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

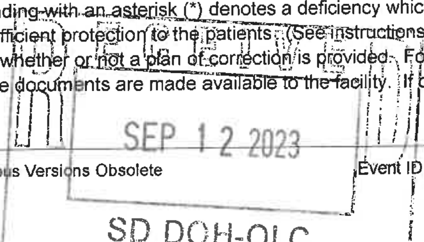
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. BUILDING ______ B. WING ______	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/21/23 through 8/23/23. Tieszen Memorial Home was found not in compliance with the following requirement: F609.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson/ Laura Wilson	Administrator	9/6/2023 9/12/23

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



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	435069	A. BUILDING ______ B. WING ______	08/23/2023

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

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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure two of two resident-to-resident altercations had been reported to the South Dakota Department of Health (SD DOH) in the designated time frame for one of one sampled resident (6). Findings include: 1. Review of resident 6's medical record revealed: *Diagnoses of the following: Sensorineural hearing loss, bilateral, major depressive disorder, epilepsy, and chronic pain. *Her most recent Brief Interview of Mental Status (BIMS) examination score was 14 indicating she was cognitively intact. *The care plan updated on 7/19/23 for physically aggressive behavior: -Do not argue with the resident. -Refer to Social Services for evaluation. -Reinforce unacceptability of verbal abuse. -Remove from public area when behavior was disruptive and unacceptable. -Monitor and document target behaviors. -Assist in selection of appropriate coping mechanisms. Review of resident 6's nursing progress notes on the following dates revealed: *7/9/23 6:08 p.m. "resident [resident 6 name] slapped resident [resident 10 name] when resident B exited the bathroom because she was taking to long and [resident 6 name] needed to use the bathroom." *Registered Nurse (RN) C, "unusual occurrence completed and social services notified." *7/10/23 9:31 a.m. "unusual report due to resident	F 609	Any and all unusual occurence reports that are completed as it pertains to resident to resident altercations with Resident #6 will be reported to SD Dept of Health in the designated time frame as required by this regulation if it involves abuse, neglect, exploitation or mistreatment. It will be reported by the licensed nurse on duty at the time of the incident and the social services coordinator will complete the follow-up of the incident in the time frame required. The administrator has updated the unusual occurrence report to indicate the need for the report to the SD Dept of Health. The Social Services Coordinator will maintain a list of all of the unusual occurrence reports that involve a resident to resident altercation and monitor to ensure the report has been filed if it meets the criteria for submission. The Social Services Coordinator will submit the report to the administrator on a weekly basis to review for compliance and will also submit the report to the monthly Quality Assurance and Performance Improvement meeting for their review and further recommendations. Addendum: The facility administrator has provided education to the Social Services Coordinator and facility nursing staff on the reporting requirements of resident-to resident altercations, abuse, neglect, and misappropriation of property as well as updated the policy/procedure for reporting unusual occurrences timely.	9/12/23 9/12/23

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F 609	Continued From page 2	F 609		

hitting roommate. Communicated with resident and explained not to use violence. Talk to a nurse or myself when frustrated." social services E.
*7/19/23 2:34 p.m. "Resident hit another resident in the face. Witnessed by another resident's family member who told [name] Activity Assistant, what happened. Watched video on CCTV with [administrative assistant name] and [resident 6 name] did hit another resident on the face. When I asked her why, she communicated with me that she did not and it was a lie. A report was made to the charge nurse." social services E.

Interview on 8/22/23 at 3:12 p.m. with certified nursing assistant (CNA) H in regards to resident to resident incidents revealed she would:
*Separate the individuals.
*Get another employee to supervise for the safety of the residents.
*Notify the charge nurse to investigate and document the situation.

Interview on 8/23/23 at 8:56 a.m. with licensed practical nurse (LPN) F in regards to resident to resident incidents revealed she would:
*Separate the individual.
*Assess for injuries.
*Notify the director of nursing (DON) and social services.
*Document in the chart and fill out an incident report.
*Report it to the state.

Interview on 8/23/23 at 2:01 p.m. with social services E revealed she:
Was aware of the two incidents with resident 6 in July 2023.
Was not aware that resident to resident altercations should have been reported to the SD

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F 609	Continued From page 3	F 609		

DOH.
Had set up a behavior counseling appointment for resident 6 after the incident occurred on 7/19/23.

Interview on 8/23/23 2:46 p.m. with DON B in regard to resident to resident incident reporting revealed:
*Staff completed an incident report and then it would have been forwarded to herself or social services.
*Social Services usually reviewed the resident to resident and elopement incidents.
*Nursing reviewed the falls and falls with injury.
*Incidents were reviewed and discussed at the unusual occurrence meeting.
*She was not aware the incidents for resident 6 had not been reported to SD DOH.
* Her expectation was resident to resident incidents should have been reported.

Review of the provider's undated policy/procedure for resident abuse and neglect revealed:
*"The Corporation, in accordance with the Federal Rules, will not tolerate Resident abuse or Neglect. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, or staff of other agencies serving the individual, family members or legal guardians, friends, or any other individuals. The policy is clarified as follows: ...
Any act that is suspicious of abuse will be reported to the South Dakota Department of health within 24 hours."

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 8/21/23 through 8/23/23. Tieszen Memorial Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Wilson	Administrator	8/31/2023

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RECEIVED
AUG 31 2023
SD DOH OLC

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	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	08/22/2023

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/22/23. Tieszen Memorial Home (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/24/23. Please mark an F in the completion date column for K241 identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain the one-hour fire resistive rating of vertical openings in the following: *The west stair enclosure walls did not extend to the underside of the roof deck of the 1976	K 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Wilson
TITLE: Administrator
(X6) DATE: 8/31

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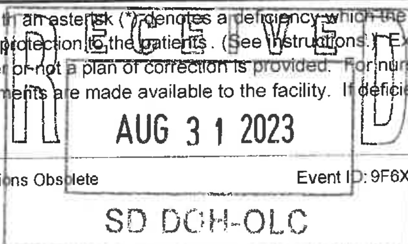

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	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/22/2023**

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K 241	Continued From page 1 addition. *The north basement stair enclosure door was equipped with a twenty-minute, fire-resistive door assembly. *The east and west stair enclosure doors were not provided with labels and contained glass vision panels. Findings include: 1. Observation on 8/22/23 at 12:37 p.m. revealed a twenty-minute, fire-resistive door assembly had been installed in the north stair enclosure from the basement. Review of the previous life safety code survey revealed the original one and three-fourth inch metal door had been replaced with the present door approximately eight years ago. 2. Observation on 8/22/23 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 8/22/23 at 3:36 p.m. revealed the west stair enclosure walls did not extend to the underside of the roof deck. Further observation revealed the exterior window was exposed to the 1976 addition roof. Review of the previous life safety code data identified that had been part of the original construction. 4. This deficiency affected the second-floor smoke compartment and a maximum of twenty-two residents with accompanying staff.	K 241		

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	435069	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/22/2023**

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

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 ______	08/23/2023

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/21/23 through 8/23/23. Tieszen Memorial Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/21/23 through 8/23/23. Tieszen Memorial Home was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 8/31/2023