STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	**312 EAST STATE ST , MARION, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/26/26 through 5/28/26. Tieszen Memorial Home was found not in compliance with the following requirements: F554, F628, F700, F732, F804, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/26/26 through 5/28/26. Areas surveyed included potential abuse and neglect and resident rights related to verbal abuse and HIPAA violations. Tieszen Memorial Home was found in compliance.	F0000		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, observation, document review, and policy review, the provider failed to ensure that food was kept and served at a safe temperature for one of one Memory Care Unit dining room, and that food was palatable, appetizing, and warm in one of one main dining room. Findings include: 1. Interview on 5/26/26 at 11:27 a.m. with resident 23 in room revealed that her food was sometimes	F0804	Resident Council meetings are held monthly under the coordination of the Activity Department with minutes taken by activity staff that list the various concerns (if any) for each department. The concerns expressed by resident #23 and #8 had been addressed by the dietary department but not specifically documented in the resident council minutes. Additional documentation will be added to the minutes on file as any issues are resolved and kept with the original minutes from each of the meetings. Managers responsible for the departments with concerns will be responsible for submitting the documentation for anything needing attention from the monthly resident council meeting. The facility also has implemented a Dietary Council that meets quarterly that is comprised of the Administrator, Assistant Administrator, Dietary Consultant and several residents including resident #8, 53, 54, 57, and 58 where their concerns had been discussed and addressed. This information had beeen communicated to the dietary department by the Administrator and the residents present felt the concerns had been addressed but there had not been any written documentation included with the resident council minutes. Going forward, any council documentation will be included in the monthly resident council minutes by the Administrator or Assistant Administrator	7/12/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	6/16/2026

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F0804 SS = E	Continued from page 1 cold. 2. Review of resident 23's electronic medical record (EMR) revealed her 5/1/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. 3. Interview on 5/26/26 at 11:30 a.m. and 2:27 p.m. with resident 8 in her room revealed that some of the food tasted "bland" and was sometimes cold. There were no spices or sauces, such as ketchup, mustard, or mayo, at her table to use. She stated she had discussed this at the Resident Council meeting before. 4. Review of resident 8's EMR revealed her 3/30/26 BIMS assessment score was 15, which indicated her cognition was intact. 5. Observation and interview on 5/26/26 from 11:46 a.m. through 11:59 a.m. in the Memory Care Unit dining room revealed that a staff member brought in a food warmer with food in it. She plugged it into the wall, and the temperature indicated it was 159 degrees Fahrenheit (F). Certified nursing assistant (CNA) N checked the temperature of the food within the food warmer and stated the ribs were 118 degrees F and the corn was 132 degrees F. She removed the potato salad from the refrigerator in the kitchenette, and it was 57 degrees F. CNA N was going to serve the food to the residents. When asked what the serving temperature should be, she stated she did not know and called someone from the kitchen. The kitchen staff member informed her they had to check what the food temperatures were supposed to be and would get back to her. 6. Observation and interview on 5/26/26 at 12:03 p.m., in the Memory Care unit dining room with licensed practical nurse (LPN) O revealed she entered the dinging room, checked the temperature of the food with a different thermometer, and the ribs were 110 degrees F. She stated they should be greater than 165 degrees F. She checked the temperature of the ribs on another tray, and they were 122 degrees F. The corn was 120 degrees F. She removed the potato salad from the refrigerator, and the temperature was 56 degrees F. She said the temperature of the cold food should be less than 41	F0804	The dietary staff will be re-educated by the consultant dietician on the importance of following the resident choices form that the resident has completed and will include the form when the residents are served to remind them of their choices. Dietary staff will also be re-educated by the consultant dietician on the importance of maintaining proper temperatures of the food being served and having appropriate seasonings/sauces available for the menu being served. It is inappropriate for dietary staff to comment on another department's staffing as they are not familiar with the tasks and responsibility of other departments. The nursing department was fully staffed each day of the survey. Dietary staff will also be re-educated on waiting until the appropriate nursing staff is present in the dining room before plating meals for delivery to the residents in the dining room. Food service delivery will be monitored in the dining room by the Social Services coordinator for residents #8, 23, 20, 53, 54, and 57 as well as 3-4 other random residents to ensure they are satisfied with what they have been served and to also include what those resident chose for the monitored meal 3 times weekly for 4 weeks and logged for documentation of the reviews. Any issues with the meals will be brought to the attention of the cook on duty immmediately for prompt resolution and documented as such. The monitoring logs will be shared with the dietary manager and also submitted to the monthly QAPI meeting by Social Services for review and further recommendations. The temperature for food delivered to the memory care unit will be taken and logged by the dietary department personnel delivering the food to the unit for each meal served. The logs will be changed from monthly to weekly in order to spot check the temperatures more frequently. If there are any issues with the food not meeting temperature requirements, dietary staff can address those issues immediately. The weekly logs will be monitored by the dietary manager and then submitted to the monthly QAPI committee for their review and further recommendations. The nursing department staff assigned to the memory care unit will be re-educated by the consultant dietician on temperatures for refrigerated items and the importance of taking those temperatures daily to ensure refrigerated items are maintained within the appropriate parameters.	

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F0804 SS = E	Continued from page 2 degrees F and stated she was taking the food to the kitchen. 7. Interview on 5/26/26 at 12:12 p.m. with CNA N revealed it was the CNAs responsibility in the Memory Care unit to take the temperature of the food and to serve it. She stated she was not educated on what the food temperatures were supposed to be. 8. Observation and interview on 5/26/26 from 12:28 p.m. through 12:38 p.m. in the Memory Care unit kitchenette with LPN O revealed she brought in a food warmer with food trays in it. She took the temperature of the food, and it was at a safe serving temperature. She poured a glass of milk from a gallon of milk that was in the refrigerator in the Memory Care Units' kitchenette, and it was 42 degrees. She stated she was going to get a new gallon of milk. LPN O came back with a new gallon of milk, she poured a glass of milk, and the temperature was at a safe serving temperature. She verified that the thermometer in the refrigerator read 50 degrees F. She called maintenance to come check it. She could not find the refrigerator temperature logs and said the refrigerator temperature was supposed to be checked daily. 9. Observation and interview on 5/26/26 at 12:41 p.m. in the Memory Care unit dining room with CNA P revealed she removed two bowls of potato salad from the refrigerator and was going to serve it to the residents without checking the temperature. After she was asked by the surveyor, she checked the temperature, and it was 51 degrees. She then called the kitchen for new potato salad for the residents. 10. Observation on 5/26/26 at 12:44 p.m. in the Memory Care unit kitchenette revealed LPN O instructed the staff not to use anything from the refrigerator since the food was not meeting safe temperatures and needed to be discarded in the trash can. 11. Interview on 5/27/26 at 3:00 p.m. with residents 8, 20, 53, 54, and 57 during the Resident Council meeting revealed that resident 8 reported that	F0804	They will also be re-educated by the consultant dietician to avoid storing items in the door of the refrigerator. Daily logs will be maintained by the nursing staff in the memory care unit that record the temperatures of the food and the refrigerator and turned in weekly. The Director of Nursing or designee will review the logs on a weekly basis to ensure the temperatures have been taken appropriately and given to the monthly QAPI meeting for their review and further recommendations.	7/12/2026

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F0804 SS = E	Continued from page 3 sometimes her food was "cold" and that the pork and chicken were "dry and hard to swallow." Resident 20 reported that her food was "often cold" and thought some of the food was "for the younger generation." She ate in the main dining room. Resident 53 reported that the meat was dry and hard to chew. He ate in the main dining room. Resident 54 reported that her food was "sometimes cold" and was "sometimes too spicy". She ate in the main dining room. Resident 57 reported that his food was cold about "half of the time", the roast beef was "hard to chew," so he was sometimes unable to eat it. He ate in the main dining room. The residents stated they had discussed this at the Resident Council meetings before and were unsure what was being done about it. 12. Review of resident 20's EMR revealed her 5/1/26 BIMS assessment score was 15, which indicated her cognition was intact. 13. Review of resident 53's EMR revealed her 5/18/26 BIMS assessment score was 15, which indicated his cognition was intact. 14. Review of resident 54's EMR revealed her 4/22/26 BIMS assessment score was 15, which indicated her cognition was intact. 15. Review of resident 57's EMR revealed his 3/4/26 BIMS assessment score was 13, which indicated his cognition was intact. 16. Review of the March, April, and May 2026 Resident Council meeting notes revealed there were complaints about the food not tasting good, the toast being hard, the pork being hard, some of the food being hard to swallow, they requested condiments, and they were not always served what they had circled on their food menus that they	F0804		

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F0804 SS = E	Continued from page 4 wanted. The notes indicated the dietary manager (DM) was either present for the meeting or notified of the residents' concerns. It did not indicate what was done to address the complaints. 17. Interview on 5/28/26 at 1:03 p.m. with dietary staff E and F, and DM G revealed that dietary staff E and F were training to be the new DM's. They thought the food was cold because it sometimes sat in the window for too long before being served to the residents when the CNAs were short-staffed and could not serve it right away. DM G recently switched to the spring and summer menu, and the residents did not like it, so she had to make some changes. She changed what meats she was buying due to the complaints of the meat being dry. She did not document what she had done to try to resolve the issues related to the food issues brought up in the Resident Council meeting, but she tried to address the issues "on the spot." DM G stated that the Memory Care Units' food was brought over in a warmer and was served last. She had noticed that the temperatures were not always recorded, and some temperatures did not meet the required serving temperature. She said the CNA working in the Memory Care unit was responsible for checking food temperatures before serving the food to the residents. She thought the CNAs completed a computer training course regarding checking food temperatures. 18. Interview on 5/28/26 at 1:25 p.m. with registered nurse (RN)/infection control (IC) C revealed that the CNAs completed a computer training course regarding checking food temperatures. The food serving temperatures were listed at the bottom of the sheet that the CNA recorded the food temperatures on. 19. Interview on 5/28/26 at 1:56 p.m. with director of nursing (DON) B revealed she expected the CNAs to take the food temperatures before serving the food to the residents on the Memory Care unit, and not to serve the food if it did not reach the serving temperature. In the main dining room, she expected the dietary staff to plate the residents food until a CNA staff member was available to serve the food. 20. Review of the Memory Care food temperature log	F0804		

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=0804 3S = E	Continued from page 5 from 3/29/26 to 5/26/26 revealed that there were 52 instances of hot foods documented as less than 135 degrees F, and there were 10 instances where the food temperatures were not documented as taken. The bottom of the food temperature logs stated that the temperature of the hot foods needed to be at least 135 degrees F and the cold foods needed to be 41 degrees F or colder. Any foods that were not meeting safe food temperatures was to be reported to their supervisor immediately. 21. Review of the May 2026 Memory Care Unit refrigerator temperature logs revealed that all temperatures were documented daily at an acceptable range. 22. Review of the provider's 2013 Food Temperature policy revealed that hot foods were to be held and served at a temperature of at least 135 degrees F. "All cold food items must be maintained and served at a temperature of 41 degrees F or below." "Food sent to the unit for distribution...will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees for hot foods. Unit refrigerators will be monitored for temperatures that maintain food at or below 41 degrees F."	F0804		
=0812 3S = 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.	F0812	All dietary staff will be re-educated by the consultant dietician, Administrator and Assistant administrator on the importance of checking the walk-in refrigerator contents for any foods that are deemed unsafe for consumption. All items mentioned in finding #1 were discarded immediately on 5/26/2026. The work assignment checklsts for the cooks will be revised by the Administrator and Assistant Administrator to include checking the walk-in refrigerator for any food that may be spoiled or deemed unsafe. The cooks will document on the assignment sheets anything they find during their observations to include any items discarded due to spoilage. The assignment sheets will be turned into the Dietary manager daily for review and to spot check them for accuracy. The Administrator and/or Assistant Administrator will also develop a log for the dietary manager to conduct twice weekly spot checks of the walk-in refrigerator for any evidence of food items deemed unsafe for consumption.	

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F0812 SS = E	Continued from page 6 (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 food items did not spoil in one of one walk-in refrigerators in the main kitchen, and one of one refrigerator on the Memory Care Unit was clean. Findings include: 1. Observation and interview on 5/26/26 at 12:04 p.m. in the walk-in refrigerator in the main kitchen with dietary F revealed, two one-pound containers of strawberries left in a flat. Both containers had moldy strawberries in them. There was a five-pound box of red bell peppers with six peppers in it. All the peppers had mold growing on them. Dietary F started working at the facility in December 2025 and, was being trained to take over some of the dietary manager's duties after she retired. He had completed his ServSafe training. He confirmed there were moldy strawberries and red bell peppers in the walk-in refrigerator. He agreed they should have been removed. He took them out of the walk-in refrigerator and discarded them. 2. Interview on 5/27/26 at 11:02 a.m. with dietary manager G regarding the moldy strawberries and red bell peppers revealed that she expected them to be discarded when found. The facility was having issues with the condensation ventilation in the walk-in refrigerator, and maintenance was working on it. The dietary staff were trying to rotate produce to reduce exposure to the condensation. She agreed the moldy strawberries and red bell peppers should have been removed from the walk-in refrigerator and discarded. 3. Observation on 5/26/26 at 12:14 p.m. of the Memory Care Units refrigerator revealed that there was a dried brown substance that covered the bottom of the refrigerator. 4. Interview on 5/27/26 at 2:25 p.m. with certified nursing assistant (CNA) L revealed the refrigerator in the Memory Care unit was to be cleaned on Saturdays by the overnight CNAs.	F0812	All logs will be reviewed at the monthly QAPI meeting for their review and further recommendations. This process will become part of the regular duties for the cooks in the dietary department to ensure the food in the walk-in refrigerator is safe for consumption. The nursing department staff assigned to the memory care unit will be re-educated on cleaning and monitoring the temperature of the refrigerator in the memory care unit. by the consulting dietician or designee and documenting those tasks. Daily logs will be maintained by the nursing staff working in the memory care unit that record that it is clean and within the acceptable temperature range and turned in weekly to the Director of Nursing. The Director of Nursing or designee will review the logs on a weekly basis to ensure the refrigerator is clean and within the acceptable temperature range. All logs will be presented to the monthly QAPI meeting by the Director of Nursing for their review and further recommendations.	7/12/2026

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F0812 SS = E	Continued from page 7 5. Interview on 5/28/26 at 1:03 p.m. with dietary manager (DM) G revealed that it was the CNAs responsibility to clean the refrigerator in the Memory Care Unit. She was not sure who was responsible for monitoring that the cleaning of that refrigerator was completed. 6. Interview on 5/28/26 at 12:39 p.m. and 1:44 p.m. with registered nurse (RN)/Infection Control (IC) C revealed it was the overnight CNAs responsibility to clean the Memory Care Unit refrigerator, and they had it on a cleaning schedule. She thought the dietary staff was responsible for monitoring that it was cleaned. 7. Interview on 5/28/26 at 1:56 p.m. with director of nursing (DON) B revealed she expected the refrigerator in the Memory Care Unit to be cleaned by the overnight CNAs. She could not find that task on the CNAs checklist and stated she would put that task on their checklist. She stated DM G was responsible for monitoring the cleanliness of the Memory Care Units' refrigerator. 8. Review of the provider's 2013 Food Storage policy revealed, "Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination." "8. All stock must be rotated with each new order received. Rotating stock is essential to assure [ensure] the freshness and highest quality of all foods." 9. Review of the provider's February 2021 Facility refrigerator cleaning and monitoring policy revealed that "all facility refrigerators shall be cleaned, monitored, and maintained routinely to ensure sanitary storage conditions." "Each department utilizing a refrigerator is responsible for ensuring routine cleaning and monitoring is completed according to this policy." The policy listed the medication room and activity room refrigerators, and did not list the refrigerator in the Memory Care Unit.	F0812		

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F0880 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. §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	F0880	Type text here Nursing assistants H and I will be re-educated on catheter care, hand hygiene and glove usage by the Staff Education nurse. The staff education nurse or designee will conduct reviews of nursing assistants H and I when performing cares on Resident #5 2-3 times per week to ensure catheter care, hand hygiene and glove usage is appropriate when delivering care to the resident. The staff education nurse will re-educate all nursing assistants on catheter care, hand hygiene and glove usage while delivering care to residents. Licensed nurses will conduct infection control monitoring of the nursing assistants while performing catheter care, hand hygiene and gove usage 2-3 times a week on each shift for a minimum of 4 weeks to ensure proper procedures are being followed. All monitoring forms will be turned into the Director of Nursing or designee for review. Monitoring forms will be provided to the monthly QAPI for their review and further recommendations. Housekeepers J and K will be re-educated by the Infection Control nurse and maintenance director of the proper procedures for cleaning a resident room and glove usage. Housekeepers J and K will be monitored 2-3 times a week for 4 weeks for resident #57, 58, 39 and 66 rooms as well as 2-3 other random resident rooms by the maitnenance director or designee to ensure proper room cleaning and glove usage procedures are being followed. All housekeepers will be re-educated by the Infection Control nurse and maintenance director on the proper procedures for cleaning a resident room and glove usage. Housekeepers will be monitored 2-3 times per week for 4 weeks by the maintenance director or designee to ensure proper room cleaning procedures and glove usage procedures are being followed. The maintenance director will submit the monitoring forms to the administrator or assistant administrator for the monthly QAPI meeting for further review and recommendations.	7/12/2026

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F0880 SS = E	Continued from page 9 prohibit employees with a communicable 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: Based on observation, interview, record review, and policy review, the provider failed to ensure standard infection control prevention practices were followed by one of two observed certified nursing assistants (H) who used soiled gloves to obtain Aquaphor (a skin ointment) from a jar, and did not wear gloves for high-contact care provided to one of one sampled resident (5) who required Enhanced Barrier Precautions (EBP, glove and gown use when providing contact care), and by two of two observed housekeepers (J and K) who did not change their gloves before going from a dirty to a clean task while cleaning three of three observed residents rooms (39, 57, 58, and 66). Findings include: 1. Observation on 5/27/26 at 3:37 p.m. of CNAs H and I in resident 5's room revealed he was lying in bed on his back, and he had a urinary catheter (flexible tubing inserted into the bladder to drain urine) bag hanging on the side of his bed frame. There was a sign on his bathroom door from the Centers for Disease Control (CDC) that indicated he required EBP, and it included what personal protective equipment was to be worn and with what activities.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 10 CNAs H and I sanitized their hands and put on a gown and a pair of gloves. CNA H used a washcloth with a cleanser on it that she had prepped prior to the surveyor coming into the room, to clean resident 5's buttocks. With those same gloved hands, she scooped Aquaphor out of the jar with her gloved right hand, and applied it to his buttocks. CNA H removed the glove on her right hand, and adjusted resident 5's incontinence (involuntary leakage of urine or bowel leakage) brief, pulled his pants up, put a transfer sling (a specialized fabric support used with a mechanical lift) underneath him, and removed her other glove. Without washing her hands or putting on a pair of clean gloves, CNA H attached the full body lift (a mechanical lift used to lift a person's full body) to the sling, handled the urinary catheter bag and hooked it on the sling strap, which was above the level of the resident's bladder, and transferred him to his wheelchair. He had approximately 350 milliliters (mL) of urine in his urinary catheter bag. 2. Interview on 5/27/26 at 3:50 p.m. with CNA H revealed that she was to wear gloves when assisting residents who were on EBP for their personal hygiene care and transfers. She acknowledged that she used a soiled glove to obtain Aquaphor from the jar. CNA H acknowledged that she was to keep the urinary catheter bag below the level of the resident's bladder and stated that not doing so could cause backflow of urine into the resident's bladder and increase his risk for infection. 3. Review of resident 5's electronic medical record (EMR) revealed that he admitted to the facility on 7/16/25. His 4/13/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. He had a diagnosis of neuromuscular dysfunction of the bladder. He had a 12/15/25 physician's order for an indwelling urinary catheter and 2/20/26 physician's order for Aquaphor to be applied to his buttocks with each brief change. His 4/17/26 care plan indicated he required EBP because he had a urinary catheter, and to keep the urinary catheter bag below the level of the bladder. 4. Observation on 5/27/26 at 8:25 a.m. of housekeeper J cleaning residents 57 and 58's room revealed she put on a pair of gloves, cleaned the	F0880		

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F0880 SS = E	Continued from page 11 toilet bowl with a toilet brush, and wiped the outside of the toilet using a cloth that had cleaner on it. With those same gloved hands, she obtained a new cloth, sprayed it with a cleaner, and wiped the top of the residents' dresser, end tables, and bedside tables. She removed and discarded her gloves in the trash can, and sanitized her hands. 5. Observation on 5/27/26 at 8:31 a.m. of housekeeper J cleaning resident 66's room revealed she put on a pair of gloves, sprayed the bathroom sink and toilet with a cleaner, and then wiped the sink, bathroom hand rail, and the toilet. She cleaned the toilet bowl with a brush and then changed the garbage bags. With those same gloved hands, she picked up items on the resident's bedside table to wipe the table, she wiped the top of the dresser, the end table, and the personal refrigerator. With those same gloved hands, she mopped the bathroom, turned the bathroom light switch off, and removed the mop head. She obtained a new mop head and mopped the bedroom floor. She moved resident 66's bedside table to mop under it and then moved it back. She removed the mop head, removed and discarded her gloves in the trash can, and sanitized her hands. 6. Observation on 5/27/26 at 10:53 a.m. of housekeeper K cleaning resident 39's room revealed she sanitized her hands, put on a pair of gloves, sprayed the bathroom sink and toilet with cleaner, and cleaned the toilet bowl with a brush. With those same gloved hands, she mopped the resident's room, pulled out resident 39's bedside table to mop under it, and then replaced it. She wiped down the bathroom sink and the outside of the toilet. She removed and discarded her gloves in the trash can, and sanitized her hands. 7. Interview on 5/27/2026 at 11:10 a.m. with housekeeper K revealed that hand washing or sanitizing was to be completed before entering a resident's room and when changing gloves, which were to be changed between tasks. She acknowledged that she did not change her gloves after cleaning the toilet and stated she should have. 8. Interview on 5/28/26 at 11:32 a.m. with maintenance M revealed he was the maintenance director and the supervisor for the housekeeping and laundry departments. He expected the	F0880		

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F0880 SS = E	Continued from page 12 housekeepers to change their gloves when going from a dirty task to a clean task, and sanitize their hands after glove removal. 9. Interview on 5/28/26 at 12:39 p.m. with registered nurse (RN)/Infection Control (IC) C revealed that she expected the CNAs to wear gloves when assisting residents who were on EBP with their personal hygiene care and transfers. The CNAs were to remove their soiled gloves after providing incontinent care to the resident, sanitize their hands, put on a new pair of gloves to apply Aquaphor, and to keep the resident's urinary catheter bag below the level of the resident's bladder when there was urine in the bag. She stated that not doing so would increase the resident's risk for infection and bladder spasms. 10. Interview on 5/28/26 at 1:56 p.m. with director of nursing (DON) B revealed she expected CNA H to remove her soiled gloves, sanitize her hands, and put on a new pair of gloves before taking Aquaphor from the jar. She expected the CNAs to wear gloves when assisting residents on EBP with their personal hygiene care and transfers. She expected CNA H to empty resident 5's urinary catheter bag before putting it above the level of his bladder and stated that not doing so put the resident at risk for infection. 11. Review of the CDC's EBP sign revealed that staff were to wear gloves and a gown for high-contact resident care activities, which included dressing, providing hygiene care, changing incontinence products, and transferring. 12. Review of the provider's January 2025 EBP policy revealed that the facility was to follow the CDC and the Center for Medicaid and Medicare Services (CMS) guidelines regarding EBP to prevent the spread of multidrug-resistant organisms. The staff were to use EBP for the residents who have an indwelling medical device, and to wear a gown and gloves for high-contact activities, including dressing, transferring, providing hygiene care, and changing incontinent briefs. 13. Review of the provider's March 2019 Indwelling Urinary Catheter Care and Removal policy revealed "Our policy is to follow the guidelines of Lippincott Nursing Procedures Manual regarding this nursing	F0880		

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F0880 SS = E	Continued from page 13 procedure." 14. Review of the Lippincott Nursing Procedures Manual revealed that the catheter urinary bag was to be kept below the level of the bladder to decrease a patient's risk for a catheter-associated urinary tract infection (CAUTI). 15. Review of the provider's May 2018 Disinfecting and Cleaning Resident' Rooms policy revealed that gloves should be used for housekeeping tasks, removed after each room was cleaned, and hand hygiene should be performed after removing gloves. The bedside tables were to be cleaned daily.	F0880		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that one of one sampled resident (66), who was left unsupervised to take her medication by a licensed practical nurse (LPN) (U), was assessed for the ability to safely self-administer medications. Findings include: 1. Observation on 5/27/26 at 8:31 a.m. in resident 66's room revealed she was not in her room, and there was a medication cup with a grey pill inside of it and a bottle of Refresh Eye Drops sitting on her bedside table. 2. Interview on 5/27/26 at 8:41 a.m. with nursing assistant (NA) S revealed she verified that resident 66 had a pill in a medication cup on her bedside table and a bottle of eye drops. She paged the nurse. 3. Interview on 5/27/26 at 8:50 a.m. with registered nurse (RN) T revealed she verified that there was a pill in a medication cup on resident 66's bedside table, and that the resident's family brought her the	F0554	Resident #66 does not have orders for self-administration of medications nor is it appropriate for resident #66 to self-administer medications. LPN U as well as licensed nurses who are responsible for medication administration will be re-educated by the Director of Nursing and/or Staff Education Nurse on medication administration and watching residents take their medicine. The Director of Nursing or designee will monitor medication administration by LPN U with resident #66 twice weekly for 4 weeks to ensure LPN U is following appropriate procedures for medication administration. Licensed nurses administering medications will also be monitored 4 to 6 times per week for 4 weeks to ensure medications are not being left at the bedside and residents are being observed while taking their medications being administered by the Director of Nursing or designee. Any negative findings will extend the monitoring another two weeks. The Director of Nursing will provide the monitoring logs to the monthly QAPI meeting for their review and further recommendations.	7/12/2026

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F0554 SS = D	Continued from page 14 bottle of Refresh Eye Drops, but it contained baby oil. She verified that resident 66 did not have orders to self-administer her medications, and her care plan did not indicate she was able to. She verified that the pill in the medication cup was levothyroxine (thyroid medication) 75 micrograms (mcg), which was due at 7:00 a.m., and left on resident 66's bedside table by LPN U. 4. Interview on 5/27/26 at 8:55 a.m. with LPN U revealed that she left the levothyroxine on resident 66's bedside table, and she was supposed to watch her take it because she did not have a physician's order to self-administer her medication. 5. Review of resident 66's electronic medical record (EMR) revealed she admitted to the facility on 5/4/26. Her 5/12/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a diagnosis of hypothyroidism (when your thyroid gland does not produce enough essential hormones). She had a 5/5/26 physician's order for levothyroxine 75 mcg to be administered daily. There was no physician's order for her to self-administer her medication. 6. Interview on 5/27/26 at 8:58 a.m. with director of nursing (DON) B revealed that she expected LPN U to watch resident 66 take her levothyroxine because she did not have a physician's order to self-administer medications or have a self-administration safety assessment completed. She was not aware that resident 66's family brought in the Refresh Eye Drops bottle that contained baby oil when she was admitted to the facility. She expected that the bottle would be labeled to indicate who it was for and what was in the bottle, baby oil. 7. Review of the provider's August 2007 Medication-Self-Administration Policy revealed "If a resident wishes to self-administer drugs, the Care Team will assess the resident's cognitive, physical, and visual ability to carry out this responsibility utilizing the medication self-administration assessment on PCC [point click care]." "All self-administered medication must have a written order from a physician indicating approval. Also [,] a physician order is necessary to allow a resident to keep a specific drug in their room."	F0554		

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	The Social Services Coordinator has been re-educated by the Administrator on the necessity of notifying the appropriate state agencies via electronic submission when a resident is discharged or transferred from the facility and to keep documentation of the submission. The Social Services Coordinator has developed a log to track all residents who discharge or transfer from the facility that will include the name of the resident, date of discharge or transfer, and the date submitted to the appropriate state agency. The Social Servics Coordinator will maintain the log along with any and all documentation of the electronic submission. The log will be reviewed by the Administrator or Assistant Administrator on a weekly basis to ensure all discharges and transfers have been appropriately reported. The logs will also be reviewed at the monthly QAPI meeting for their review and further recommendations.	7/12/2026

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=0628 SS = D	Continued from page 16 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the	F0628		

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F0628 SS = D	Continued from page 17 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F0628		

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F0628 SS = D	Continued from page 18 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review the provider failed to ensure the Office of State Long-Term Ombudsman (an advocate of residents' overall quality of care and rights) was notified when a resident discharged from the facility, for one of two sampled residents (6). Findings include: 1. Review of resident 6's electronic medical record (EMR) revealed she was discharged on 4/21/26 to another facility. Her primary care physician (PCP) was notified of the intent to discharge on 4/21/26 and the facility received a physician's order on 4/21/26 for resident 6 to be discharged to the assisted living with her current orders. There was no documentation that the Office of State Long-Term Care Ombudsman was notified of resident 6's	F0628		

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F0628 SS = D	Continued from page 19 transfer to another facility. 2. Interview on 5/27/26 at 4:19 p.m. with social services (SS) D revealed resident 6 transferred to the assisted living facility attached to the nursing home. She was not aware she needed to report the discharge to the ombudsman. She had reported it to Dakota at Home due to the change in pay source. She did not print the ombudsman notifications out after she submitted them and had no documentation of previously submitted notifications to prove she had submitted them. She stated the computer screen would indicate the submissions she sent to the ombudsman were accepted. 3. Interview on 5/28/26 at 11:33 a.m. with administrator A revealed resident 6's ombudsman notification was made that morning. Administrator A had also given SS D education and showed her how to download the form from the ombudsman notification submission website. SS D started a binder to keep the submissions in starting today (5/28/26). 4. Review of the provider's May 2025 Discharge/Transfer/Death Notification policy revealed "It is the policy of the Tieszen Memorial Home to notify the appropriate state agencies when a resident is discharging/transferring death from either the nursing home or assisted living center. If a resident is transferring or discharging from either Tieszen Memorial Home or Marion Assisted Living, the Social Services Coordinator or her designee will notify the appropriate agencies (ex. Ombudsman, VA) of such discharge/transfer/death. This can either be via email submission, online portal, or phone call, in a timely manner."	F0628		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F0700	Resident #1 has passed away since the survey. All vacant resident beds will be checked by the maintenance director to ensure there are no half side rails left on any of the open beds and submit the report to the Administrator. The Maintenance Director will be re-educated by the Administrator on the importance of removing half side-rails on any discharged resident's bed to ensure the next resident occupying that bed will only have half side-rails if their has been communicating indicating there is a physician's order and the appropriate assessments have been completed. A log will be developed and maintained by the maintenance director indicating which residents in the facility have the appropriate orders and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	**312 EAST STATE ST , MARION, South Dakota, 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
=0700 SS = D	Continued from page 20 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to complete a side rail assessment for one of seven sampled residents (1). Findings include: 1. Observation and interview on 5/26/26 at 2:32 p.m. with resident 1 in her room revealed she was sitting in her recliner. She had bilateral half siderails on her bed. She stated she did use the side rails to move around in bed. 2. Interview on 5/27/26 at 3:02 p.m. with Minimum Data Set (MDS) Coordinator Q revealed that resident 1 moved to a new room on February 4th. Resident 1's bed in her previous room did not have side rails. MDS Coordinator Q did the quarterly side rail safety assessments for the residents who had side rails. Resident 1 did not use side rails, so MDS Coordinator Q did not complete a side rail safety assessment for her. She was not aware the bed in resident 1's new room had side rails. She confirmed there was no physician's order obtained, and a safety assessment was not completed for resident 1. 3. Interview on 5/28/26 at 2:01 p.m. with administrator A regarding resident side rails revealed that MDS Coordinator Q completed the side rail assessments. She stated side rails required a physician's order. Quarterly side rail assessments were to be completed and reassessed to ensure they were being used for the intended purpose. 4. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 1/10/24. Her Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. She needed one staff members assistance with transfers. There was no documentation of a physician's order or a side	F0700	Type text here assessments for half side rails. Any residents discharging or have a change in those orders will be communicated to the maintenance director by the licensed nurses and/or MDS Coordinator for placement or removal of half side rails. The Resident Room turnover form will be updated by the Administrator of designee to include half side-rails as another item to be checked when a room is vacated. The maintenance director will present the side-rail log and rooom turnover forms to the monthly QAPI meeting for their review and further recommend-atins.	7/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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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
F0700 SS = D	Continued from page 21 rail safety assessment in resident 1's EMR. 5. Review of the provider's June 2014 Half Side Rail Assessment policy revealed, "It is the policy of the Tieszen Memorial Home to perform evaluations at least quarterly to ensure that the use of half side rail is appropriate. Upon admission, if the resident's physician orders ½ side rails for mobility/repositioning, a Bed Rail/Assist Bar Evaluation form will be completed by a licensed nurse. The Bed Rail/Assist Bar Evaluation Form will be completed a minimum of quarterly by the Licensed Nurse completing the MDS Assessment forms to ensure the use of ½ side rails continues to be appropriate for the resident being evaluated."	F0700		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F0732	The Nursing staf and secretary/receptionist staff responsible for posting the nursing staff information in the facility will be re-educated by the Administrator and Assistant Administrator on the requirements necessary on the form to include the current census information. The education will also include the need to continually update the census information throughout the day as changes occur. The posted staffing sheet will be submitted to the Director of Nursing at the end of each day for review of the necessary census information. In the event of missing census information, the Director of Nursing will re-educate staff as it occurs. All staffing forms will be submmitted to the Administrator or designee to be kept with the original master nursing schedules. All informatiob will be reviewed at the monthly QAPI meeting for their review and further recommendations.	7/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	**312 EAST STATE ST , MARION, South Dakota, 57043**

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F0732 SS = D	Continued from page 22 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review the provider failed to ensure the daily posted nurse staffing information included the resident census. Findings include: 1. Observation from 5/26/26 at 5:00 p.m. through 5/28/26 at 7:48 a.m. of the daily posted nurse staffing form located on the wall near the reception desk revealed it did not include the resident census as required. There was a spot for the census that was blank. 2. Interview on 5/28/26 at 11:59 a.m. with director of nursing (DON) B revealed that secretary R completed the daily posted nurse staffing form, gave it to the night nurse, and the night nurse posted it on the wall by the reception desk. 3. Interview on 5/28/26 at 12:01 p.m. with secretary R revealed she completed the daily posted nurse staffing form and gave it to the night nurses to post on the wall by the front reception desk. The nurse was to edit the form for staffing changes. Secretary R was not aware that the resident census needed to be included on the nurse staffing form.	F0732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	**312 EAST STATE ST , MARION, South Dakota, 57043**

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F0732 SS = D	Continued from page 23 4. Interview on 5/28/26 at 12:07 p.m. with DON B revealed that she expected the night nurse to add the current resident census to the daily nurse staffing form. 5. Review of the provider's May 2025 Staff Posting policy revealed the staffing form should include "the resident census at the beginning of the shift for which the information is posted."	F0732		

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 _____	05/28/2026

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 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 5/26/26 through 5/28/26. Tieszen Memorial Home was found not in compliance with the following requirements: S169.	S 000	Type text here	
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain door alarming as required for two randomly observed exterior doors (west dining room and activity room). Findings include: 1. Observation on 5/27/26 at 2:39 p.m. revealed the west exit door from the dining room leading into the courtyard was equipped with a door	S 169	The maintenance director will be re-educated on the need to monitor the alarmed exits on a regular basis to ensure they are working properly by the administrator and/or assistant administrator. The maintenance director will update the logs to include 2 times per week monitoring of the alarmed doors mentioned in the findings. All doors will be monitored at least weekly x 3 months to ensure they are functioning correctly. Both doors mentioned were fixed prior to the end of the onsite survey. The maintenance director will conduct the monitoring and submit the findings/logs to the monthly QAPI meeting for their review and further recommendations.	7/12/2026

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

TITLE: Administrator

(X6) DATE: 6/16/2026

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 _____	05/28/2026

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 169	Continued From page 1 alarm. Testing that doors alarm by opening the door revealed the alarm would not sound when the door was opened. Interview with the maintenance director at the time of the observation and testing confirmed that condition. He stated that doors alarm had worked correctly when he last tested it as part of his quarterly door alarm checks. He further stated he believed a transformer for the alarm must have failed. He then added he had recently had to replace a couple transformers for other doors due to brown outs caused by voltage issues from the electric company. 2. Observation on 5/27/26 at 2:46 p.m. revealed the exit door from the activity room to the courtyard was equipped with a door alarm. Testing that doors alarm by opening the door revealed the alarm would not sound when the door was open. Interview with the maintenance director at the time of the observation and testing confirmed that condition. He stated that doors alarm had worked correctly when he last tested it as part of his quarterly door alarm checks. He further stated he believed that doors alarm transformer had also failed due to the same issue as the west exit door of the dining room.	S 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 EAST STATE ST , MARION, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 5/27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Tieszen Memorial Home was found not in compliance. Please mark an F in the completion date column for the K241 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies via the Fire Safety Evaluation System (FSES) dated 5/28/26.	K0000		
K0241 SS = C Bldg. 01	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 STANDARD 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 two random locations (west stair enclosure and north basement stair enclosure). Findings include: 1. Observation on 5/27/26 at 11:37 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 several years ago.	K0241		F

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	6/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 EAST STATE ST , MARION, South Dakota, 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
K0241 SS = C Bldg. 01	Continued from page 1 2. Observation on 5/27/26 at 2:21 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 5/27/26 at 2:46 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. 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.	K0241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. BUILDING B. WING	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 EAST STATE ST , MARION, South Dakota, 57043

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E0000	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 5/27/26. Tieszen Memorial Home was found in compliance.	E0000		

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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 rogram participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	6/16/2026