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 _____	C 12/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 12/18/23 and concluded 12/20/23. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to remove medication from the bed side for 1 of 1 sampled resident (Resident #6) assessed as not able to self-administer medications (SAM). Failure to remove medication from the resident's room for a resident assessed as not able to self-administer medications may result in medication errors and/or harm to the resident. Findings include: Review of the facility policy "Self-Administration of Medication" occurred on 12/20/23. This policy, dated 1990, stated, ". . . Each resident has the right to self-administer medications only if an interdisciplinary team determines that it is clinically appropriate. . . . Nursing staff is responsible for safe and adequate drug storage on the Units of all drugs unless physician orders for bedside use. . . ."	F 554	F554: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #6: She had her medication immediately removed from the room. The medication was placed in the medication cart and an order was obtained. Staff reinforced with the resident and her family the need to give all medications to the nurse to determine the use and to get an MD order for OTC medications. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. As all residents are at risk for the possibility of having this issue to occur.	1/29/24

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

Electronically Signed | 01/19/2024

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.

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F 554	Continued From page 1 Review of Resident #6's medical record occurred on all days of survey. The record contained a staff assessment for self-administration of medications completed on 11/27/23. The SAM evaluation stated, ". . . Is it appropriate for resident to self - administer any medications? 'No'. . . ." A physician's order included, ". . . I am not able to self-administer my own medication." Observation on 12/19/23 at 9:29 a.m. showed a bottle of [a brand of topical muscle spray] on the bedside table in Resident #6's room. Observation on 12/20/23 at 12:15 p.m. showed Resident #6 seated in her recliner chair in her room, a bottle of [a brand of topical muscle spray] was located on the table next to her. When asked if she uses the muscle spray, Resident #6 stated she hasn't used it for a while now. When asked where she applies the muscle spray, she reported she applies it to the back of her neck, on her wrists and stated, "I like that stuff." When asked if the staff assist her to apply it, she stated, "They haven't yet, I haven't asked them to." During an interview on 12/20/23 at 1:15 p.m., an administrative staff member (#2) confirmed Resident #6 is not appropriate to self-administer medications and medication should not be left in her room.	F 554	3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Medication Self-Administration policy will be reviewed with all staff by either the LTC DON or Quality Manager on a one-on-one basis or in a small group setting by January 29, 2024, with a staff sign off to ensure understand of the policy. All staff will be instructed to monitor resident's rooms for OTC and prescription medications. Signage will be placed by all entrances to the unit asking family members to bring all medications to the nurse. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Ongoing random audits of resident□s rooms will occur weekly x4, then monthly x2 then quarterly x2. The Director of Nursing and the QA Nurse Manager will conduct these audits. The DON will aggregate, analyze and then report at the quarterly QA meeting. This will begin the week of 01/15/24. 5. Include dates when corrective action will be completed. January 29, 2024	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		1/29/24

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F 583	Continued From page 2 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to promote privacy and confidentiality of the medication	F 583	F583: 1. Address how corrective action will be	

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F 583	Continued From page 3 administration records for 1 of 3 days of survey. Failure to promote resident privacy may result in viewing of resident records by other residents, visitors, or unlicensed staff. Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/20/23. This policy, dated February 2008, stated, ". . . 10. Procedure For Passing Medications: . . . B. Keep the electronic MAR [EMAR] closed while not in use . . ." - Observation on 12/18/23 at 4:53 p.m. showed the medication cart A unattended with the EMAR opened to resident's information. The nurse (#4) returned to the medication cart at 4:59 p.m. - Observation on 12/18/23 at 4:59 p.m. showed a nurse (#4) documented a blood sugar for a resident on the EMAR, prepared an insulin for administration, gathered supplies, took the resident to her room, and failed to secure the EMAR, leaving the resident's information in view. The nurse returned to the medication cart at 5:06 p.m. During an interview on 12/19/23 at 1:14 p.m., two administrative nurses (#2 and #3) stated they expected nurses to follow facility policy for securing of the EMAR. The facility failed to promote privacy and confidentiality of the resident's MAR when unattended by staff.	F 583	accomplished for those residents found to have been affected by the deficient practice. No resident was directly affected by this finding. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk for a breach of their privacy. 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Patient Privacy policy will be reviewed with staff who work on the medication carts (RN, LPN, and CMA) by either the LTC DON or Quality Manager on a one-on-one basis or in a small group setting by January 29, 2024, with a staff sign off to ensure their understanding of the policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Monitoring of staff throughout each shift will be conducted. This will be done weekly x4, then monthly x2. The Director of Nursing and the QA Manager will conduct these audits. The DON will aggregate, analyze and then report the	

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F 583	Continued From page 4	F 583	findings at the quarterly QA meeting. This will begin the week of 01/05/24. 5. Indicate dates when corrective action will be completed. January 29, 2024	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		1/29/24

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F 625	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or resident's representative a written bed hold notice for 3 of 3 residents (Resident #3, #5, and #17) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice and include the reserve bed amount does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of the facility policy "Discharge or Transfer of Residents" occurred on 12/20/23. This policy, dated October 2017, stated, ". . . To improve care coordination by providing information to the resident/family if going home or the receiving health care organization and provider that can help them provide quality care to our residents. . . Forms Used: . . . Bedhold Notice Form. . ." - Review of Resident #3's medical record occurred on all days of survey. Hospital transfers occurred on 04/28/23, 05/23/23, 06/16/23, 10/28/23 and 11/09/23. The record lacked documentation the facility provided the resident and/or their representative with a written bed hold notice or the reserve bed hold amount at the time of each of the above hospital transfers. - Review of Resident #5's medical record occurred on all days of survey. A hospital transfer occurred on 03/12/23. The record lacked documentation the facility provided the resident	F 625	F625: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #3, #5, and #17 were not provided the proper notice of their bed hold rights prior to transferring to a higher level of care. Specifically, the associated cost and duration of the bed hold, for moth Medicaid and Private Pay residents. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk for not having this requirement met due to the incomplete transfer/bed hold form. 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Bed Hold form will be revised to include all the required elements. The new form and the currently Bed Hold Notice policy will be reviewed with all nursing staff by either the LTC DON or Quality Manager on a one-on-one basis or in a small group setting by January 29, 2024, with a staff sign off to ensure their understanding of the policy.	

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F 625	Continued From page 6 and/or their representative with a written bed hold notice or the reserve bed hold amount at the time of the transfer. - Review of Resident #17's medical record occurred on all days of survey. A hospital transfer occurred on 11/21/23. The record lacked documentation the facility provided the resident and/or their representative with a written bed hold notice or the reserve bed hold amount at the time of the transfer. During an interview on 11/19/23 at 4:55 p.m., an administrative staff member (#2) confirmed the facility staff failed to provide bed hold notices to Resident's #3, #5, and #17 or their representatives when transferred to the hospital.	F 625	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Each transfer will be reviewed, and the transfer form reviewed to ensure the strict compliance with the regulatory requirements and the facility policy. The Director of Nursing will review 100% of these charts for the next 3 months. This will begin the week of 1/15/24. The DON will aggregate, analyze and then report the findings at the quarterly QA meeting. 5. Indicate dates when corrective action will be completed. January 29, 2024	
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, record review, policy review, and staff interview, the facility failed to follow professional standards of practice for medication administration for 1 of 2 sampled residents (Resident #17) who received insulin and 1 of 1 sampled resident (Resident #13) who received eye drops. Failure to document medication administrations after administration, prime insulin pens, and follow the physician's	F 658	F658: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #17: The resident had no direct adverse effects from this finding - insulin	1/29/24

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F 658	Continued From page 7 orders when administering medications may impede the therapeutic effectiveness of the medications, cause adverse events such as medication errors and low blood sugar. Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/20/23. This policy, dated February 2008, stated, ". . . Medications are administered only pursuant to a Provider's Orders. . . . 2. Medication Administration Record: A. All medications administered . . . must be recorded on the electronic MAR . . . All medications should be charted immediately after they are given . . . 3. Responsibilities: A. The professional nurse is responsible for the correct administration of medications as ordered by the doctor. . . ." Review of the facility policy titled "Insulin Pen Use" occurred on 12/20/23. This policy, dated 2010, stated, ". . . prime safety needle with 2 units prior to each administration . . . " - Observation on 12/18/23 at 4:59 p.m. showed a nurse (#4) documented a blood sugar of 176 for Resident #17 and documented insulin administration. The nurse prepared a Humalog Kwikpen (insulin) for administration by placing a needle on the end of the pen, gathered supplies, and took Resident #17 to her room. The nurse (#4) administered 9 units of Humalog insulin to Resident #17 without priming the insulin pen. Resident #17 continued into the dining room for the supper meal. The nurse (#4) stated the 9 units of insulin she	F 658	administration and documentation. Resident #13: The resident had no direct adverse effects from this finding - eye drop administration and documentation. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk of medication administration negative effects related to not following the Medication Administration policy and associated documentation requirements. 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Medication Administration, Insulin Pen, and Eye Medications Procedure policies will be reviewed with all staff who pass medications (RN, LPN, and CMA) on the unit will be taught by either the LTC DON or Quality Manager on a one-on-one basis or in a small group setting by January 29, 2024, with a staff sign off to ensure their understanding of the policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audit reviews of medication administration and documentation with staff will be completed weekly x4, monthly x2, and then quarterly x2. The Director of	

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F 658	Continued From page 8 administered were "the sliding scale plus meal coverage". Review of Resident #17's medical record occurred on all days of survey. Current physician's orders included "Humalog Kwik Pen . . . Per Sliding Scale . . . If Blood Sugar is 151 to 200, give 5 Units. . . . At meal time add extra units for meal coverage 2 units for 1/2 meal and 4 units for whole meal. . . ." The nurse (#4) documented medication administration prior to administration, failed to prime the insulin pen prior to insulin administration, and failed to assess Resident #17's meal intake prior to administration of additional insulin per physician's orders. - Observation on 12/19/23 at 9:04 a.m. showed a nurse (#5) administered Timolol Maleate 0.5% (eye drops) to Resident #13. At 9:07 a.m. the nurse administered Brimodine Tartrate 0.2% (eye drops) to Resident #13. Review of Resident #13's medical record occurred on all days of survey. A current physician's order stated ". . . Brimodine Tartrate 0.2% eye gtt [drop] 1 drop OU [both eyes] BID [two times a day], separate from other eye drops by 10 minutes . . ." The nurse (#5) failed to wait 10 minutes before administering the Brimodine eye drop to Resident #13 per physician's orders. During an interview on 12/19/23 at 1:14 p.m., two administrative nurses (#2 and #3) stated they expected nurses to follow physician's orders as	F 658	Nursing will perform these audit reviews. The DON will aggregate, analyze and then report the findings at the quarterly QA meeting. This will begin the week of 01/05/24. 5. Indicate dates when corrective action will be completed. January 29, 2024	

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F 658	Continued From page 9 written, document medications after they are administered, and follow facility policy for priming of insulin pens.	F 658		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of nurse staffing schedules, staff time sheets, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 2 of 91 days reviewed (05/14/23 and 05/26/23). Failure to ensure sufficient, qualified nursing staff are available eight consecutive hours a day has the potential to affect the health and safety of all the residents residing in the facility. Findings include: On 12/18/23, the facility provided a copy of the nurse staffing schedules, and nurse time sheets	F 727	F727: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was directly affected by this finding. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk for	1/29/24

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F 727	Continued From page 10 for the period of April 1 - June 30, 2023. A review of the schedules showed the facility failed to have the required RN coverage on 05/14/23 and 05/26/23. During an interview on 12/19/23 at 2:05 p.m., an administrative staff member (#2) confirmed the facility lacked RN coverage on the above dates.	F 727	understaffing of Registered Nurses (RN). 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. This regulation will be reviewed with the leadership team and the scheduler by the LTC DON on a one-on-one basis, with staff sign off to ensure understand of the regulation. In situations where the RN hours will be fewer than 8 hours in a day, the Director or another Nurse Leader designee will be assigned to the Charge Role for at least 8 hours in a day. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. RN staffing levels will be monitored weekly x4, monthly x2, and then quarterly x2. The Director of Nursing will perform these audit reviews. The DON will aggregate, analyze and then report the findings at the quarterly QA meeting. This will begin the week of 01/05/24. 5. Indicate dates when corrective action will be completed. January 29, 2024	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		1/29/24

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F 759	Continued From page 11 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 6 residents (Resident #13 and #17) observed during medication pass. Three medication errors occurred during staff administration of 28 medications, resulting in a 10% error rate. Failure to administer medications correctly and per physician's orders may result in residents receiving an ineffective dose and experiencing adverse side effects such as low blood sugars. Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/20/23. This policy, dated February 2008, stated, ". . . Medications are administered only pursuant to a Provider's Orders. . . . 3. Responsibilities: A. The professional nurse is responsible for the correct administration of medications as ordered by the doctor. . . ." Review of the facility policy titled "Insulin Pen Use" occurred on 12/20/23. This policy, dated 2010, stated, ". . . prime safety needle with 2 units prior to each administration . . ." Review of Resident #17's medical record occurred on all days of survey. Current physician's orders included "Humalog Kwik Pen . . . Per Sliding Scale . . . If Blood Sugar is 151 to	F 759	F759: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #17: The resident had no direct adverse effects from this finding - insulin administration and documentation. Resident #13: The resident had no direct adverse effects from this finding - eye drop administration and documentation. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk of medication administration negative effects related to not following the Medication Administration policy and associated documentation requirements. 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Medication Administration, Insulin Pen, and Eye Medications Procedure policies will be reviewed with all staff who pass medications (RN, LPN, and CMA)	

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F 759	Continued From page 12 200, give 5 Units. . . . At meal time add extra units for meal coverage 2 units for 1/2 meal and 4 units for whole meal. . . ." - Observation on 12/18/23 at 4:49 p.m. showed a nurse (#4) documented a blood sugar of 176 for Resident #17. The nurse prepared Humalog Kwikpen (short acting insulin) for administration to Resident #17 by placing a needle on the end of the pen, gathered supplies and took Resident #17 to her room. The nurse (#4) dialed the insulin pen to 9 and administered 9 units of Humalog insulin to Resident #17. The nurse (#4) failed to prime the insulin pen and failed to assess Resident #17's meal intake prior to insulin administration. Review of Resident #13's medical record occurred on all days of survey. A current physician's order stated ". . . Brimodine Tartrate 0.2% eye gtt [drop] 1 drop OU [both eyes] BID [two times a day], separate from other eye drops by 10 minutes . . ." - Observation on 12/19/23 at 9:04 a.m. showed a nurse (#5) administered Timolol Maleate 0.5% (eye drops) to Resident #13. At 9:07 a.m. the nurse administered Brimodine Tartrate 0.2% (eye drops) to Resident #13. The nurse (#5) failed to wait 10 minutes before administering the Brimodine eye drop to Resident #13 per physician's orders. During an interview on 12/19/23 at 1:14 p.m., two administrative nurses (#2 and #3) stated they expected nurses to follow physician's orders as	F 759	on the unit will be taught by either the LTC DON or Quality Manager on a one-on-one basis or in a small group setting by January 29, 2024, with a staff sign off to ensure their understanding of the policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Medication administration and documentation tracers with staff will be completed weekly x4, monthly x2 and then quarterly x2. The Director of Nursing will perform these audit reviews. The DON will aggregate, analyze and then report the findings at the quarterly QA meeting. 5. Indicate dates when corrective action will be completed. January 29, 2024	

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F 759	Continued From page 13 written, and follow facility policy for priming of insulin pens.	F 759		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		1/29/24

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F 801	Continued From page 14 or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for	F 801		

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F 801	Continued From page 15 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#1) maintained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on 12/19/23 at 9:15 a.m., a dietary manager (#1) stated she failed to complete the required number of continuing education hours to maintain certified dietary manager (CDM) certification, and it expired on 11/30/23. The facility failed to ensure the dietary manager (#1) maintained CDM certification.	F 801	F801: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was directly affected by this finding. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are potentially at risk for understaffing of a clinically qualified nutrition professional. 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. An internal leader will be completing the required Certified Food Manager training and certification. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 801	Continued From page 16	F 801	The Administrative Assistant will track the dietary manager's certification and expiration to ensure our facility's regulatory compliance. 5. Indicate dates when corrective action will be completed. January 29, 2024	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of	F 849		1/29/24

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F 849	Continued From page 17 the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of	F 849		

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F 849	Continued From page 18 the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State	F 849		

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F 849	Continued From page 19 scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides	F 849		

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F 849	Continued From page 20 orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents records contained the hospice election form for 1 of 2 residents (Resident #12) and the certification of a terminal illness for 2 of 2 residents (Resident #9 and #12) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: - Review of Resident #9's medical record occurred on all days of survey and identified Resident #9 elected Hospice services on 02/10/23. The medical record lacked the physician's certification of the terminal illness. - Review of Resident #12's medical record occurred on all days of survey and identified Resident #12 elected Hospice services on 09/14/23. The medical record lacked the hospice election form and the physician's certification of	F 849	F849: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #9 was deceased prior to receiving the LTC 2567. Resident #12 missing hospice documentation was requested from hospice and received by Garrison Memorial Nursing Facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who are receiving hospice services are potentially at risk for not having their medical records kept up to date with the most recent hospital related paperwork.	

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F 849	Continued From page 21 the terminal illness. During an interview on 12/20/23 at 10:45 a.m., an administrative nurse (#7) confirmed the medical records for Resident #9 lacked the certification of the terminal illness and Resident #12 lacked both the certification of terminal illness and the hospice election form.	F 849	3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. A meeting with the hospice leadership team was held on January 17, 2024, from 1:00pm-1:35pm with the LTC DON and the Quality Manager to review the contractual agreements and requirements related to regulatory documentation they must provide us with upon admission and ongoing, including the hospice election form and the physician's certification of the terminal illness. The Quality Manager has documentation that this meeting took place. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will perform audits of charts for all residents who are on hospice and new residents admitted for hospice services. This will be conducted monthly x3, then quarterly x3. The DON will aggregate, analyze and then report the findings at the quarterly QA meeting. 5. Indicate dates when corrective action will be completed. January 29, 2024	