Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375362	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shanoan Springs Nursing and Rehabilitation	2500 South 12th Street Chickasha, OK 73018

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. On 03/24/26, a past noncompliance Immediate Jeopardy (IJ) situation was determined to have existed related to the facility's failure to ensure Res #3 received a mechanically soft diet without bread per physician order. Res #3 was provided a grilled cheese sandwich and side salad for an evening meal, which resulted in a choking episode requiring emergency services.On 03/24/26 at 3:15 p.m., the OSDH was notified and verified the existence of the past noncompliance IJ related to the facility's failure to ensure residents received physician ordered therapeutic diets.On 03/24/26 at 3:28 p.m., the administrator was notified of the immediate jeopardy situation.Based on observation, record review, and interview, the facility failed to ensure a resident received a physician ordered mechanical soft diet without bread for 1 (#3) of 3 sampled residents reviewed for therapeutic diets.The dietary manager identified 22 residents received therapeutic diets.Findings:On 03/23/26 at 11:35 a.m., dietary staff were observed preparing residents' lunch trays. Nursing staff were observed verifying the accuracy of physician-ordered diets prior to tray service.On 03/23/26 at 11:55 a.m., Res #3 was observed seated in a wheelchair in the dining room. Nursing staff were observed providing a mechanically soft lunch meal per physician order. Res #3 was observed consuming the meal independently without signs or symptoms of swallowing difficulty or choking.On 03/24/26 at 12:15 p.m., Res #3 was observed seated in a wheelchair in the dining room, independently consuming a mechanically soft lunch meal without signs or symptoms of swallowing difficulty or choking.The facility self-identified non-compliance on 03/11/26 and suspended dietary staff involved in the incident pending investigation. The facility implemented the following measures in response to the noncompliance:Immediate diet order audit completed for all residents to ensure that no additional meals were served without verification of the residents ordered diet consistency on 03/11/26.A monitoring tool was implemented for the next meal service and on-going to verify meal trays matched physician ordered diets for all residents on 03/11/26.Registered dietician observed dietary preparation processes and provided additional re-education as needed on 03/12/26 and 03/16/26.Scheduled dining room nursing assignments to increase staff presence and supervision during meal service on 03/12/26.A multi-disciplinary quality assurance meeting was conducted, and a root cause analysis was completed to determine contributing factors and identify improvements needed to prevent recurrence on 03/13/26.Speech therapy assessed Res #3 and added gravy/sauce to ground meat items to improve moisture and aid in swallowing on 03/14/26. Res #3 had continued monitoring during meals to ensure safety with updated dietary modification.Dietary/nursing staff in-serviced on the importance of following physician-ordered diets on 03/16/26. A two-step meal tray verification policy implemented requiring dietary staff to verify diet orders and tray accuracy during tray preparation and nursing staff to conduct a second verification prior to tray delivery to residents on 03/16/26.An undated Providing Medical Nutrition Therapy policy, read in part, Therapeutic diets will be served according to doctor order.An undated medical diagnoses sheet for Res #3 showed the resident was admitted with medical diagnoses which included cerebral infarction, dysphagia, and dementia.A physician order for Res #3, dated 08/27/24, showed mechanical soft texture diet with no bread.A quarterly assessment for Res #3, dated 12/24/25, showed the resident was severely (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

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cognitively impaired with a BIMS score of 5. The assessment showed the resident required a mechanically altered diet and set-up assistance with eating.A care plan for Res #3, revised 01/04/26, showed the resident had a potential nutritional problem related to dysphagia and cognitive deficits with an intervention to serve a mechanically altered diet with no bread as ordered.An OSDH incident report form, dated 03/11/26, showed Res #3 was observed in the dining room unable to move air effectively during dinner meal. The report showed nursing staff began abdominal thrusts and were unable to clear obstructing food. Res #3 was sent to the hospital via EMS. The report showed Res #3 was served a grilled cheese sandwich and a side salad for evening meal. The report showed the dietary staff had not served Res #3 a mechanically soft textured diet without bread.An emergency department note, dated 03/11/26, showed the resident presented to ER from nursing home for choking episode. The note showed supplemental oxygen, a breathing treatment, and suction were administered revealing a small piece of lettuce.A nurse note for Res #3, dated 03/11/26, showed the resident returned to the facility alert and talking with staff. The note showed Res #3 stated they felt better.On 03/23/26 at 11:40 a.m., cook #1 stated they had prepared Res #3's dinner tray on 03/11/26 and acknowledged misreading the dietary card, resulting in the provision of an incorrect diet.On 03/23/26 at 11:45 a.m., the dietary manager stated Res #3 received an incorrect diet due to inadequate staff education regarding therapeutic diets. The dietary manager stated the cook and dietary aide should have recognized that the meal items were not consistent with a mechanically soft diet and should not have been served.On 03/23/26 at 12:45 p.m., dietary aide #1 stated they provided Res #3 with the incorrect diet. Dietary Aide #1 stated they questioned whether a grilled cheese sandwich and salad were appropriate for a mechanically soft diet; however, the cook confirmed the items were appropriate at that time.On 03/24/26 at 11:00 a.m., the administrator stated the cook and dietary aide had not received adequate training and, as a result, provided an improperly textured meal to Res #3. The administrator stated Res #3's physician-ordered mechanically soft diet did not include bread or salad. The administrator stated the dietary staff involved were immediately suspended and re-educated on therapeutic diet requirements.On 03/24/26 at 11:05 a.m., Res #3 stated they experienced a choking episode during dinner several days prior, which required hospital intervention for removal of the obstructing food. Res #3 stated symptoms resolved immediately following the intervention and denied any prior or subsequent choking episodes.Through staff interviews and record review, including in-service documentation and monitoring logs, it was determined the facility achieved compliance as of 03/16/26.