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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	312 EAST STATE ST MARION, SD 57043

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/17/2024 through 12/19/2024. Tieszen Memorial Home was found not in compliance with the following requirements: F585, F689, F695 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/17/2024 through 12/19/2024. The area surveyed included resident safety related to elopement (left facility without staff knowledge). Tieszen Memorial Home was found in compliance.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson
TITLE: Administrator
(X6) DATE: 1/13/2025

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.

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F 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585	Social Services Coordinator visited with Resident #19 to confirm Resident #19 still requests that the bed be removed from the room. Resident #19 has changed his mind and no longer wishes to have the bed removed from the room. The conversation was witnessed by another facility staff member. Social Services Coordinator also reviewed the policy and procedure for concerns, complaints and grievances with Resident #19. Social Services Coordinator visited with Resident #24 regarding the wait time for dining service at meal times. Resident was reminded of the requirement of no more than 14 hours between supper and breakfast without a substaintial snack and that supper service could not start prior to 5:45 pm. The Administrator and Dietary Manager will conduct a staff meeting with the dietary staff to re-educate them on ensuring timely meal service at each meal. A monitoring log will be established to document start and stop times of the noon and supper meals to determine where potential issues are occurring for a period of 4 weeks. The Dietary Manager will review the logs 3-5 times per week to identify any issues and address them with the staff involved. The logs will be reviewed at the monthly QAPI committee meeting for their review and further recommendations. Social Services Coordinator also reviewed the policy and procedure for concerns, complaints and grievances with resident #24. Social Services Coordinator visited with Resident #18 regarding the facility's plicy and procedure for concerns, complaints and grievances and the process for submitting a concern, complaint or grievance. The Administrator will visit with the Dietary Manager regarding meal service, and re-educate the dietary staff on order of meal services for serving residents. The administrator, along with the interdisciplinary care team have revised the grievance policy/ procedure to encompass concerns and complaints. A form has been developed for anyone, including residents, families, guests and staff to use if they want to. The form will not be required to be used at any time. Verbal and written concerns, complaints and grievances will be documented and tracked by the Social Services Coordinator/Department to ensure concerns, complaints and grievances are addressed and resolved in a timely manner. The Activity Coordinator and the Social Services Coordinator or their designees will work together to track and document any concerns, complaints or grievances that come up at the monthly Resident Council Meeting. Writeen minutes will be prepared by the Activity and Social Services Department Representatives following each Resident Council Meeting to include concerns, complaints and grievances that were brought up by those present at the meeting.	

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F 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to effectively implement and follow their policy related to grievances for three of three sampled residents (18, 19, and 24)	F 585	Each of the items will be discussed under "Old Business" to ensure the concerns, complaints grievances have been resolved. If a representative from the department in question is not present at the Resident Council meeting, the concern, complaint or grievance will be communicated with the appropriate department and documentation attached to the minutes. Residents will be educated at each Resident Council meeting and at the time of each MDS assessment interview on the concerns, complaints, grievance policy/procedure by the Social Services Coordinator or designee to ensure residents understand how to voice their concerns, complaints, and grievances. The Activity and Social Services Departments will bring the minutes of the Resident Council Meetings and the concerns, complaints and grievance logs to the monthly QAPI meetings for their review by the committee to ensure these items are being tracked, addressed, and resolved in a timely manner. This wil become part of the regular QAPI meeting process going forward. All facility staff will be educated on the updated concerns, complaints, grievance policy/procedure by the Administrator via the facility education plateform of Relias Learning.	1/30/2025

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with unresolved reported concerns. They failed to ensure:
*Residents were informed and information was available on how to file a grievance.
*All grievances were documented and included the date received, summary statement of resident's grievance, steps taken to investigate and keep resident informed of progress, summary of pertinent findings or conclusion, any necessary corrective action, and date the grievance was resolved.
*Documentation of grievances and their resolution was maintained.
*Resident council notification of group-reported grievance progress and resolution.
Findings include:

1. Interview on 12/17/24 at 9:32 a.m. with resident 19 in his room revealed he:
*Reported he had requested that his bed be taken out of his room because he slept in his recliner and wanted more room to use his electric wheelchair.
*Stated he had asked "the maintenance man" and "anyone who will listen" about it and it "still hasn't been done."
*Was not sure how to file a grievance regarding his unresolved request to have his bed removed from his room.

2. Interview on 12/17/24 at 3:08 p.m. with resident 24 revealed:
*She sometimes waited 30 to 45 minutes in the dining room for her meal.
-The wait for supper was "the worst."
*It was difficult for her to wait that long because she had back pain and her legs would go numb.
*She had reported her concern at the resident council meeting a couple of weeks ago.

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F 585	Continued From page 4 *She was told that there was new staff in the dietary department but nothing had improved. 3. Interview with the residents during a resident group meeting on 12/18/24 at 1:00 p.m. revealed: *The resident council met monthly. *Eight residents attended the group meeting who regularly attended the resident council meetings. *They reported that they did not know how to file grievances. -Each department was to address reported concerns related to that specific department. -They verbally expressed their concerns to those department staff members. -If those staff were not at the resident council meeting, activities coordinator (AC) C would pass on their concerns. *There was no follow-up with the residents when they brought their concerns to each department outside of the resident council meeting. *Concerns about the food and long wait times for meal service had been brought up at resident council meeting. -Concerns were discussed verbally, and the residents stated there was no follow-up at the next meeting regarding those concerns. --Resident 3 stated she "seeks out" the answers because she knew where to find the department heads. -Resident 18 stated that she felt like her table was always served last and that she had told the cook "Multiple times," but she felt that there was no communication in that department. -There had been "turnover" in the dietary department and previous concerns were not followed up on. --One resident stated, "We have to start all over." -A resident shared a concern about meals and vegetables being repeated and that they lacked	F 585		

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variety.
*Resident 17 confirmed their concerns were conveyed verbally and that there was no form they filled out when they had a complaint or concern.

4. Interview on 12/19/24 at 10:16 a.m. with AC C revealed she:
*Organized the resident council meetings, took the minutes, and emailed the minutes to each department head after the meeting.
*Confirmed residents often shared concerns about the long wait times and the food during resident council meetings.
*Stated that most concerns were addressed by that department's staff that attended the resident council meeting.
-If staff from those departments of expressed concern were not in attendance, social services coordinator (SSC) J would email those concerns to the applicable department head.
*Had not included the resident concerns in the resident council minutes.
*Had not assisted a resident in filing a grievance.

5. Interview and review of emails on 12/19/24 at 10:32 a.m. with SSC J revealed:
*She was the grievance coordinator.
*She had worked there for three years.
*She was aware of one resident grievance since she had worked there and that was handled by her and administrator (ADMIN) A.
*There was no specific form to fill out when a resident had a complaint, concern, or a grievance.
*Resident concerns were brought to her by the resident, the families, and facility staff in person, by email, or over the phone.
-Sometimes she received a note that a specific

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F 585	Continued From page 6 resident wanted to talk to her. -She did not have a specific documented tracking system of resident concerns. --Some were documented in her emails, or the resident's electronic medical record (EMR), but most were addressed verbally. *She would notify each department involved if a resident had a concern with that department. -This was done verbally or by email. *Only "very serious concerns" were brought to the administrator if they could not be resolved. *She was aware of the resident's concerns regarding the food and long wait times in the dining room. -She had emailed the dietary department about concerns related to the food and long wait times on 11/15/24. --Review of that email confirmed that she wrote, " ...several residents tell me the meal was not good last night and it's become a regular thing. They are also telling me they are being served later and later and later ... several didn't wasn't o go because they weren't served until well after 6pm." *She was aware that resident 19 had requested to have his bed removed. -She confirmed she had documented his request in the EMR during his care conference held on 10/23/24. -She stated she had emailed maintenance about his request several times and that the last email she sent was 12/10/24. --Review of that email confirmed she wrote, " ...he wants the bed taken out as he refuses to sleep in it." -She was not sure if that situation had been resolved. 6. Interview on 12/19/24 at 11:20 a.m. with ADMIN A regarding resident concerns and the	F 585		

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grievance process revealed:
*She considered a grievance to be very serious in nature concerning abuse, neglect, or mistreatment.
*She expected issues like missing items, food complaints, and resident concerns to be handled immediately.
-That was a verbal process.
--She confirmed they did not have a specific form to be filled out, but said that residents could "write a note and slip it under the door" if they wanted to.
*Department heads would learn of resident concerns at resident council meetings, or they would be emailed concerns after the meeting.
*She confirmed that SSC J was the grievance official.
*She stated, "Residents were told [SSC J] was their person if they had concerns or complaints."
*She was not aware of the process for tracking or following up with resident concerns as this was handled by SSD J.
*She stated there were no grievances available to be reviewed as there had been no grievances filed in the past three years because "nothing rose to the level of a grievance."

7. Review of the provider's "Resident Grievance: 2024" sheet revealed:
*There were nine concerns listed between 4/4/24 and 11/1/24.
-Two of those concerns had no documented follow-up provided.
*There was one concern regarding the food made by resident 1 on 7/2/24.

Review of the provider's Resident Council minutes from July 2024 through December 2024 revealed:

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*Each month's meeting minutes included:
-The date and time the meeting was held.
-Motions to open and close the meetings.
-The number of residents in attendance.
-A statement that the previous month's "council notes were reviewed."
-Names of staff members present.
-"Old Business: NONE"
- "New Business:" included:
--A resident's right was reviewed each month.
-"Special things residents have interest in doing throughout the month of ...."
-The dessert of the month.
*The September minutes revealed: "Residents want more fresh fruit for meals. They would like watermelon, cantaloupe, and strawberries that are ready to eat. They also stated the scalloped potatoes have no flavor."
-There was no documented follow-up of that concern for October, November, or December of 2024.

Review of the provider's revised July 2003 Resident Council policy revealed:
*"The resident council is an open meeting opportunity for residents to let their voices be heard."
*Time is spent covering areas of concern including nursing care, dietary services, activities available, general comfort, etc ..."
*No definitions or guidance was provided regarding the difference between a concern and a grievance.

Review of the provider's May 2019 Resident Grievances policy revealed:
*"Responsible Party: Social Services Coordinator."
*"It is the policy of the Tieszen Memorial Home to

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F 585	Continued From page 9 provide a grievance procedure for any resident who feels they have a grievance." *If a resident has a grievance, the following procedure will be used: (This is the exact language from the resident policy manual)". *See the review of the provider's 6/1/21 Tieszen Memorial Home Resident Policy Manual below. Review of the provider's 6/1/21 Tieszen Memorial Home Resident Policy Manual revealed: *"Grievances. If you have a grievance, please use the following procedure. Each grievance will be recognized and resolved within a time frame as indicated within the procedure. This procedure is in no way designated to discourage the registration of a grievance. A grievance may be related to treatment provided or treatment not provided, the behavior of other residents, the infringement of the residence rights, or other areas of treatment or care." *"If you have a grievance, contact the Administrator or the Social Service Coordinator. The grievance can be oral or in writing. You have a right to engage and be represented by your own legal counsel. If the grievance has not been resolved with a meeting of the resident/responsible party/appointed representative within 5 days, the grievance should be given to the Administrator. At this point the grievance will need to be in writing to assure that the problem remains the same as what was presented at the on-set. The Administrator may ask that the resident or appointed representative meet with him/her to discuss the problem. If the problem is not solved within 10 days, the grievance can be registered with the governing board of the nursing home. This must be in writing. Or, you may contact the State Ombudsman, telephone # [redacted], or other	F 585		

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client advocate. Their name and addresses can be found elsewhere in this manual."
*The telephone number provided in that manual for the States Ombudsman was not the correct telephone number.

Review of the provider's resident rights document A Matter of Rights, in their Admission Handbook revealed:
*"Grievances. You have the right to speak up about grievances and have them responded to promptly and fairly."
*" All residents have the right:
-[T]o voice concerns and complaints, spoken, in writing, or anonymously, about the treatment and care we provide or the behavior of other residents.
-[T]o information on how to file a grievance or complaint.
-[T]o timely response by us in which we agree to consider the issue or issues you raise and to act upon them as may be appropriate.
-[T]o be free from any pressure intended to discourage you from voicing your concerns or complaints."
*"Residents have the right to voice grievances without fear of discrimination or reprisal for doing so."
*"A grievance of a resident or someone acting on behalf of a resident should be directed to our administrator, to an appropriate department head, or to a designated grievance contact person. It will be helpful if you include: your name, the date, how to reach you, if you are not the resident, details of the situation or event."
*" Please be as specific as possible in describing the "what," "where," "when," and "who" involved in your concern or complaint."
*No definitions or guidance was provided

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F 585	Continued From page 11 regarding the difference between a concern and a grievance.	F 585		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to: *Adequately assess, reassess, and monitor for resident changes in cognition and safety awareness for self and others for one of eight sampled resident (19) who used a power wheelchair for mobility. *Obtain a physician's order for use with cognitive ability acknowledged for that resident. Findings include: 1. Observation on 12/17/24 at 12:18 p.m. of resident 19 while he exited the dining room while in his power wheelchair revealed he bumped into resident 210's chair, who was seated at the table. 2. Observation on 12/19/24 at 10:46 a.m. of resident 19 while in his power wheelchair revealed he hit the couch in the hallway seating area near the chapel with his power wheelchair and moved that couch by several inches. 3. Review of resident 19's paper chart and	F 689	A physician's order will be obtained by the licensed nurse for an Occupational Therapy evaluation for Resident #19 to ensure Resident #19 is safe and appropriate to continue usage of a power chair. In the event resident #19 is no longer safe and appropriate to continue using the power chair, Resident #19 will be transitioned to a traditional manual wheelchair. The policy and procedure for Electric Wheelchairs/ Scooters will be updated to reflect the following: Any resident who wishes to utilize a power chair within the facility must have a physician's order for an Occupational Therapy evaluation prior to being able to use a power chair. The purpose of the Occupational Therapy evaluation is to ensure the resident is safe to use the power chair. Once the resident has successfully passed the requirements for safe usage of the power chair, the resident will be permitted to use the power chair in the facility. Each resident using a power chair will have an annual assessment by Occupational Therapy at the time of their annual MDS assesment to ensure they continue to utilize the power chair in a safe manner. Additional assessments may be required in the event of a significant change in the resident's condition or if the resident's use is a safety issue to themselves or others in the facility. In the event it has been determined the resident is currently unsafe and the OT evaluation has not been conpleted, the residetn would be transitioned to a non-power device until the evaluation can be completed. A log will be maintained by the MDS Coordinator or designee of all residents utilizing power chair devices to ensure their evaluations are being completed as per the updated policy/procedure for Electric Wheelchairs/Scooters. The MDS Coordinator or designee will procedure the logs to the monthly QAPI meetings monthly for 3 months for their review and further recommendations. Facility staff will be educated on the updated policy/ procedureby the Administrator via the facility education plateform of Relias Learning.	1/30/2025

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(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 689	Continued From page 12 electronic medical record revealed: *He was admitted on 4/11/23. *His diagnosis included *He received an occupational therapy (OT) evaluation for the initial use of the power wheelchair on 6/21/23 and was discharged from OT on 7/5/23. -That evaluation indicated: --"Pt [patient] has demo [demonstrated] independent and safe operation of his power wc [wheelchair] within the SNF [skilled nursing facility] and outside the SNF/ALF [assisted living facility]." --His safety awareness was "Intact." --His decision-making ability for routine activities was "independent." *His 7/16/24 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact. *His 10/15/24 BIMS assessment score was 9, which indicated he was moderately cognitively impaired. *An 11/22/24 progress note (PN) indicated, " ... resident will make a point to follow the [floor cleaning] machine multiple times throughout the duration of cleaning. Most times, resident passes the machine extremely close where maintenance has had to move out of resident's way. Other times when resident passes the machine the motorized wheelchair with [would] get hooked on the floor machines wheel resulting in maintenance having to stop to wait until resident becomes unhooked from machine. Resident's wheelchair is swung around to the side once wheels are hooked and that is when resident is able to unhook himself after [the cleaning] machine is stopped. Per staff, this happens often when floor are being washed by motorized machine. At this point, no injuries have been	F 689		

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	435069	A. BUILDING ______ B. WING ______	C 12/19/2024

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F 689	Continued From page 13 conducted by staff or resident. Resident was spoken to by writer regarding safety and proper use of his electric wheelchair, resident acknowledged writer with a head nod. Will continue to monitor PRN [as needed]. Social services verbally notified." *An 11/29/24 PN indicated, "Resident has been riding in electric wheelchair most of the day and getting close to other staff, residents, and visitors when passing by. Writer asked resident to be mindful of where he is driving and make sure he is not getting too close or running into people. Resident made a few remarks to rider about not looking out for others and that he drives just fine. Later resident came to writer and mentioned how many people he had ran over today with his wheelchair. Writer repeated for resident to be mindful of others and cautious about getting too close. Writer explained poor decision making could impact his ability to keep his electric wheelchair if he does not practice safe driving. Resident told writer no and drove wheelchair away." *An 11/30/24 PN indicated, "Resident yelling out at staff about getting other residents, "Out of his way" and demanding that he gets cared for prior to other residents." *A 12/2/24 PN indicated, "Resident was in electric wheelchair and got very close to one of our staff members. Staff made a comment about resident getting too close and resident laughed at staff and continued riding around in wheelchair." *A 12/13/24 PN indicated, "Secretary reported that resident was driving his electric wheelchair around the entry way this morning when he ran into the face mask dispenser. Resident also continues to get very close to writer and other staff in the hallway when driving around. Rude to staff when they mention he is getting too close."	F 689		

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F 689	Continued From page 14	F 689		

*There was no physician order for resident 19's use of the power wheelchair.

4. Interview on 12/19/24 at 9:33 a.m. with physical therapy assistant P revealed:
*They communicated with nursing through email.
*OT evaluated residents for use of their ability to safely use their power wheelchairs.
-Residents were to be reassessed for safe operation of power wheelchairs annually or if there was an incident that involved their unsafe driving of the power wheelchair.
*She confirmed resident 19 was evaluated for use of his power wheelchair in June 2023.
*She was not aware of resident 19's unsafe power wheelchair driving incidents.
-She reviewed her emails and stated she had not received any emails regarding resident 19.
*Resident 19 had not been reassessed by therapy for his ability to safely operate his power wheelchair since his June 2023 evaluation.

5. Interview 12/19/24 at 10:09 a.m. with secretary E regarding resident 19 driving his power wheelchair revealed she:
*Reported a concern regarding resident 19 having been observed getting too close to other residents and staff while driving his power wheelchair.
*Was aware resident 19 had recently hit the mask stand in the entryway with his power wheelchair.

6. Interview on 12/19/24 at 1:16 PM with anonymous registered nurse O regarding resident 19 driving his power wheelchair revealed she:
*Had concerns about resident 19's safety while driving his power wheelchair.
-Stated, "He gets too close," and "He tries to be funny and one of these days it's not going to be

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F 689	Continued From page 15 funny." *Documented those concerns in the EMR and reported them to the director of nursing. *Confirmed that residents were evaluated by OT when they had a power chair they wanted to use. -She did not know how often the resident was reassessed by OT. Review of the provider's revised June 2023 Electronic Methods of Transportation (Electric Scooters, Electric Wheelchairs, etc) Policy revealed: *"Any resident using an electric transportation device must be safe in the operation of the device ..." *"Any resident who wishes to use an electric transportation device must have a physician's order to do so." *"If at any time, a resident is observed to be operating their electronic transportation device in an unsafe manner, the licensed nurse will be notified. In order for the resident to continue to operate the device, an evaluation will need to be completed by the therapy department to ensure the resident is safe to use the device."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		

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F 695	Continued From page 16 by: Based on observation, interview, record review, and policy review the provider failed to ensure the oxygen concentrator filter was clean and the nasal cannula tubing was changed weekly, for one of three sampled residents (4) who received oxygen from four oxygen concentrators that were separately located throughout the facility. Findings include: 1. Observation and interview on 12/17/24 at 8:57 a.m. with resident 4 in her room revealed: *She was able to say hello but was unable to answer questions about her oxygen. *She wore an oxygen nasal cannula (flexible tubing with prongs that deliver oxygen into the nose) connected to an oxygen concentrator beside her chair. *The nasal cannula connected to that oxygen concentrator was not labeled or dated. *The filter on the back of that oxygen concentrator had visible gray dust. 2. Observation on 12/17/24 at 11:18 am in the sunroom revealed: *An oxygen concentrator located in the back corner labeled "TMH#7". *Attached to that concentrator was a plastic bag labeled with resident 4's first name and last initial, and had "date issued 10/20," and "O2 tube" written on it. -Inside that bag was a nasal cannula with a piece of tape attached to it that was dated "10/6." 3. Observation on 12/17/24 at 12:10 p.m. of resident 4 in the dining room revealed she wore an oxygen nasal cannula connected to an oxygen concentrator labeled "#8" which was located under the window behind her chair.	F 695	The Director of Nursing or designee will develop a tracking form to list all oxygen concentrators being used by residents in the facility and their location. Licensed nurses are assigned the task of cleaning the concentrator filters, along with replacing and dating the tubing/cannulas on a weekly basis for each of the concentrators in use. The Director of Nursing or designee will monitor the tracking form and spot check the concentrators on a weekly basis to ensure the cleaning/replacing is being done. The Director of Nursing or designee will bring the tracking form to the monthly QAPI committee for three months to be reviewed and for any further recommendations. Licensed nurses will be re-educated on the current policy and procedure for oxygen concentrator cleaning via the facility's education platform of Relias Learning	1/30/2025

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4. Observation on 12/17/24 at 3:03 p.m. of oxygen concentrator "#8" located in the dining room revealed a plastic bag labeled with resident 4's initials and dated "12/17/24" was attached to that concentrator.
-Inside that bag was a nasal cannula with a piece of tape attached to it that was dated "11/17/24."

5. Interview and review of the treatment administration record (TAR) on 12/19/24 at 9:53 a.m. with director of nursing (DON) B regarding resident 4's oxygen revealed:
*She confirmed that resident 4 used oxygen continuously and there were four separate concentrators that were located in her room, the sunroom, the chapel, and the dining room for her to use.
*Those concentrators were only used by resident 4 because she was the only resident who required oxygen outside of their room at that time.
*Portable oxygen tanks were only used when a resident went out of the facility or if their oxygen levels dropped too quickly to be moved from one concentrator to another.
-Resident 4 had not required a portable oxygen tank.
*When a resident was started on oxygen an order was to be added to the TAR to change the nasal cannulas weekly.
*She expected that all nasal cannulas would be changed and documented on Sunday evenings by the nurse who worked the night shift.
*That nurse would know which nasal cannulas needed to be changed because it would be indicated on the residents' TAR in the electronic medical record (EMR).
*Resident 4's TAR did not include to change the nasal cannulas or the location of the

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F 695	Continued From page 18 concentrators used by resident 4. -She stated, "It looks like hers may have been missed." 6. Review of resident 4's electronic medical record revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated she was moderately cognitively impaired. *A 10/10/24 physician's order reflected oxygen at 1 to 5 liters per nasal cannula four times a day to keep oxygen greater than 90 percent. *A 9/27/24 physician's order to "Check O2 sat [saturation] qid [four times a day], Document Oxygen if in use." *Resident 4's MAR and TAR did not include to change the nasal cannulas. -There was no indication when the nasal cannula had last been changed on any of the four concentrators used by resident 4. Review of the provider's revised May 2024 Oxygen Administration Policy revealed: *"Tieszen Memorial Home's standard of practice for nursing staff for oxygen administration." *"Infection Control: ...Oxygen mask, nasal cannula and equipment storage bag will be changed weekly, labeled and dated."	F 695	Typo text here	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 19 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	reflect the expectations of infection control. All staff will be educated on the importance of checking expiration dates, regular cleaning schedules, items that can and can not be shared and general infection control expectations for each of their departments. The facility Administrator, Director of Nursing, Infection Control Nurse, and Maintenance Director will develop the education for the staff using the facility's education platform of Relias learning. All updated policies, logs, and education will be discussed at the monthly QAPI meeting for review to ensure staff are following the facility expectations in infection control. This will remain on the monthly QAPI meeting agenda indefinitely.	

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
A. Based on observation, interview, and policy review the provider failed to ensure proper infection control practices for the cleaning of shared safety slings for two of two sampled residents (4 and 19) who required the use of a sit-to-stand lift (mechanical lift used to assist to a standing position for transfers). Findings include:

1. Observation on 12/17/24 at 8:21 a.m. of a sit-to-stand lift parked in the hallway revealed:
*The lift had a laminated sign on the side of it that read "12".
*There was a medium-sized sling draped over the lift.

2. Observation on 12/17/24 at 8:32 a.m. with resident 4 and nursing assistant (NA) D revealed:
*NA D used a sit-to-stand lift labeled "11" to transfer resident 4 from her wheelchair to her

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F 880	Continued From page 21 recliner and then placed that lift in the hallway outside that room. -The lift had two green safety slings stacked on top of it, one medium-sized and one large. 3. Observation and interview on 12/17/24 at 9:23 a.m. with NA D revealed: *NA D brought sit-to-stand lift 11 into resident 19's room with the 2 green safety slings stacked on top of it. -She used that lift to transfer resident 19 from his electric wheelchair to his recliner. *NA D used a cleaning wipe to wipe the metal parts of lift 11 but did not wipe the sling and then parked that lift in the hallway with those two safety slings stacked on top of it. *NA D called this lift "the one-person EZ stand." *She confirmed that lift 11 was used to transfer residents 4 and resident 19. *There were three or four other residents who also used that lift on the second floor. *The two green safety slings were shared by all the residents depending on what size they needed. -One was a size medium, and the other was a size large. *She stated the two safety slings were washed when they were visibly soiled, and they were "sanitized once a day. 4. Interview on 12/19/24 at 11:33 a.m. with RN/infection control nurse M regarding the lift slings revealed: *She indicated that each resident who used a full-body lift had their own sling. *She stated that sit-to-stand lift slings are shared between residents. -They were to be wiped with a disinfectant wipe between being used for assisting residents.	F 880	The Administrator will purchase enough slings for the E-Z stand to ensure each resident using the E-Z stand will have their own sling for use. Extra slings will be purchased to ensure replacements are available in the event a resident's sling is sent to laundry for cleaning. The Policy/Procedure for the E-Z stand has been updated by the Infection Control Nurse to reflect this change in regads to each resident having their own sling. B. The Director of Nursing, Infection Control Nurse, Wound Care nurse, and Medical Director will review and revised the Enhanced Barrier Policy/Procedure to reflect current facility practice that still follows the CMS guidance for Enhanced Barrier Precautions. C. All alcohol based hand sanitizer throughout the facility will be checked for expiration dates and labeled to reflect current expiration dates of the product contained in the dispensers. Due to the discontinuation of the cartridges for all the wall mount units through out the facility, the cartridges will be refilled from stock supply that is current and not expired. The facility maintenance director will maintain a log of which units are refilled, the date refilled, and the expiration date of the stock supply that is being used to refill the cartridges. All expired ABHS found in the facility will be discarded. The Administrator, Maintenance Director and Infection Control nurse will update the policy and procedure on ABHS for the facility and educate staff to continually check expiration dates. The Maintenance Director will provide the logs to the monthly QAPI committee meeting for their review and any further recommendations for the next three months. The Director of Nursing, Infection Control nurse and Maintenance Director have completed a thorough cleaning of all items in the bathing rooms and supply closets through out the facility and have eliminated any and all items that have expired, shared, or stored in those areas. All items that are stored in the mentioned areaswill be properly labeled/dated. Personal items for residents will be stored in their individual caddies and brought to the bathing rooms at the time of their bath/shower for their use and then returned to their resident room upon completion of the bath/shower. Logs will be developed for the nursing assistants and housekeeping assistants to check for unnecessary items and expired items in their work areas by their department heads and infection control nurse. The Director of Nursing and Infection Control nurse will update the policy/procedure for common/shared use items. The licensed nurses will be assigned to monitor the logs and spot check for compliance on a weekly basis to ensure the areas are clean and the products in those areas are necessary and not expired. The Director of Nursing and Infection Control nurse will review and update policies and procedures to	

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F 880	Continued From page 22 -They were to be sent to the laundry when they were visibly soiled. Review of the provider's June 2017 EZ stand and mechanical lift policy revealed: *"Each resident has a dedicated harness that will be laundered if soiled." *"EZ stand is cleaned with disinfecting wipes between each use." B. Based on interview, observation, record review, and policy review the provider failed to ensure one of one sampled resident (20) with an open wound had been placed on enhanced barrier precautions (EBP). Findings include: 1.Interview on 12/17/24 at 11:32 a.m. with housekeeper F revealed there were no residents on second floor that had precautions in place which would require her wear a gown and gloves while cleaning the room. 2. Observation and interview on 12/17/24 at 11:40 a.m. with NA D in the hallways of the second floor revealed: *A metal cart at the nurse's station that had a box of disposable gloves, a box of straws, a plastic container with yellow gowns inside, and a binder with a sunflower on it. *NA D stated that the sunflower symbol was to be used to indicate a resident was on precautions that required them to wear a gown and gloves. -The sunflower would be posted on the resident's door or in their room on the dresser. *NA D stated when a resident was on COVID-19 precautions their door would be closed. *NA D stated contact precautions were used for residents that had catheters or any open wound or surgical site. *No resident doors or dressers were observed to	F 880	reflect the expectations of infection control. All staff will be educated on the importance of checking expiration dates, regular cleaning schedules, items that can and can not be shared and general infection control expectations for each of their departments. The facility Administrator, Director of Nursing, Infection Control Nurse, and Maintenance Director will develop the education for the staff using the facility's education platform of Relias learning. All updated policies, logs, and education will be discussed at the monthly QAPI meeting for review to ensure staff are following the facility expectations in infection control. This will remain on the monthly QAPI meeting agenda indefinitely.	1/30/2025

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F 880	Continued From page 23 have a sunflower symbol. -NA D stated there were no residents on the second floor who required any type of precautions. 3. Observation on 12/19/24 at 9:10 a.m. of resident 20 revealed: *He had aa air mattress to relieve pressure. *He had a cushion in his recliner and wheelchair. *There were multiple open areas of skin on his mid-buttocks. *No wound dressings were present. *No drainage was visualized. *The skin areas were covered with a white cream. 4. Interview on 12/19/24 at 9:10 a.m. with RN/skin nurse L revealed: *She did not monitor all skin issues. *She monitored all pressure ulcers. *She had been monitoring resident 20's stage II pressure ulcer (partial thickness skin loss that results from pressure). *She stated that she would have considered resident 20's wound as an open wound. *Resident 20's open areas to his buttocks were a result of pressure. *Resident 20's pressure ulcer was not present when he was admitted to the facility. *Resident 20's pressure ulcer had been improving and on 12/18/24 the treatment to the area had changed due to suspected yeast near the wounds. *She indicated that she would have placed a resident on Enhanced Barrier Precautions (EBP) (the use of gown and gloves with high contact resident care activities) if the wound was draining. *There were no residents with draining wounds. *She stated that she worked with the infection control nurse when deciding when to initiate	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	312 EAST STATE ST MARION, SD 57043

(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
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precautions.

5. Interview on 12/19/24 at 9:50 a.m. with RN/infection control nurse M regarding EBP revealed:
*A resident would be placed on EBP if there was an indwelling medical device, a major wound or open skin area, or if the resident was a carrier of a multi-drug resistant organism (MDRO).
*She stated the size of the wound and the ability to cover it would determine if EBP was needed.
*She would have expected a resident with a stage II pressure ulcer for an extended period would need to be on EBP.

6. Review of resident 20's electronic medical record (EMR) revealed:
*He was admitted on 11/5/20.
*He had a 10/28/24 Brief Interview of Mental Status (BIMS) assessment score of 12 which indicated he was moderately cognitively impaired.
*His 12/18/24 care plan included:
-A 5/3/24 initial focus area that indicated he had "a pressure ulcer to his left buttock and a pressure ulcer to his right buttock r/t [related to] decreased mobility."
-A 5/6/24 initial focus area that indicated activities of daily living performance deficit. The intervention included:
--He was not able to ambulate and required assistance to wheel his wheelchair.
--He used a sit-to-stand lift to assist with his transfers.
--He required substantial to maximum assistance to turn in bed, as well as lay down in the bed and sit up in the bed.
--He required substantial to maximum assistance with putting on and taking off his clothes.
--He required substantial to maximum assistance

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to use the toilet and perform his hygiene.
*His 12/18/24 care plan did not include the need for EBP.
*Weekly wound documentation indicated he had a stage II pressure ulcer.

Review of the provider's 4/24 Enhanced Barrier Precaution policy revealed:
*"Use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status".
*"Residents shall remain on these precautions the duration of their stay or until the indwelling medical device is removed or wound is healed."
*If a resident was placed on EBP "It will be communicated by an orange sunflower placed on the resident's door."

C. Based on observation, interview, and policy review the provider failed to ensure the alcohol-based hand sanitizers used throughout the facility were not expired. Findings include:

1. Observation on 12/18/24 from 8:54 a.m. to 9:05 a.m. of the alcohol-based hand sanitizers (ABHS) hanging on the walls outside the resident rooms in the second-floor hallway revealed:
*There was a dispenser hanging outside each resident room below the nameplate.
-Seven outdated on 9/24.
-One outdated on 11/24.
-Three outdated on 9/23.
-Three outdated on 10/24.
-One outdated on 1/23.

2. Continued observation on 12/18/24 at 9:00 a.m. of the second floor revealed:
*A large pump-style bottle of ABHS on a

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F 880	Continued From page 26 medication cart that was labeled as outdated on 8/22. *There was no ABHS available in the resident rooms. 3. Observation on 12/18/24 between 9:01 a.m. and 9:03 am with registered nurse (RN) I revealed: *RN I cleaned her hands with the ABHS located on the medication cart then entered resident room 214. *RN I used the wall-hanging hand sanitizer located outside of room 209 to clean her hands then entered resident room 210. 4. Observation on 12/18/24 at 9:08 a.m. of the first floor revealed: *The wall-hanging dispenser outside room W101 that contained ABHS that was labeled with an outdate of 9/24. *The wall-hanging dispenser outside a public bathroom adjacent to the conference room that contained ABHS that was labeled with an outdate of 9/24. *The pump Purell ABHS located outside the chapel was labeled as outdated on 10/22. 5. Interview on 12/18/24 at 10:53 a.m. with housekeeper F regarding the wall-mounted ABHS dispensers revealed: *Housekeepers were to check those ABHS dispensers and replace the ABHS when there was very little left in them. *Wall-mounted ABHS refills were provided by the maintenance department. *She had been working there five months and had not checked the expiration dates of the ABHS refills.	F 880		

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6. Interview on 12/19/24 at 9:45 a.m. with DON B regarding outdates revealed:
*She expected the person who obtained the items from the basement that were not frequently used, was responsible for checking those items' outdatse.
*She stated all other supplies were used frequently enough that they did not outdate.

7. Interview on 12/19/24 at 11:33 a.m. with RN/infection control nurse M regarding ABHS revealed that maintenance was responsible for checking these outdates because maintenance oversaw housekeeping.

8. Interview on 12/19/24 at 12:21 p.m. with maintenance regarding ABHS outdates revealed:
*He was responsible for checking the outdates on the ABHS.
*He stated the labels on the wall-hanging ABHS dispensers may have indicated that they were outdated but he refilled the dispensers from a large bottle of ABHS.
*He indicated that the large bottles of ABHS on the medication cart were the type of bottles he used when he would refill the wall ABHS dispensers.
*He presented a large bottle of ABHS that was consistent in appearance with the bottle on the medication cart. *The large bottle of ABHS he presented outdated on 11/27.
*He stated that there was no way to identify if the ABHS in the wall-hanging dispensers were outdated.
*He stated that the wall-hanging dispensers were emptied so frequently that they would not outdate.
*He indicated that if a bottle contained green colored ABHS that would mean it was the "old" alcohol-based hand sanitizer.

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*He confirmed that a bottle of green colored ABHS was in the conference room, and it outdated on 6/23.

Review of the providers 4/20 Hand Sanitizer policy revealed:
*"The Maintenance Director or his designee is responsible for refilling said dispensers as needed."
*"When the cartridges are refilled, the maintenance director or his designee checks the bulk container that is being used to refill the cartridges to ensure it is not outdated."

D. Based on observation, interview, and policy review the provider failed to ensure proper infection control practices in the shower and whirlpool rooms include:
*Shampoos, lotions, creams, and deoderants were not shared between residents to prevent cross-contamination during bathing.
*Items stored in the whirlpool and shower rooms were not expired. Findings include:

1. Observation on 12/18/24 at 8:13 a.m. of the second-floor shower room revealed:
*On the counter was a white plastic basket with an unidentified thick sticky yellow and brown substance that coated the caps of three razor caps and the bottom of the basket.
*The basket contained the following:
-A bottle of Dermasil lotion that was not labeled.
-A bottle of baby shampoo that was not labeled.
-An electric razor bag.
-A rusty bobby pin.
*The following items were in a tall wooden cabinet and were not labeled:
-Two bottles of McKesson body lotions.
-Dove bar soap.

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-Five hair products.
-Five scented body sprays.
-Three baby powders.
-Two sticks of deodorant.
-A curling iron.
-An electric razor with facial hairs in the blades.
-Two combs.
-Three nail clippers.
-A bottle of Dermasil dry skin treatment.
-A partial bottle of T-Gel shampoo.
-A partial bottle of anti-dandruff shampoo.
-A partial bottle of chlorhexidine gluconate 4% solution (a strong antiseptic skin cleanser).
-Two unwrapped toothbrushes.
-Two denture cups with surface discoloration.
*The same tall wooden cabinet contained the following outdated items:
-A partial box of alcohol wipes (12/16).
-A disposable bathing glove (1/19).
-A bottle of roll-on antiperspirant (10/22).
-A partially used bottle of rubbing alcohol (2/24).
-A tube of Colgate toothpaste (10/22).
-A partial tube of Aloe Vest daily moisturizer (9/24).
-A partial tube of Cavilon barrier cream (10/30/24).
-A partial bottle of Tena cleansing cream (5/22).
-A container of Sani-cloth disinfectant wipes (3/23).
*The following items were under the sink.
-A container of Sani-wipes.
-Three spray bottles of cleansers.
-Three bottles of whirlpool disinfectant.
-Two bottles of Oasis 499 HBV disinfectant.
-A gallon container of shampoo.
-A partial bottle of white distilled vinegar was outdated as of 8/25/22.

2. Observation on 12/18/24 at 8:39 a.m. of the

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supply closet located behind the second-floor nurses' desk revealed:
*A tall wooden cabinet contained thee following outdated resident supplies:
-An unopened tube of Cavilon barrier cream (5/7/23).
-A partial bottle of hydrogen peroxide 3% solution (2/23).
-A suction canister (7/14).
*The following items were under the sink:
-A spray bottle labeled "water for plants".
-A spray bottle labeled Virex II256 disinfectant cleaner.
-A white tub that contained an unidentified black and white flakey substance and a brown-substance.
-A blue pail.

3. Observation on 12/18/24 at 8:47 a.m. of the second-floor housekeeping closet revealed:
*Purell hand sanitizer for the wall dispensers that outdated on 10/23.
*A bottle of rubbing alcohol that outdated on 8/23.

4. Observation on 12/18/24 at 10:15 a.m. in the east whirlpool room revealed:
*The top of the whirlpool was coated in a layer of dust.
*A purple 4-drawer plastic container was coated with a layer of dust.
*On the counter next to the sink there were:
-An electric razor that was not labeled.
-One visibly soiled elastic hair tie.
-A black fan with blades and a front blade guard that was coated with a thick layer of dust.
-An open COVID-19 "BinaxNOW" test kit that contained three unopened COVID-19 tests that had an expiration date of 12/12/23.
*On the whirlpool shelf there were:

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F 880	Continued From page 31 -Six shampoo bottles that were not labeled. -One conditioner bottle that was not labeled. -A bottle of antidandruff shampoo that was not labeled or dated. *A sign posted on the wall stated, "Please perform nail care with EVERY bath." *The following items were in the tall wooden cabinet and were not labeled: -An open container of powder that was not labeled. -Five open bottles of scented lotion that were not labeled. -13 open bottles of body spray that were not labeled. -Six open containers of stick deodorant that were not labeled. -An open tube of Aquaphor that was not labeled. -Three open tubes of barrier cream that were not labeled. -A tube of denture cream with an expiration date of 11/28/23. *In that cabinet there was a broken plastic bin labeled "Nail Care" that contained: -A black elastic hair scrunchy with long gray hair in it. -Four wrapped Riesen candies. -Three pairs of nail clippers. -Two hair picks. -A hairbrush containing a large amount of long grey hair. -A roll of white bandage gauze. -Three rolls of partially used medical tape. -An electric razor that contained gray facial hairs. -More than five hair combs. *Under the sink, in that whirlpool room, there was: -A urinal without a lid that was not labeled. -A denture cup without a lid that was not labeled. -A box containing six pairs of new compression stockings.	F 880		

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-A metal bottle of "Goof off" adhesive remover.
-A visibly soiled gray and white scrub brush.
-Two blue scrub pads.
-A red funnel.
-A dry visibly soiled towel that was discolored a brown color.
-An open whirlpool "soap and body wash" container.
-A container labeled "Body Fluid Cleaner" that was discolored and rusted on the bottom.
-Two one-gallon jugs of "Whirlbath CitrusKleen".
--One was open.
-A half-full jug of Barbicide
*Next to the whirlpool there were two uncovered white clothes basked lined with clear trash bags one contained:
-Multiple visibly used gloves.
-A visibly wet pull-on incontinent undergarment.
-A tan-lined absorbent wound dressing with visible tan drainage on the padding.
*The second uncovered white clothes basket contained multiple used washcloths and towels.
*A sign above the sink that indicated instructions for enhanced barrier precautions with three residents listed by first name and last initial [residents 1, 35, and 31].

6. Observation and interview on 12/18/24 at 10:37 a.m. with CNA G revealed:
*CNA G was in resident 108's room, seated on his bed, and took resident 108's blood pressure.
*She exited resident 108's room with a stethoscope, a pulse oximeter, and that blood pressure cuff.
*Without sanitizing those items, she placed them on a metal cart in the hallway that stored contained yellow gowns, Sani wipes, and trash bags.
*She indicated the equipment on that cart was

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shared for use with all the residents.
*She confirmed she had used the blood pressure cuff, pulse oximeter, and stethoscope with the resident in room 108.
-She stated, "They will need to be cleaned before they are used again" and then exited the area without cleaning them.

7. Observation and interview on 12/18/24 at 10:45 a.m. with CNA H revealed:
*She had worked as a bath aid a couple times a week for six years.
*She had received additional training to be a bath aide.
-That training included additional training with another bath aide.
*She had used the north whirlpool room to complete baths that day.
-She preferred to use the north whirlpool room but could use either whirlpool room on the first floor or the shower room on the second floor.
*She stated any resident could be bathed or showered in any tub room.
*She identified three residents (5, 9, and 56) who received showers in the shower room on the second floor.
*She stated the shampoos, body washes, and conditioners on the whirlpool were used for all residents if they did not have a name on them.
*She confirmed that the Aquaphor on the counter was used as a barrier cream and was used for multiple residents who received baths in that whirlpool room.
*She confirmed that the electric razors were shared for residents who used the tub room and were to be cleaned with an alcohol wipe between residents and that the remaining facial hairs were to be dumped in the trash.
*She stated that resident skin assessments were

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completed by the bath aide with each resident's bath or shower.
-She would report to the nurse any new open skin areas or areas of concern she discovered during a resident's bath.
--Areas of concern were to be reported to the nurse "right away" and the nurse would come to observe them at that time.
*She stated when there was a new open skin area or area of concern, she would document that in the electronic medical record system under the skin assessment at the end of the day.
-If there were no new areas of concern she would not need to document.
*She confirmed the only areas reported to the nurse were new areas.
-Skin areas that the nurse already knew about were already being looked at by the nurse and were not assessed during the resient's bath time.
-She confirmed that she did not check for expiration dates on products she used in the whirlpool room.

8. Interview on 12/19/24 at 11:33 a.m. with RN/infection control nurse M regarding the tub and shower rooms revealed:
*She stated that there was no risk of cross contamination of the shared products once the product was dispensed from the bottle.

Review of the provider's 5/10 Disinfection and Cleaning of Electric Razors policy revealed:
*"Electric razors must be cleaned and disinfected after use. This includes shared/community razors provided by the facility and resident's personal razors."
*"After each use the head is disassembled from the razor base. Excess whiskers, skin and debris are brushed away with a razor cleaning brush."

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F 880	Continued From page 35 *"Razor heads should be rinsed with warm water and dried." *"The entire razor including the razor head is wiped down with a EPA registered disinfection wipe." *"Daily razor heads are disassembled, brushed off, rinsed with warm water and placed in a container of 70% isopropyl alcohol for a minimum of 10 minutes."	F 880		

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

PRINTED: 01/03/2025
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 12/17/24. Tieszen Memorial Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson

TITLE: Administrator

(X6) DATE: 1/9/2025

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.

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	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/17/2024

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TIESZEN MEMORIAL HOME	**312 EAST STATE ST** **MARION, SD 57043**

(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 A recertification survey was conducted on 12/17/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Tieszen Memorial Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 12/18/24. Please mark an F in the completion date column for K 241 deficiencies identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain the one-hour fire resistive rating of vertical openings in the following: *The west stair enclosure walls did not extend to the underside of the roof deck of the 1976 addition.	K 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson
TITLE: Administrator
(X6) DATE: 1/9/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	**312 EAST STATE ST** **MARION, SD 57043**

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K 241	Continued From page 1 *The north basement stair enclosure door was equipped with a twenty-minute, fire-resistive door assembly. *The east and west stair enclosure doors were not provided with labels and contained wired-glass vision panels. Findings include: 1. Observation on 12/17/24 at 9:37 a.m. revealed a twenty-minute, fire-resistive door assembly had been installed in the north stair enclosure from the basement. Review of the previous life safety code survey revealed the original one and three-fourth inch metal door had been replaced with the present door approximately ten years ago. 2. Observation on 12/17/24 at 10:21 a.m. revealed the upper and lower east and the upper west stair enclosure doors had not been provided with labels to identify the fire-resistive rating. The upper and lower east stair enclosure doors had been equipped with a thirty-five by twenty-one-inch wired-glass vision panel. Review of the previous life safety code data identified that had been part of the original construction. 3. Observation on 12/17/24 at 11:36 a.m. revealed the west stair enclosure walls did not extend to the underside of the roof deck. Further observation revealed the exterior window was exposed to the 1976 addition roof. Review of the previous life safety code data identified that had been part of the original construction. 4. This deficiency affected the second-floor smoke compartment and a maximum of twenty-two residents with accompanying staff.	K 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	**312 EAST STATE ST** **MARION, SD 57043**

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K 241	Continued From page 2 The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.	K 241		F

PRINTED: 01/03/2025
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10647	A. BUILDING: ______ B. WING ______	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	**312 E STATE ST MARION, SD 57043**

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/17/2024 through 12/19/2024. Tieszen Memorial Home was found in compliance	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/17/2024 through 12/19/2024. Tieszen Memorial Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	1/9/2025