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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 East State St Marion, SD 57043

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 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 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 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 (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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 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 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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. 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 [DATE]. 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 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]. 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [NAME] 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 [NAME] Memorial Home or [NAME] 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 East State St Marion, SD 57043

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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 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 [NAME] 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 1/2 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 1/2 side rails continues to be appropriate for the resident being evaluated.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 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. 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.