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 _____	05/26/2022

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 5/24/22 through 5/26/22. Tieszen Memorial Home was found not in compliance with the following requirements: F604 and F812.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and	F 604		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	6-15-22

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 _____ B. WING _____	05/26/2022

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 604	Continued From page 1 document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the use of Tabs chair and bed alarms (position change alarms) was based on assessed assessment for use, physician acknowledgement and order, evaluation for effectiveness or least restrictive measure, and appropriately care planned for five of five sampled residents (26, 31, 33, 35, 47). Findings include: 1. Observations and interviews with resident 47 revealed: *On 5/24/22 at 11:29 a.m.: -She was seated in a lounge chair in front of the window in her shared room facing the hallway. -A Tabs alarm cord was clipped to her recliner that was by the wall on her half of the shared room. *On 5/24/22 at 4:35 p.m.: -She was in her lounge chair in her room with the overbed table angled away in front of her. -She was leaning forward to reach a pencil on the floor and replied that she could not reach it. -The alarm cord was clipped to the back of her shirt and stretched out as she reached for the pencil. -When asked what was clipped to her shirt, she explained the alarm cord was to "call staff" and reported the Tabs alarm was moved to her bed when she was there. *On 5/25/22 at 3:41 p.m.: -She was seated as before with the alarm cord clipped to the back of her shirt and working on a word search puzzle. -She confirmed she had a serious injury from a	F 604	1. Resident 47 has been reassessed by the Director of Nursing and the Interdisciplinary care team as it relates to the use of a TABS monitor. Per the assessment, it has been determined the TABS monitoring device is no longer needed and was removed on 6/10/2022. 2. Resident 33 has been reassessed by the Director of Nursing and the Interdisciplinary care team as it relates to the use of a TABS monitor. Per the assessment, it has been determined the TABS monitoring device is no longer needed and was removed on 6/10/2022. 3. Resident 35 has been reassessed by the Director of Nursing and the Interdisciplinary care team as it relates to the use of a TABS monitor. Per the assessment, it has been determined the TABS monitoring device is no longer needed and was removed on 6/10/2022. 4. Resident 26 has been reassessed by the Director of Nursing and the Interdisciplinary care team as it relates to the use of a TABS monitor. Per the assessment, it has been determined the TABS monitoring device is no longer needed and was removed on 6/10/2022.	

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 _____	05/26/2022

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 604	Continued From page 2 fall and was still sore from it. -A grabber reacher tool was not visible in her room. When asked, she reported she could use a grabber reacher tool like her roommate had for when she dropped pencils on the floor. Review of the 4/25/22 final fall investigation report submitted by the provider to the South Dakota Department of Health revealed: *The fall occurred on 4/23/22 at 4:45 p.m. in the resident's room. *The resident reported "her pencil had fallen and she was attempting to pick it up." *The conclusion of the investigation stated: -She "enjoys independence in the facility with regards to ambulation." -Cue cards and signs were to be provided to remind her to use her call light and walker. -A "red star" was posted outside her door to "indicate resident had fallen--notifies staff to check on resident to ensure safety." -An "action taken by facility" was to review and revise the care plan. A progress note dated 4/29/22 at 3:03 a.m., 12 hours after resident 47 returned from the hospital, revealed: *She was "experiencing intermittent confusion forgetfulness and has been trying to self-transfer." *An alarm was put in place to "ensure resident safety" and it was "set off multiple times" when she attempted to transfer. *"In leu [sic] of this, TABS alarm will be kept on resident as necessary fall precaution." Review of the 5/5/22 significant change minimum data set (MDS) assessment for resident 47 revealed:	F 604		

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 _____	05/26/2022

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 604	Continued From page 3 *She had mild impairment recalling current date and needed cues. *She needed weight bearing support to transfer between surfaces and move about with a walker or wheelchair. *Her prior functioning for mobility had been independent with her walker. *Bed and chair alarm restraints were coded as used daily. *The care area assessment for falls noted: -She had a history of falls with the fall on 4/23/22 resulting in a hip fracture. -She was able to stabilize her balance by herself with her four-wheel walker. -"She is impulsive and attmepts [sic] to self transfers so a tabs alarm was placed." The provider was requested during the survey to provide copies of the Tabs alarm assessment including the medical symptom being treated. However, only fall risk assessments were provided, which revealed: *The 5/9/22 assessment, the score was 13 compared to a score of 8 on the 4/13/22 assessment. A score "above 10 represents HIGH RISK." *The "parameter" (factors) that caused the increased score included the recent fall, increased incontinence, and the balance problem. The active care plan with a start date of 7/2/19 for resident 47 regarding risk for falls revealed: *The risk was not revised to address the recent fall with injury but remained as related to medications with fall-related side effects and bilateral knee pain. *The only new intervention added on 4/29/22 after her recent fall was "Tabs Alarm on at all times." *An intervention started on 7/2/19 to keep items	F 604		

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 _____	05/26/2022

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 604	Continued From page 4 she frequently uses within easy reach to avoid fall was not revised to address reaching for pencils that had fallen on the floor. *An intervention dated 1/15/20 was "Falling Star Program" without any further instructions. Review of the physician orders revealed no order for the use of the Tabs alarms. Interview on 5/25/22 at 3:42 p.m. with registered nurse (RN) E revealed she: *Confirmed the serious fall occurred but was not aware of the factors that contributed to the fall. *Did not know if a reacher tool had been offered to help resident 47 pick-up items that dropped on the floor. Interview on 5/25/22 at 3:13 p.m. with director of nursing (DON) B revealed, when asked about the Tabs alarms and assessment for the indication of use, she replied, "If they're not allowed we'll take them all off, I guess. If we use them, there's no way to defend the use so I guess we'll remove all of them." 2. Observation of resident 33 on 5/24/22 at 11:53 a.m. in the Memory Care Unit dining room revealed she was seated in a wheelchair with cord attached to the back of her sweatshirt fastened to a Tabs alarm. Review of resident 33's medical record revealed: *She was admitted on 7/13/21. *Her diagnoses included dementia with behaviors. *Her 4/12/22 quarterly MDS assessment indicated a bed alarm/chair alarm was used daily. *Her current care plan included a 7/23/21 start date for the following interventions:	F 604		

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 _____	05/26/2022

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 604	Continued From page 5 -"Uses a Tab alarm while in the chair." -"Uses a Tab alarm while in bed." *No physician order for the Tabs alarm. *No medical conditions were identified that warranted the use of the Tabs alarms. *No assessment for the Tabs alarms that evaluated the appropriateness of the devices and whether those devices met the definition of a physical restraint. *No assessment for the Tabs alarms that evaluated the psychosocial impact of the devices on the resident. *No ongoing re-evaluation for the need of the Tabs alarms and the effectiveness of those devices in treating the medical conditions identified. Interview on 5/26/22 at 9:14 a.m. with social services designee J revealed she: *Was not involved in the process of using Tabs alarms but was aware that the alarms were discussed with the resident's representative and though approval was obtained for their use. *Had not evaluated the impact those devices had on the resident's psychosocial well-being. Interview on 5/26/22 at 10:22 a.m. with RN C revealed: *Their policy indicated no physician order was needed. *There were no physician orders for Tabs alarms. *There were no assessments conducted on Tabs alarms. 3. Observation and interview on 5/24/22 at 8:35 a.m. with resident 35 revealed she: *Was sitting in her wheelchair with a Tabs alarm attached to her shirt. *Required help with transferring from bed to her wheelchair.	F 604		

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 _____	05/26/2022

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 604	Continued From page 6 *Had fallen in the past. *Said it "feels like something is pulling" when she was attached to the Tabs alarm. *Observation on 5/24/22 at 12:00 p.m. revealed she had been eating lunch in the dining room with a Tabs alarm attached to her and the wheelchair. *Observation on 5/25/22 at 11:00 a.m. revealed she was sitting in a wheelchair in her room with a Tabs alarm attached. Interview and record review on 5/25/22 at 2:42 p.m. with RN C regarding Tabs alarm use revealed: *She was not aware that resident 35 had a Tabs alarm, was unsure when the alarm was placed on resident 35, but confirmed that nursing staff initiated the use of alarms. *Resident 35 had been self-transferring and had fallen in the past. *She agreed that resident 35's care plan had not identified the use of a Tabs alarm for an intervention and there were no nurses' progress note found indicating when and why the Tabs alarm was initiated. *The end of shift nursing report had not provided any information about the use of the Tabs alarm. Interview on 5/25/22 at 2:45 p.m. with DON B regarding Tabs alarms revealed she had not been aware that resident 35 had a Tabs alarm. Interview on 5/25/22 at 2:52 p.m. with MDS coordinator D regarding Tabs alarms revealed: *She was not aware about the use of the Tabs alarm for resident 35 and agreed the MDS had not been appropriately coded for an alarm use. agreed that the MDS had not been coded for	F 604		

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 _____	05/26/2022

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 604	Continued From page 7 alarm usage for resident 35. *She had not known about a Tabs alarm used on resident 35 prior to the interview. *She usually had a list of residents identified using Tabs alarms but had no list. Review of resident 35's care plan dated 1/29/21 revealed: *She was identified as being in the Falling Star Program with a star placed outside of resident's door indicating fall risk. *There was no mention of the use of a Tabs alarm while in her wheelchair. 4. Observation and interview on 5/24/22 at 2:24 p.m. with resident 26 revealed she: *Had been laying in her bed with a Tabs alarm attached to her shirt. *Stated, "I have only fallen once since I moved in." On 5/24/22 at 3:22 p.m., while at the nurse's station across the hall from resident 26's room, this surveyor heard a beeping noise come from her room. Upon entering her room, I observed her sitting on the side of her bed with the Tabs alarm sounding, and she stated, "I want to move to my recliner." Interview on 5/25/22 at 3:10 p.m. with RN C revealed she: *Was not aware that resident 26 had a Tabs alarm. *Did not think there was any reason for her to have an alarm. *Was not sure who put it on her. *Had not done a safety alarm assessment. *Stated, "There was no reason for her to have one, she had one fall since coming to the facility and that was shortly after her husband passed	F 604		

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 _____	05/26/2022

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 604	Continued From page 8 away." Observation on 5/25/22 at 4:54 p.m. revealed resident 26 was in her room sitting in her wheelchair with a Tabs alarm attached to her shirt. She was reaching for the doorknob and the alarm sounded. She asked, "Is it time to go to supper?" Follow-up interview on 5/26/22 at 9:27 a.m. with charge nurse C regarding resident 26 and the alarm she stated, "We are leaving the Tabs alarm on her because she is a fall risk, we will do an assessment and add it to her care plan." Review of resident 26's care plan revealed there was no documentation for a Tabs alarm. 5. Observation on 5/24/22 at 9:49 a.m. of resident 31 in her room revealed: *She self-transferred from her recliner to her bed. *RN K then entered the room to assist resident 31 from her bed to her wheelchair and clipped the Tabs alarm to the back of her sweater before exiting the room. Interview on 5/24/22 at 11:15 a.m. with RN K revealed: *The Tabs alarm was placed on resident 31 for fall precautions. *Resident 31's baseline mood state was anxious. *She frequently removed the Tabs alarm from her shirt and would get up by herself without asking for assistance. Review of resident 31's record revealed: *Over the past 13 months from 4/30/21 through 5/25/22, she had 29 falls recorded on the "Resident Fall Tracking Log." *"[Provider's name] Fall Report" from 12/20/21	F 604	5. Resident **31** is a very high risk for falls. The nursing staff conducted a study of resident **31** over a 72 hour period of time to evaluate and assess the use of the TABS alarm. The resident alarmed 32 times in that 72 hours but had zero falls during that time. The facility Administrator, Director of Nursing Maintenance Director, and contracted therapists met and the facility will be switching the TABS alarms to a bed and/or chair sensor pad for resident **31**. The sensory pad will have a signal that is transmitted to the pagers of the nursing assistant assigned to the resident. There will be no alarm sounding. The sensor pads have been ordered and will be implemented as soon as they arrive to the facility. The current TABS alarm will remain in place (care planned as such) until the new sensor pads arrive and can be placed in use. Any intervention used on resident **31** will be reassessed on a quarterly basis by licensed nurse to determine the effectiveness of the fall prevention intervention and continued use. The Director of Nursing will monitor the fall prevention interventions for resident **31** on a weekly basis for a 4 week period and bring those findings to the monthly QA meeting for their review and further recommendations. **LW 6/24/2022** Any resident who is currently using a TABS monitor or has a fall prevelance will be assessed by the Director of Nursing or designated license nurse for use of a bed and or chair sensor pad (when they arrive at the facility) if appropriate. If it is determined the resident would be appropriate to use a bed and/or chair sensor, it will be placed appropriately for use. The sensor pad will be documented in the resident's chart and care plan by the licensed nurse. The continued use of the sensor pad will be reassessed by the licensed nurse on a quarterly basis or upon a significant change in the resident's condition. The Director of nursing will maintain a list of residents using a sensor pad for the purpose of preventing falls. The Director of nursing will present the list of these residents to the QA Committee monthly for their review and further recommendations. 6/29/22	

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 _____	05/26/2022

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 604	Continued From page 9 indicated, "Resident took TABS [Tabs alarm] off." -No Tabs alarm assessment was found anywhere in resident 31's record. -The provider's standard fall report indicated that a Tabs alarm was an acceptable immediate intervention after a resident fell. *Resident 31's care plan identified a 9/16/21 intervention for "Tabs monitor on at all times. Monitor/Check every 30 minutes and record." *Section P of her 4/11/22 MDS indicated bed and chair alarms were used daily. *On 4/13/22, her "Fall Risk Assessment" score was 19, indicating she was at a high risk for falls. Review of the provider's fall risk assessment policy and procedures, revised 11/2007, revealed the assessment was completed with each MDS and reviewed during the resident's care conference if the resident had several falls. Review of the provider's safety alarm policy and procedures, dated 9/2015, specified: -The policy is to "outline the procedure for use of alarm devices used to alert staff attention to a resident in an unsafe situation." -"It is the policy of the [provider's name] to provide alternatives for monitoring residents that are a fall risk that are less restrictive than a restraint." -"Resident alarm systems may be used at the discretion of the licensed nurse or upon physician orders for any resident considered unsafe to transfer independently and lacking the cognitive ability to wait for assistance." -"A physician's order is not required to initiate and use alarm." -"Before the alarm is installed the nursing staff will explain the alarm to the resident and also contact the resident's responsible party so they understand why they have it."	F 604		

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 _____	05/26/2022

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 604	Continued From page 10 -"If the resident's condition changes the licensed nurse may discontinue the alarm unless ordered by physician."	F 604		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene and glove use for food preparation and meal service during three of three meal services by two cooks (H and I). Findings include: 1. Observation on 5/24/22 from 8:53 a.m. to 9:11 a.m. revealed cook H: *Wore the same gloves while she did the noon meal prep. *Used her gloves to pick up multiple kitchen	F 812	1. Cook H will be re-educated by the Registered Dietitican and the Dietary Manager on glove usage and handwashing. The education provided will also include the policy and procedure, a test, and hands on learning.	

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 _____	05/26/2022

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 812	Continued From page 11 utensils while she was preparing the roast beef for the residents with diets that called for ground meat. *Did not change her gloves or perform hand hygiene until after she had finished with the noon meal preparation. *Then took her gloves off and washed her hands. 2. Observation on 5/24/22 from 11:11 a.m. to 11:24 a.m. revealed cook I: *Did not wash his hands prior to putting his gloves on. *Used a marker to label lids and got a squirt bottle of thickener from the cupboard. *Filled cups with milk, water, supplements and thickener, stirring them with a plastic spoon. *Put lids on the cups while wearing the same gloves. *Took his gloves off and put them in the garbage, he did not wash his hands. Observation on 5/24/22 from 11:25 a.m. to 11:40 a.m. revealed: *Cook H was wearing a glove on her left hand to serve the noon meal. She: -Started serving lunch by picking up plates and dietary cards with her gloved hand. -Touched the counter and trays with her gloved hand. -Searched through the plate covers and handed one to an aide through the serving window. -Went back to serving the meal with the same glove on her left hand. -Put a piece of bread on the plate with a tongs and re-positioned the bread on the plate with her gloved hand. -Finished serving lunch with the same glove on her left hand. -Put bread and roast beef in a Styrofoam	F 812	2. Cook I will be re-educated by the Registered Dietician and the Dietary Manager on glove usage and handwashing. The education provided will also include the policy and procedure, a test, and hands on learning.	

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 _____	05/26/2022

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 812	Continued From page 12 container for a room tray and again re-positioned the bread with her gloved hand. 3. Observation on 5/24/22 at 4:53 p.m. revealed: *Cook I was wearing gloves to serve the evening meal. He: -Touched his face mask. -Got tongs out of a drawer. -Grabbed a plate with his gloves on and began serving the evening meal. Interview on 5/24/22 at 4:58 p.m. with cook I revealed he: *Had been educated about hand washing and glove use. *Stated, "If I leave the steam table, I take my gloves off and wash my hands before I put new gloves on to continue serving the meal." Interview on 5/25/22 at 9:49 a.m. with registered dietitian (RD) G and dietary manager F about glove use in the kitchen revealed: *They both agreed that: -Kitchen staff should not use gloves while serving meals due to the possibility of cross contamination. -Staff should use tongs and other utensils to plate the meals. -Staff should wash their hands before putting gloves on and between glove use. *RD G stated they "had just talked about it at the last education session we had done for dietary staff." The glove use policy was requested and the policy that was received from Administrator A was titled, "Bare Hand Contact with Food and Use of Plastic Gloves." Review of the policy, taken from the 2013 Becky Dorner & Associates, Inc. policy	F 812	3. Cook I will be re-educated by the Registered Dietician and the Dietary Manager on glove usage and handwashing. The education provided will also include the policy and procedure, a test, and hands on learning. All Dietary staff will be re-educated by the Registered Dietician and the Dietary Manager on glove usage and handwashing. The education will include the policy and procedure, a test, and hands on learning. In addition, the Dietician, Dietary Manager, or their designee will conduct audits 2-3 times per week on Cook H and Cook I for a period of 4 weeks. If the proper procedures have been followed during this time period, the audits will be reduced to weekly for an additional 4 weeks. Audit results will be submitted to the QA committee by the dietary manager for their review and further recommendations. In addition, the Dietician, Dietary Manager, or their designee will conduct random audits of the dietary staff 2-3 times per week to ensure compliance of the proper procedure for 4 weeks. If the proper procedures are followed correctly, the audits will be reduced to weekly for an additional 4 weeks. Audit results will be submitted to the QA committee by the dietary manager for their review and further recommendations.	6/23/2022

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 _____	05/26/2022

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 812	Continued From page 13 & procedure manual 4-9 revealed: "3. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves..." "6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed..." "7. Wash hands after removing gloves."	F 812		

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 _____	05/26/2022

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
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 from 5/24/22 through 5/26/22. Tieszen Memorial Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson
TITLE: Administrator
(X6) DATE: 6/9/2022

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.

RECEIVED
JUN 09 2022
SD DOH-OLC

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 **01 - MAIN BUILDING 01** B. WING _____	**05/24/2022**

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/24/22. Tieszen Memorial Home (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/24/22. Please mark an F in the completion date column for K241 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	K 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson
TITLE: Administrator
(X6) DATE: 6/9/2022

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.

RECEIVED
JUN 09 2022
SD DOH-OLC

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 _____	**05/24/2022**

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
K 241	Continued From page 1 addition. *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 glass vision panels. Findings include: 1. Observation on 5/24/22 at 1:30 p.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 eight years ago. 2. Observation on 5/24/22 at 2:10 p.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 vision panel. Review of the previous life safety code data identified that had been part of the original construction. 3. Observation on 5/24/22 at 2:48 p.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 _____	**05/24/2022**

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
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

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIESZEN MEMORIAL HOME	312 E 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) COMPLETE DATE
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 5/24/22 through 5/26/22. 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 5/24/22 through 5/26/22. Tieszen Memorial Home was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 6/9/2022

RECEIVED
JUN 09 2022
SD DOH-OLC