facility to ensure that the resident environment remain as free of accident hazards as is possible to prevent accidents. Each resident receives adequate supervision and assistive devices to prevent accidents. A. Resident # 8 was re-evaluated by Physical Therapy with recommendations to use a butt sling with the standing lift to prevent resident from slipping out of the lift, the care plan was updated to reflect therapy recommendations. 2. All residents that use the standing lift have the potential to be affected by this deficient practice. 3. All residents using the standing lift will	12/5/18

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F 689	Continued From page 4 stand lift. During the transfer the harness sling slid up the resident's back to the axilla area and the resident leaned forward causing the resident's elbows to bow outward above the shoulders. Observation on 10/30/18 at 3:49 PM showed two CNAs (#4 and #5) assisted Resident #8 on and off the toilet using the stand lift. During the transfer the harness sling slid up the residents back to the axilla area and the resident leaned forward causing the resident's elbow to bow outward above the shoulders. During an interview on 10/30/18 at 5:26 p.m. a physical therapist (#6) stated staff may need to use the butt sling for Resident #8's transfers. STORAGE OF MEDICATIONS/CHEMICALS/TOOLS 2. Based on observation, review of facility policies, and staff interview, the facility failed to provide an environment free from accidents and/or hazards for 1 of 1 nursing units. Failure to secure hazardous materials/tools and medications placed cognitively impaired/wandering residents at risk for accidents and injury. Findings include: Review of the facility policy titled "Drug Storage and Security" occurred on 10/31/18. This policy, dated September 2017, stated, "A. Security: All medications stored on the clinic premises will be kept in cabinets or refrigerators. . . ."	F 689	be re-assessed for appropriateness by Physical therapy prior to Dec. 5th. 4. A review of this deficiency and training will be done at an all staff meeting on Nov. 26th. 5. A QA study will be conducted for the next 3 months, by Physical Therapy and Nursing across all three shifts, Physical therapy will do day observations and education, along with nursing who will also do evening and night observations. Three observations will be done on a weekly basis times one month, one observation per week times one month and randomly for one year. The Vice President of Nursing will report all QA findings to the Hospital QA on a quarterly basis, for further recommendations and further actions. B. All residents have the potential to be affected by the deficient practice of leaving medications unattended in the nursing office. The pharmacy when delivering medications will have a direct hand off of medications to a nurse and a signature will be obtained and taken back to the Pharmacy, Policy medication management page 2 Medication Administration identifies the signature process. This policy will be reviewed at an all staff in-service on Nov. 26th. A QA study will be conducted by unit manager of Nursing Facility on medications being brought to the unit and	

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F 689	Continued From page 5 Review of the facility policy titled "Chemical Storage" occurred on 10/31/18. This policy, dated 2015, stated, "All chemicals shall be stored in a safe place. . . ." Observation on 10/30/18 at 8:29 a.m. showed an 8 x 8 cardboard box, containing medications in an unattended/unlocked chart room. The medications included 30 tablets of Daliresp (used to treat Chronic Obstructive Pulmonary Disease) and 28 tablets of Donepezil (used to treat Alzheimer's disease). The chart room remained unattended until 9:13 a.m. During an interview on 10/30/18 at 9:13 a.m., a licensed nurse (#7) stated the pharmacist brought the medications and left them. During an interview on 10/31/18 at 1:20 p.m., an administrative nurse (#8) stated she expected the pharmacy staff to hand the medications to a nurse. Observation on 10/30/18 at 08:35 a.m. showed two bottles of rubbing alcohol, a bottle of electronic duster, and a can of WD 40 in a unlocked cabinet in the nurses station. Observation on 10/31/18 at 8:45 a.m. with a license nurse (#2) showed an unlocked cabinet in the nurse's station contained the above chemicals, a hammer, and a screwdriver. ENVIRONMENT 3. Based on observation and staff interview, the facility failed to ensure resident hallways	F 689	appropriate signatures are obtained. This study will be conducted for 3 months, on a daily basis for time one week, 3 times per weeks for 3 weeks, 2 times per week times one month, 2 times per month times 1 month then randomly for one year. The Vice president of Nursing will report the results of the study to the hospital QA committee on a quarterly basis, for further recommendations and actions if appropriate. C. The deficient practice of having chemicals on the nursing unit in an unlocked cabinet has the potential to affect all residents. On 10-31-18 a lock was placed on the cupboard at the nurse□s station that housed the WD40, Rubbing Alcohol, and electronic duster, long with a hammer and screwdriver. The policy Chemical Storage (limited tools) was reviewed at an all staff in-service on Nov. 26th 2018 A QA study will be conducted by the unit manager for a 3 month time frame monitoring the storage of chemicals on the nursing unit. It will be done 2 times per week for one month, weekly time one month, then 2 per month times one month, and randomly for one year. The Vice President of Nursing will take all QA finding to the Quarterly QA committee for further recommendations and further action as needed. D. The deficient practice of not properly storing resident use equipment, and	

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F 689	Continued From page 6 remained free from clutter and accident and/or hazards for 2 of 2 hallways. Failure to maintain safe, clutter free, and passable hallways has the potential to place all residents at risk for accidents and injury. Observations of the hallways showed: * 10/30/18 at 08:03 a.m., three wheelchairs (WC), one regular chair, three sit to stand lifts and two garbage cans lined up on the right side of the hallway from resident rooms 314 to past room 311. Observations showed residents walking on the left side of the hallway, using the hand rail, toward the dining room for breakfast. Observations showed one unidentified resident caught his WC on a sit to stand lift as he self propelled down the hallway. * 10/30/18 at 08:05 a.m., housekeeping staff place their cleaning cart on the right side of the hallway. * 10/30/18 at 08:18 a.m., staff placed three breakfast food carts on the left side of the hallway; and two dirty dish carts and two medication on the right side of the hallway. * 10/30/18 at 08:23 a.m., a housekeeping cart in front of room 305 on left side, and a sit to stand lift across the hall on the right side. * 10/30/18 at 12:37 p.m., a cleaning cart on the right side of the hallway and one almost in the middle, on the left side of the hallway. * 10/31/18 at 07:59 a.m., multiple items stored on the right and left sides of the hallway. During an interview on 10/31/18 at 1:36 p.m., an administrative nurse (#8) agreed staff should not store items on both sides of the hallways.	F 689	rolling carts to prevent clutter in corridors could potentially place all residents who walk independently at risk for accidents. The policy Storage of Carts in Corridors and resident equipment, was developed and will be reviewed at an all staff in-service on Nov. 26th 201. An in-service with housekeeping was completed by Housekeeping manager 11-14-18 to review policy and QA study, see agenda and attendance record. A QA study will be completed by the unit manage for a 4 month time frame to monitor policy compliance, on the day and evening shift. Daily times one week, 3 times a week times 3 weeks, weekly times one month and then randomly times one year. The Vice President of Nursing will Report all finding to the Quarterly QA meeting for further recommendations and further action as needed.	