

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

ORIGINAL

PRINTED: 06/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2016
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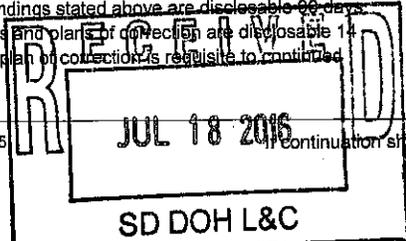
NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST STATE ST MARION, SD 57043
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/31/16 through 6/2/16. Tieszen Memorial Home was found not in compliance with the following requirements: F176, F226, F332, F431, and F441.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, policy review, and record review, the provider failed to ensure self-administered medication assessments were done for four of four sampled residents (3, 5, 7,17). Findings include: 1a. Observation on 6/1/16 at 1:30 p.m. with the registered nurse (RN) E revealed: *Resident 5 received a nebulizer (breathing) treatment. *RN E added the medication and started the nebulizer. She then told the resident she would return in about fifteen minutes. b. Observation on 6/1/16 at 4:47 p.m. with resident 7 revealed: *RN E had added the medication to the nebulizer.	F 176	1. The Director of Nursing will develop a policy addressing self administration of nebulizer treatments. An evaluation for self administration of nebulizer treatments will be done for Resident #5 and #7 by the Director of Nursing or her designee (licensed nurse). 2. Resident #3 is not appropriate to self administer any medication and the pink cream in a medication cup should not have been left by his bedside. 3. Resident #17 should not have had her Miralax mixed prior to her sitting down at the table. 4. The Director of Nursing or her designee (licensed nurse) will complete self-administration assessments on those residents who may be able to self administer medications as appropriate. The Director of Nursing will re-educate RN "E" and all licensed nurses on the proper policy and procedure for residents with nebulizer treatments, leaving medications at bedside, and the proper procedure for those residents utilizing Miralax. The Director of Nursing and/or her designee (licensed nurse) will monitor the administration of the above mentioned medications and treatments for nurses "D" and "E" as well as all licensed nurses to ensure medications are being administered appropriately. Once that is complete, the Director of Nursing and/or her designee will monitor 2-3 nurses monthly for appropriate administration of medications and treatments listed above for 3 consecutive months.	7/01/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Aura Wilson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/11/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 176	<p>Continued From page 1</p> <p>*She stated she would be back in about ten to fifteen minutes.</p> <p>c. Interview on 6/1/16 at 5:20 p.m. with RN E revealed it was routine to leave the resident's room when a nebulizer was running.</p> <p>Interview on 6/2/16 at 8:30 a.m. with the director of nursing (DON) revealed nursing staff did not watch nebulizer treatments. When asked how they would know if they had received the full amount of medication she did not respond.</p> <p>Review of the assessment for self-administration of medications included the resident can administer inhalant medications with proper procedure.</p> <p>2. Observation on 5/31/16 at 12:30 p.m. and on 6/1/16 at 1:00 p.m. with resident 3 revealed: *A medication cup with a pink cream was sitting at his bedside. *It appeared to be unused.</p> <p>Interview on 6/1/16 at 1:50 p.m. with RN E revealed she did not know who had left it there. She took it and disposed of the cup stating it should have not been left on his bedside table.</p> <p>Interview on 6/2/16 at 8:30 a.m. with the DON revealed no creams should have been kept at the bedside.</p> <p>3. Observation on 5/31/16 at 5:25 p.m. with resident 17 revealed the Miralax (laxative) had been mixed in her apple juice before she had set down at the table.</p> <p>Interview on 5/31/16 at 5:30 p.m. with licensed</p>	F 176	<p>The Director of Nursing will provide the data from the monitoring that has occurred to the Regular Quality Assurance and Performance Improvement meetings for their review and any further recommendations monthly for 3 months.</p>	

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F 176	Continued From page 2 practical nurse D revealed: *She had mixed the resident's laxative in her juice before the meal. *She mixed everyone's laxative before breakfast and supper and left it at their table where they sat. -She had a list of sixteen residents who received a laxative mixed in juice before breakfast. -And the list had six residents who received a laxative mixed in juice before supper. 4. Record review of residents 3, 5, and 7 revealed no assessments were completed for self-administration of medications. Review of the August 2007 self-administration of medication policy revealed: *The team would assess the resident's ability to self-administer medications. *They must have a written order from the physician to self-administer medications. *They must have a written order from the physician to keep medications in their room.	F 176			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to report a fall with	F 226	Resident #2's fall was on 9/16/15. A report will be sent into the state. The facility Director of Nursing and Administrator will update the facility's policy and procedure for Falls and Unusual Occurrences to include notification to the SDDOH on any falls of serious injury. The Facility DON and Administrator will also educate the licensed nurses on the updated policy and updated form used to document falls to include the reporting requirements to the SDDOH. The Facility DON will keep a log of all falls that include injury of serious nature and monitor them for compliance in reporting to SDDOH. The DON will present the logs to the regular Quality Assurance and Performance Improvement Committee for their review and any further recommendations monthly for 3 months.	7/01/16	

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F 226	<p>Continued From page 3</p> <p>serious injury to the South Dakota Department of Health (SD DOH) for one of one sampled resident (2). Findings include:</p> <p>1. Review of the fall report for resident 2 revealed:</p> <ul style="list-style-type: none"> *On 9/16/15 she had an unwitnessed fall in her room. *She complained of lower back and right hip pain. *Staff noticed she was moaning and grimacing with any slight movement. *She was sent to Sanford Hospital for evaluation immediately following the fall on 9/16/15. <p>Review of resident 2's medical record revealed:</p> <ul style="list-style-type: none"> *Diagnosed with a compression fracture of the lower back. *Hospitalized from 9/16/16 through 9/18/16. <p>Interview on 6/2/16 at 9:30 a.m. with the director of nursing (DON) regarding resident 2's fall revealed:</p> <ul style="list-style-type: none"> *An internal investigation had been completed. *She referred this surveyor to the social service designee (SSD) for information on whether it was reported to the SD DOH. <p>Interview on 6/2/16 at 11:10 a.m. with the SSD regarding resident 2's fall revealed she:</p> <ul style="list-style-type: none"> *Did not report falls to the SD DOH. *Was responsible for reporting unusual occurrences to the SD DOH that included suspected abuse, misappropriation of property, and elopements. *Stated the nursing staff were responsible for reporting falls to the SD DOH. <p>Interview on 6/2/16 at 12:35 p.m. with the DON revealed she:</p>	F 226		

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F 226	Continued From page 4 *Was not aware falls were not being reported to SD DOH. *Acknowledged the above fall should have been reported the SD DOH.	F 226			
F 332 SS=D	Review of the provider's May 2009 Falls and Unusual Occurrence Reports policy revealed it did not address the reporting of falls to the SD DOH. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure a less than 5 percent (%) medication error rate for 2 of 32 resident's (5 and 16) observed medication administrations. Findings include: 1. Observation on 5/31/16 at 5:20 p.m. with registered nurse (RN) D revealed a potassium medication was crushed with other medications for resident 5. Observation on 5/31/16 at 5:35 p.m. with RN D revealed a potassium medication was crushed with other medications for resident 16. Interview on 6/1/16 at 4:20 p.m. with the pharmacist revealed the above potassium medication should have not been crushed.	F 332	Resident #5 and #16's medication administration records have been updated indicating those medications can not be crushed. The facility Director of Nursing will educate RN "D" on the policy/procedure for crushing medications. The Director of Nursing will also re-educate all the licensed nurses on the correct policy/procedure for crushing medications. The DON and/or her designee will monitor RN "D" and 2-3 nurses for the crushing of medications 2-3 times per week for three months. The DON will present the findings to the regular Quality Assurance and Performance Improvement committee meeting for their review and any further recommendations monthly for three months.	7/01/2016	

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F 332	Continued From page 5	F 332			
F 431 SS=D	<p>Review of the November 2007 crushing medications policy revealed: *The medications not to be crushed were posted in the medication room. -Staff could not find that posting. *There was also a copy in the Nursing Policy Manual.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to</p>	F 431	<p>The sharps containers have been moved to the medication room for disposal by the medical waste company. Sharps containers are no longer being used for disposal of narcotics. Rx Destroyer system has been implemented.</p> <p>The facility Director of Nursing and Administrator will develop a new policy and procedure for disposal of narcotics. Registered Nurse "E" and all other licensed nurses will be educated by the Director of Nursing on the new policy and procedure for disposal of narcotics. The Director of Nursing and/or her designee will monitor the narcotic drug disposal 2-3 times per week for a period of 4 weeks to ensure the licensed nurses are disposal of the medications properly. Once that is complete, the Director of Nursing and/or her designee will monitor narcotic drug disposal 1 time per week for three months. The Director of Nursing will present the documentation of the monitoring to the regular Quality Assurance and Performance Improvement committee for their review and further recommendations monthly for three months.</p>	7/01/2016	

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F 431	<p>Continued From page 6</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on interview and record review, the provider failed to ensure controlled medications were secured from unauthorized personnel for one of one unidentified resident using pain patches. Findings include:</p> <p>1. Interview on 6/2/16 at 11:00 a.m. with registered nurse E revealed the pain medication patches (narcotics) were disposed of in the sharps container.</p> <p>Interview on 6/2/16 at 12:45 p.m. with the director of nursing (DON) revealed maintenance picked up the sharps containers after they were put in the biohazard waste containers by nursing staff. They were taken by maintenance to the basement for storage until picked up by medical waste company.</p> <p>Interview on 6/2/16 at 4:10 p.m. with the maintenance director revealed: *He stored biohazard containers until he calls the biohazard company to pick them up. *He usually waited until at least five large containers were full. *He was not aware controlled medications were disposed of in the sharps containers</p> <p>Review of undated Fentanyl Patch Destruction</p>	F 431		

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F 431	Continued From page 7 policy revealed: *The sharps container needed to be stored in the medication room until the medical waste company arrived for the pickup. *The sharps container should not have been given to maintenance for disposal at any time.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	All personal items for the identified residents have been separated and stored in a sanitary manner. 1. The Nursing and Housekeeping Departments will be re-educated by the Administrator, DON, House-keeping Supervisor and Infection Control Nurse on their respective cleaning duties in resident's rooms to include the resident's personal hygiene items and the general cleaning of the resident's bathrooms. Proper storage devices will be obtained to provide each resident with clean storage areas. Housekeeping will be re-educated on the proper procedures for cleaning a resident's bathroom to include dusting, washing walls, and monitoring call-light cords that need to be replaced due to yellowing or being soiled. 2. All Nursing assistants will be re-educated by the DON and Infection Control Nurse on the proper procedure and schedule for cleaning the mechanical lifts in the facility. 3. All Nursing assistants will be re-educated by the DON and Infection Control Nurse on the policies and procedures for keeping the bathing rooms clean and orderly. Proper equipment and solutions will be made available and present in the bathing rooms to ensure multiple-use items are properly disinfected. All staff will be re-educated by the Administrator on where personal items belonging to staff will be should be stored and removed from resident care areas.		

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F 441	<p>Continued From page 8</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and manufacturer's guideline review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Appropriately clean one of two whirlpool tub rooms in the main hall and one of one shower room on the second floor. *Follow appropriate handwashing, glove use, and cleaning and disinfection guidelines prior to, during, and after cleaning bowel movement (BM) off the floor in one of one whirlpool tub rooms in the main hall. *Keep individual personal resident items separate and in sanitary condition in resident 2, 5, 13, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30's bathrooms located in four of four nursing care areas (main, north, memory and second floor upstairs). <i>ML/SDDH/JJ</i> *Clean resident's bathroom walls and shelving on a regular basis or when visibly soiled in four of four nursing care areas. *Store linens in an appropriate manner to avoid contamination in four of four nursing care areas. *Appropriately clean mechanical lifts when visibly soiled. <p>Findings include:</p> <p>1. Observation on 5/31/16 at 2:30 p.m. in resident's 18 and 19's bathroom on the second</p>	F 441	<p>4. Housekeeping staff will be re-educated by the Administrator and the Housekeeping Supervisor on the proper procedures for cleaning the resident's bathroom to include the walls and any soiled surfaces. Nursing assistants will be re-educated by the DON and Infection Control nurse on the proper procedure to clean oral care supplies for the residents.</p> <p>5. Housekeeping staff will be re-educated by the Administrator and the Housekeeping Supervisor on the proper procedures for cleaning the resident's bathrooms to include the walls and any other surfaces that need cleaning. All items will be removed from the backs of the toilets and stored in a more appropriate location.</p> <p>6. Housekeeping staff will be re-educated by the Administrator and the Housekeeping Supervisor on the proper procedures for cleaning the resident's bathrooms to include the walls and any other surfaces that need cleaning. All items will be removed from the backs of toilets and stored in a more appropriate location.</p> <p>7. CNA "B" and all nursing assistants will be re-educated by the Infection Control Nurse and the Staff Development Coordinator on infection control policies and procedures to include handwashing, cleaning of the whirlpool tub and the proper procedure to clean and disinfect areas when residents have bowel or bladder accidents.</p> <p>8. All housekeeping staff will be re-educated by the Administrator and the Housekeeping Supervisor on the proper procedures for cleaning bathrooms to include the walls and any other surfaces in the bathroom that appear to be soiled. Nursing staff will be re-educated by the DON and Infection Control Nurse on the proper procedures for storing resident items in the bathroom and the back of the toilet is not an acceptable storage area.</p>		

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F 441	<p>Continued From page 9 floor revealed: *Two residents shared that room. *A wet washcloth was hanging off the garbage can in their bathroom. *A large white bin contained both residents toothbrushes and toothpaste. *Inside that bin were heavy amounts of white toothpaste residue, a mold-like substance, and a small insect. *The shelf the white bin sat on was heavily soiled with toothpaste like debris and dust. *White washcloths had been stacked directly on top of the toilet tank. *On the wall directly beside the toilet were yellow urine-like streaks. *The call-light cord that hung across that wall by the toilet was also yellowed in color and covered in large amounts of dust. *On the wall next to the sink was a sharps container that was covered in heavy amounts of toothpaste residue and dust.</p> <p>2. Observation on 5/31/16 at 2:45 pm in the second floor hallway revealed a mechanical lift used to assist residents to a standing position. That lift had large amounts of food and unknown debris on the foot pedals.</p> <p>Observation on 5/31/16 at 4:50 p.m. in the memory care unit revealed a mechanical lift that had large amounts of food and unknown debris on the foot pedals.</p> <p>Observation on 6/1/16 at 11:11 a.m. of the mechanical lift in the hallway on the second floor revealed it was still heavily soiled with food and unknown debris.</p> <p>3. Observation and interview on 6/1/16 at 11:15</p>	F 441	<p>For all items 1-8, the Infection Control Nurse, DON, and Administrator will be conducting weekly facility tours for 4 weeks to monitor the cleanliness of the resident's bathrooms, the proper storage and cleanliness of the resident's personal belongings, the cleanliness of the mechanical lifts, the cleanliness of bathing rooms, and staff personal items are properly stored and not in resident care areas. All findings will be documented and any negative findings will be addressed with the staff on those tours to ensure cleaning is done timely and complete. Upon completion of the 4 weekly checks the facility tours will be conducted monthly to continually monitor the tasks being completed. The Administrator will bring all monitoring documentation to the regular Quality Assurance and Performance Improvement Committee for their review and further recommendations monthly for three months.</p>	7/1/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2016
NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 10</p> <p>a.m. with certified nursing assistant (CNA) A in the second floor shower room revealed:</p> <ul style="list-style-type: none"> *A mechanical lift was in the shower room. -It was heavily soiled with food and debris and had a used Kleenex on the foot pedal. *The cupboard below the sink had resident disposable undergarments that were opened and laid across a heavily soiled toilet brush. *In the top drawer there were three combs filled with hair and skin-like debris, nail clippers that were dirty co-mingled with cracker packets, pens, Visine eye drops, pantyhose, and miscellaneous papers. *She agreed the disposable undergarments should not have been stored under the sink or with a toilet brush. *She stated resident multiple-use items such as combs and nail clippers were to be cleaned after each use with Barber-cide disinfectant, but those items had not been cleaned. *She had not cleaned those items in a long time. *There was no Barber-cide available to clean multiple-use items in the shower room. *She was unsure why the crackers or Visine were in the drawer but most likely belonged to staff. <p>4. Observation and interview on 6/1/16 at 11:25 a.m. with CNA A in resident 18 and 19's bathroom revealed:</p> <ul style="list-style-type: none"> *There were bug and mold like residual in the bottom of the white container the toothbrushes were stored in. *She described the yellow streak-like stains on the wall of the bathroom near the toilet as it appeared to her to be urine. *Housekeeping was responsible to have cleaned the environmental surfaces inside the bathrooms daily. *It was the CNAs responsibility to clean and store 	F 441		

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F 441	<p>Continued From page 11</p> <p>the residents' personal care items appropriately.</p> <p>5. Observation and interview on 6/1/16 at 11:30 a.m. with CNA A in residents 20 and 21's bathroom revealed:</p> <ul style="list-style-type: none"> *A toothbrush and toothpaste in a basin was sitting on top of the toilet tank. *A specimen hat for collecting urine or BM was hanging on the wall by a nail. *Below the nail were light brown and yellow urine-like streaks. *The wall was also heavily soiled with dirt-like debris. <p>Interview on 6/1/16 at 11:44 a.m. with housekeeper F revealed:</p> <ul style="list-style-type: none"> *She only cleaned the floor, the toilet, and the sink in residents' rooms daily. *The walls were only cleaned if a resident moved to another room or had passed away. *She would not clean the covering on the sharps containers or the shelf that held the toothbrushes. <p>6. Further random room observations throughout the facility in resident bathrooms on 6/1/16 from 11:50 a.m. through 12:09 p.m. revealed:</p> <ul style="list-style-type: none"> *In residents 22 and 23's bathroom: <ul style="list-style-type: none"> -There were yellow stains on the walls behind and beside the toilet. -White washcloths for facial use and blue washcloths for use on private areas were stored on the toilet tank. *In resident 17's bathroom: <ul style="list-style-type: none"> -Washcloths and toilet paper had been stored on the toilet tank. -Talcum powder and mouthwash were co-mingled and stored in a bin directly on the toilet tank. -The wall beside the toilet had yellow and brown streaks on it. 	F 441		

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F 441	<p>Continued From page 12</p> <p>*In residents 5 and 26's bathroom: -Washcloths were stored on the toilet. -Brown stains were noted on the wall by the sink.</p> <p>*In resident 25's bathroom, a toothbrush, toothpaste, and a hair pick, were co-mingled and stored directly on top of the toilet tank.</p> <p>*In resident 13's bathroom, two used urinals were stored on top of the handicap grab bar. Next to those urinal on the wall were large yellow stains.</p> <p>*In resident 26's bathroom, mouthwash, private area cream, lip balm, Vaseline, and a thermometer had been stored in a basin on top of the toilet tank.</p> <p>*In resident 2's bathroom, personal disposable undergarments were stored directly on the floor in a mesh laundry hamper between the wall and the toilet.</p> <p>In residents 27 and 28's bathroom located in the memory care unit: -A toothbrush laid directly on top of the visibly dirty shelf. -Toilet paper was stored on top of the toilet tank. -Toothbrushes were stored with private area cream in a basin. -Large amounts of toothpaste and debris had been found in the bottom of that basin.</p> <p>*In residents 29 and 30's bathroom: -Denture cleaner was stored directly on the toilet tank. -The wall next to the toilet has white streaks and was visibly soiled. -The wall next to sharps container had large amounts of toothpaste-like residue.</p> <p>7. Observation, interview, and manufacturer's guideline review on 6/1/16 at 1:30 p.m. with CNA B in the main whirlpool tub room revealed: *There was BM on the floor.</p>	F 441	

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F 441	<p>Continued From page 13</p> <p>*CNA B grabbed a white washcloth, bent down, picked up the BM, wiped it off the floor, and threw it into the garbage can.</p> <p>*She had not washed her hands prior to or after completing the task.</p> <p>*She had not put gloves on at any time.</p> <p>*She continued to touch her face, her scrub top, and the whirlpool tub as she demonstrated the whirlpool cleaning process.</p> <p>*Her normal process for tub cleaning was to:</p> <ul style="list-style-type: none"> -Plug the drain. -Press and hold the disinfectant button on the whirlpool tub for three to five seconds before releasing it. -Grab the non-labeled spray bottle of disinfectant and spray the tub walls down. -Scrub the walls of the whirlpool tub vigorously with the brush . -Let it sit for ten minutes and then rinse. <p>*When reviewing the Cascade manufacturer's cleaning instructions for step 6, it stated: she was to have held down the disinfectant button until she saw solution coming from the jets and there was to have been one to one and one half gallons of disinfectant solution in the tub well (foot area).</p> <p>*She was unaware there needed to be one to one and a half gallons of water in the tub well.</p> <p>*She was unsure how much disinfectant solution that would require.</p> <p>*She agreed the manufacturer's guidelines made no mention of using a spray bottle of disinfectant solution.</p> <p>*She was unsure how the solution was diluted in the spray bottle.</p> <p>*She would just pour an undetermined amount into the bottle and add water.</p> <p>*She agreed she should have washed her hands and applied gloves prior to and after handling BM.</p> <p>*She stated she would have normally mopped the</p>	F 441		
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F 441	<p>Continued From page 14</p> <p>floor to clean up after a resident BM but had no mop. She was unsure where to locate one.</p> <p>8. Interview on 6/2/16 at 8:45 a.m. with the maintenance supervisor regarding the environmental cleaning and storage of linens and personal items on toilet tanks revealed: *He was in charge of housekeeping. *Walls were to be washed when visibly soiled or as needed. *He had problems with housekeeping not completing tasks as instructed. *He was unaware the walls had not been getting cleaned. *He was aware staff had a history of placing items on top of the toilet tanks. -He had instructed staff not to place any items on top of the toilet tanks. *His expectation was housekeeping was to clean as expected. *Nursing staff were responsible for cleaning resident care items.</p> <p>Interview on 6/2/16 at 9:15 a.m. with the infection control coordinator regarding the above observations revealed: *It had been her expectation nursing staff were to have cleaned all resident care items. *Residents who shared bathrooms were not to have co-mingled personal care items. *Oral personal items were not to co-mingle with private area items such as mouth wash and private area cream. *CNA B should have performed hand hygiene prior to and after touching BM and put on gloves when performing that task. *White washcloths were to be used on the face and blue on the private area of residents. *No items were to have been stored on top of the</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>toilet tank.</p> <p>*Mechanical lifts needed to be cleaned when visibly soiled.</p> <p>*She would do environmental rounds once per year.</p> <p>*She had been aware of cleaning problems with nursing and housekeeping staff.</p> <p>*She was unaware the whirlpool tub was not cleaned appropriately or the disinfection solution not being diluted appropriately for the shower room upstairs.</p> <p>Interview on 6/2/16 at 10:50 a.m. with the administrator regarding the above observations and interviews with staff and supervisory personal revealed:</p> <p>*She agreed there had been problems with staff performing cleaning as instructed.</p> <p>*CNA B should have performed hand hygiene prior to and after touching BM and put on gloves when performing that task.</p> <p>*It was her expectation the supervisors instructions were to be followed, and staff were to store items appropriately and in a sanitary manner.</p> <p>*Nursing staff were responsible for resident specific cleaning</p> <p>*Housekeeping was responsible for environmental cleaning.</p> <p>*Whirlpool tubs were to be cleaned according to manufacturer's instructions.</p> <p>*She agreed cleaners needed to be labeled with manufacturer's labels as to contents and instructions following EPA standards and guidelines.</p> <p>*Multiple-use items like combs and nail clippers were to be cleaned between resident use.</p> <p>Review of the provider's 2007 Infection Control</p>	F 441			

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F 441	<p>Continued From page 16</p> <p>Policy revealed: *All personnel were to be trained on infection control policies and practices upon being hired and periodically thereafter. *The objective of the policy was to provide a safe and sanitary environment for all residents.</p> <p>Review of the provider's 2009 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed reusable resident care equipment would be decontaminated and disinfected between resident use according to manufacturer's instructions.</p> <p>Review of the provider's current housekeeper job description revealed housekeepers were to have: *Performed day-to-day functions as assigned. *Specific tasks in accordance with daily work assignments. *"Cleaned walls and ceilings by washing, wiping, dusting, spot cleaning, disinfecting, deodorizing, etc.."</p> <p>Review of the provider's current CNA job description revealed CNAs were to: *Follow work assignments in completing and performing assigned tasks. *Perform all assigned tasks in accordance with our established policies and procedures as instructed by your supervisors. *Follow policies concerning exposure to body fluids. *Wash hands before and after performing any service for a resident. *Clean and disinfect all resident care equipment after each use. *Perform routine housekeeping duties. *Use gloves as indicated.</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>Review of the provider's 2009 Infection Control Coordinator policy revealed the coordinator was to have monitored infection control policies and practices.</p> <p>Review of the provider's 2009 Infection Control Committee-Duties and responsibilities policy revealed:</p> <ul style="list-style-type: none"> *Its objective was to have provided a safe and sanitary environment. *Help monitor and assess facility wide environmental infection control practices. *The administration was to have ensured management monitored the effectiveness of work practices related to infection control tasks, and they were evaluated and monitored. 	F 441			

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/1/16. Tieszen Memorial Home 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 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/1/16 upon correction of the deficiencies identified below. Please mark an F in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K011, K018, K021, K025, K029, K038, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider	K 011		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

7-11-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 011	Continued From page 1 failed to maintain proper separation between the nursing home and a non-conforming attached residential board and care occupancy. Findings include: 1. Observation at 9:35 a.m. on 6/1/16 revealed the ninety minute fire rated door in the two hour fire separation wall would not latch with the door closer. Further observation revealed the panic hardware used to latch the door did not contain a label identifying it was fire rated hardware. Interview with the maintenance supervisor at the time of the observation confirmed the findings. He stated the non-fire rated hardware was original to the door installation. The door was adjusted and latching properly prior to exit.	K 011	The facility maintenance supervisor will replace the panic hardware used to latch the door with appropriate fire rated hardware on the mentioned door. Monthly building tours will be conducted by the Administrator or someone she delegates to ensure all doors are latching properly. The monthly building tours will be documented and a report will be presented to the monthly Quality Assurance and Performance Improvement meetings for their review and further recommendations.	7/22/2016	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by	K 018			

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K 018	Continued From page 2 CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain a smoke tight separation of one randomly observed door to the corridor (ice machine closet). Findings include: 1. Observation at 11:10 a.m. on 6/1/16 revealed the door used to separate the ice machine closet from the corridor was impeded from closing due to a house keeping cart. Interview with the maintenance supervisor at the time of the observation indicated the ice machine needed ventilation to keep the compressor from overheating. Because that was not considered a hazardous area the door could be removed provided smoke detection was installed within the closet. Because that smoke compartment did not contain any resident sleeping rooms it would only affect the residents and staff within the smoke compartment during a fire situation.	K 018	The facility maintenance supervisor will contact the appropriate contractors to have a smoke detector installed into the room where the ice machine is located. A monthly building tour will be conducted by the Administrator or someone she delegates to ensure smoke detection is present in such areas. The building tours will be documented and a report will be presented to the Quality Assurance and Performance Improvement meetings for their review and further recommendations.	7/22/2016
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and	K 021		

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K 021	Continued From page 3 (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain self-closing doors on two randomly observed hazardous areas (activity storage and occupational storage). Findings include: 1. Observation at 10:50 a.m. on 6/1/16 revealed the doors used to separate the activity storage and occupational storage in the basement were not equipped with self-closing devices. Interview with the maintenance supervisor at the time of the observation indicated he understood if the door was locked a door closer would not be required. The basement was considered a single smoke compartment and would only affect staff if present during a fire situation.	K 021	The facility maintenance supervisor will order and install hardware to ensure the mentioned doors will be equipped with self-closing devices. The facility administrator or someone she delegates will conduct a monthly building tour to ensure all doors are properly equipped with self-closing devices. The monthly building tour report will be documented and a report will be presented to the Quality Assurance and Performance Improvement committee for their review and any further recommendations.	7/22/2016
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.	K 025		

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NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 4 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain a one-half hour fire separation for two of two smoke barriers on the ground floor. Findings include: 1. Observation at 1:10 p.m. on 6/1/16 revealed both the east and north smoke barriers located on the ground level contained penetrations. The east smoke barrier contained a sprinkler pipe penetration and a multiple wire penetration that were not sealed above the lay-in ceiling. The north smoke barrier contained two unsealed sprinkler pipe penetrations and an unsealed wire penetration above the lay-in ceiling. Interview the maintenance supervisor at the time of the observation indicated new sprinkler piping as well as new fire alarm wiring had recently been installed throughout the building.	K 025	The facility maintenance supervisor will seal all penetrations that were not completed following the most recent remodeling project. The facility maintenance supervisor will also be in contact with any contractors that are performing work at the facility and remind them it is necessary to seal any and all penetrations when they are finished with their work. A review of work completed at the facility will be completed by the maintenance supervisor and/or Administrator to monitor any potential areas. This review will be presented to the Quality Assurance and Performance Improvement Committee for their review and any further recommendations.	7/22/2016
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029		

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K 029	Continued From page 5 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain the smoke tight separation of two randomly observed hazardous areas (ground floor furnace room and schredder storage in the basement) in a building equipped with an approved automatic fire sprinkler system. Findings include: 1. Observation at 9:50 a.m. on 6/1/16 revealed the door used to separate the ground floor furnace room would not latch into the frame when allowed to close with the spring hinges. Further observation identified a two inch by two inch hole and a wire penetration that was unsealed in the wall above the door frame. Interview with the maintenance supervisor at the time of the observation confirmed the findings. The deficiency would affect no resident sleeping room smoke compartments but would affect any resident or staff within that smoke compartment during a fire situation. 2. Observation at 11:00 a.m. on 6/1/16 revealed the door used to separation the shredder storage in the basement would not close and latch when allowed to operate with the spring hinges. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The basement was considered a single smoke compartment and would only affect staff if present during a fire situation.	K 029	The facility maintenance supervisor will contact the appropriate contractors to replace and/or adjust the furnace room door (1) and the shredder storage room door (2) to ensure they latch appropriately and any penetrations are sealed appropriately. A monthly building tour will be completed by the facility administrator or someone she delegates to ensure all doors on the ground floor are closing appropriately and maintaining proper smoke separation. The monthly building tour will be documented and a report will be presented to the Quality Assurance and Performance Improvement committee for their review and any further recommendations.	7/22/2016	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 033			

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K 033	<p>Continued From page 6</p> <p>Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180</p> <p>Based on observation and record review, the provider failed to maintain the one hour fire resistive rating of vertical openings in the following:</p> <p>*The west stair enclosure walls did not extend to the underside of the roof deck of the 1976 addition.</p> <p>*The north basement stair enclosure door was equipped with a twenty minute fire resistive door assembly.</p> <p>*The east and west stair enclosure doors were not provided with labels and contained glass vision panels.</p> <p>Findings include:</p> <p>1. Observation at 11:30 a.m. on 6/1/16 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.</p> <p>2. Observation at 11:35 a.m. on 6/1/16 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</p>	K 033		

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K 033	Continued From page 7 the original construction. 3. Observation at 11:45 a.m. on 6/1/16 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.	K 033		F
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to provide delay egress instructional signage for four of nine exits (ground level exit adjacent to the nurses station, the east and west exits adjacent to the wellness center, and east exit door from the second floor). Findings include: 1. Observations between 9:30 a.m. and 11:00 a.m. on 6/1/16 revealed the exterior exit door adjacent to the nurses station, the exit doors to the east and west of the wellness center, and the east exit door from the second floor were equipped with delayed egress locking hardware.	K 038	As stated in the deficiency, the maintenance supervisor has installed the appropriate signage at all of the doors indicated. Monthly building tours will be conducted by the Administrator or someone she delegates to ensure all doors have the proper signage on them. The monthly building tours will be documented and a report will be presented at the monthly Quality Assurance and Performance Improvement meetings for their review and further recommendations.	6/30/16

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K 038	Continued From page 8 Those doors did not display the proper signage to identify the door was locked for a maximum of thirty seconds, and an alarm would sound. Interview with the maintenance supervisor indicated he was aware the signs were required and had not gotten them posted. He had the proper signs in his office and posted the signs prior to completion of the survey. This deficiency could affect all sixty-two residents, staff, and visitors in a non fire emergency situation.	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain the automatic fire sprinkler system in reliable operating condition for the nursing supply storage room in the basement. Findings include: 1. Observation at 10:35 on 6/1/16 revealed half of a lay-in ceiling tile was missing in the basement nursing supply storage room. The missing tile could allow smoke and heat to accumulate in the un-sprinklered area above the suspended ceiling without activating the fire sprinkler system. Interview with the maintenance supervisor at the time of the observation revealed he was unaware a missing ceiling tile could compromise the fire sprinkler system.	K 062	The facility maintenance supervisor will replace the ceiling tile in the basement nursing supply storage room. Monthly building tours will be conducted by the Administrator or someone she delegates to ensure there are no missing ceiling tiles in the facility. The monthly building tours will be documented and a report will be presented to the monthly Quality Assurance and Performance Improvement meeting for their review and further recommendations.	6/30/16

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K 062	Continued From page 9 This deficiency would only affect the staff present in the basement smoke compartment during a fire situation.	K 062		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Surveyor: 14180 A. Based on observation and interview, the provider failed to provide a battery pack emergency light for the generator located within the unattached garage. Findings include: 1. Observation at 1:30 p.m. on 6/1/16 revealed the diesel generator was located in an unattached garage on the north east corner of the facility. No source of lighting was present to illuminate the generator in the event it was to fail. Interview with the maintenance supervisor at the time of the observation indicated he understood a battery operated light source was required in the boiler room, but he was unaware one was necessary in to illuminate the generator. The deficiency affected one of numerous requirements for generator installations. B. Based on observation and interview, the provider failed to install an emergency shutoff switch outside the room housing the generator. Findings include: 1. Observation at 1:35 p.m. on 6/1/16 revealed there was an emergency shutoff switch located	K 144	The facility maintenance supervisor has been in contact with the appropriate contractors to have an emergency shutoff switch installed as well as a battery pack emergency light for the generator. The maintenance supervisor will also present the documentation logs for testing the lighting to the monthly Quality Assurance and Performance Improvement Meetings for their review and any further recommendations.	7/22/2016

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K 144	Continued From page 10 on the generator but not one outside of the room housing the generator. Interview with the maintenance supervisor at the time of the observation revealed he was aware a remote emergency shutoff switch was required but had not had it installed. The deficiency affected one of numerous requirements for generator installations.	K 144		

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10647	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 312 E STATE ST MARION, SD 57043
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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) COMPLETE DATE
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/31/16 through 6/2/16. Tieszen Memorial Home was found not in compliance with the following requirement: S125.</p>	S 000		
S 125	<p>44:73:02:04 Chemical-Sanitize, Disinfect, or Sterilize</p> <p>The label of chemicals used to sanitize, disinfect, or sterilize shall indicate registration with the Environmental Protection Agency as effective, safe, and approved for their intended use.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to appropriately label one of one reconstituted chemical used to disinfect one of one shower room on the second floor and two of two whirlpool tub rooms on the first floor. Findings include:</p> <p>1. Observation and interview on 6/1/16 at 11:15 a.m. with certified nursing assistant (CNA) in the second floor shower room revealed: *An unlabelled spray bottle containing a yellow liquid. *She thought the contents of the spray bottle were Penner Classic Whirlpool Cleaner. *She could not say for certainty that it was not another cleaner or bleach.</p> <p>Observation and interview on 6/6/16 at 1:30 p.m. with CNA B in the first floor west wing whirlpool tub room revealed:</p>	S 125	<p>All staff will be re-educated by the Administrator and Housekeeping Supervisor on the importance of all chemical containers being labeled appropriately. The facility Administrator, Infection Control Nurse, and/or Director of Nursing will be conducting weekly checks to monitor compliance of all chemical containers being labeled and labeled appropriately. The weekly checks will be conducted for 4 weeks or until there are two consecutive weeks with no negative findings. Once that is complete, the checks will be done on a monthly basis during the facility tours. All findings will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for their review and any further</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Aura Wilson

recomm

TITLE

Administrator

(X6) DATE

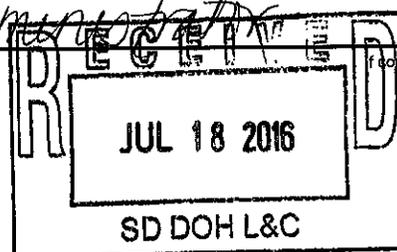
7-11-16

STATE FORM

6899

GSQX11

Continuation sheet 1 of 2



SD Department of Health Vital Records

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S 125	<p>Continued From page 1</p> <p>*An unlabelled spray bottle containing a yellow liquid.</p> <p>*She stated she thought the contents of the spray bottle was Penner Classic Whirlpool Cleaner.</p> <p>Interview on 6/2/16 at 10:50 a.m. with the administrator regarding the above labeling of cleaning products revealed:</p> <p>*She agreed labeling of cleaning products should include appropriate manufacturer's EPA labeling of what chemical was inside the bottle.</p> <p>*The label should also include information needed if an accident or hazard were to have occurred.</p> <p>Review of the provider's undated Dilution Ratio's worksheet policy received from the provider on 6/2/16 revealed:</p> <p>*All chemicals would be utilized per manufacturer's recommendations and in the original containers.</p> <p>*If the chemicals were to be placed in a container other than the original, the container must be labeled with the product contents.</p>	S 125	recommendations monthly for three months.	7/1/16
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121</p> <p>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 5/31/16 through 6/2/16. Tieszen Memorial Home was found in compliance.</p>	S 000		