STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	**803 PARK STREET POST OFFICE BOX 139, LAKE NORDEN, South Dakota, 57248**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/16/26 through 2/19/26. The areas surveyed was quality of care, nursing services, and resident rights. Avantara Lake Norden was found not in compliance with the following requirements: F760, and past noncompliance was found at F803. On 2/18/26 at 12:59 p.m., an Immediate Jeopardy was identified for a facility reported incident (FRI) related to the quality of care and treatment that occurred on 2/11/26 at 12:59 a.m. for a resident who was served the wrong diet and required life-saving measures in an attempt to dislodge the food he choked on. The investigation revealed verbal and written education was initiated on 2/11/26 for the staff, and the resident's dietary information was changed to the correct diet on the snack cart for staff to follow. Those implemented processes allowed for the immediacy to be removed. Substantial compliance was confirmed on 2/19/26 at 2:58 p.m. after review of the provider's Quality Assurance and Performance (QAPI)/Quality Assessment and Assurance (QAA) minutes, documented staff education, audit information, observation of the kitchen, changes made to the snack cart and clipboards with the snack carts. Continued observations of the dining service, observations of resident meal tickets, and interviews with staff. The provider was found to have past non-compliance at F803 related to the provider's failure to ensure a physician-ordered resident diet was followed which required staff to perform the Heimlich maneuver [life-saving measure used to clear a blocked airway] on resident 1. On 2/19/26 at 3:50 p.m. the Immediate Jeopardy template was electronically emailed to administrator A for reference and review. Census: 47	F0000		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F0760		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 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
Margaret Grimm Margarert Grimm	Administrator	03/10/2026; 3/12/2026

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F0760 SS = E	Continued from page 1 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported (FRI), observation, interview, record review, and policy review, the provider failed to ensure: Ten of forty-six sampled residents (3,4,5,6,7,8,10,11, and 13) had received their hour of sleep (HS) medications and Two of forty -six sampled residents (9 and 12) had recived the morning medicatons per physicians orders by one of of one licensed vocational nurse (LVN) J. *One of one LVN J had folowed physcian orders and applied a pain patch at the correct dosage for one one resident (2). Findings include: 1. Review of the providers 9/9/25 SD DOH FRI involving residents (2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13) revealed: *On 9/9/25 at 7:30 a.m., a resident reported she had received her medications that morning. *An audit was conducted by registered nurse (RN) F and indicated residents on the main floor and Alzheimer Care unit (ACU) had their medications signed out on their electronic medication administration record (EMAR), indicating that the residents had received those medications. *The audit for the ACU revealed that 6 out of 7 residents' medication cards still contained their medications in the bubble cards on 9/8/25 for the (HS) med pass. *The audit for the main floor revealed that 2 residents had not received their medications even though they were signed out on their EMAR on 9/9/25 for the morning med pass. *The residents had been assessed by RN F and the director of nursing (DON) B for any adverse outcomes after they had not received their HS and morning medications. No negative outcome was identified. *Resident 2, who had received the incorrect dose of Fentanyl, had been monitored and had no negative	F0760	1. Investigation of missed medication administration was completed on all residents on September 9, 2025. This included the affected residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13. Doctor and families were notified. Residents were assessed and monitored for adverse side effects. All residents are at risk for medication variances. 2. Director of Nursing (DON) provided education and completed Medication Competencies on each licensed nurse on February 25, 2026. All nurses will be re-educated by the DON or designee on medicaiton administration policy no later than April 1, 2026. 3. The Medication Administration Record will be audited by the DON or designee to ensure medications are administered to residents per physician order and that the staff understand the training. Nurses will be audited during medication administration times to ensure medications are administered per doctor orders by the DON or designee. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting and continued until the facility demonstrates sustained compliance as determined by committee.	April 1, 2026

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F0760 SS = E	Continued from page 2 outcomes. *LVN J, who had worked had been blocked from returning to the facility to work. *The physicians and the resident responsible parties had been notified. 2. Interview and observation on 2/18/26 at 7:56 a.m. with RN F revealed: *She worked full-time on the day for 21 years. *She explained that the medication cards have 30 bubbles for 30 days' worth of medications. She checked the medication card against the resident's name and punched the medication out of the bubble into a cup. She clicked “save” on the computer after the resident had taken their medication, and it turned green, which indicated completion. She stated that if the medications were not saved as administered, the medications would turn red. She stated that the red would have been noted at the end of her shift as something she had missed. She stated after she gave the medication, she placed the cards for that resident at the back of the row. Each medication pass is indicated on the medicaton card with a colored sticker on each of them. The stickers had a.m., p.m. or HS on them. She stated that if she had come to work in the morning and noticed that a resident's medication for HS was remaining at the front, that would have indicated those HS medications were never given. 3. Observation and interview on 2/18/26 at 8:20 a.m. with LPN G revealed: *She had worked at the facility since August 2025. *She completed the narcotic count for the main unit with this surveyor. *The completed shift-to-shift count of narcotics with the oncoming and the nurse going off shift to ensure they were accounted for. *The narcotics were accounted for by their count. When a new medication was brought into the facility for a resident, the medications are counted and noted, and subtracted each time it is administered to the resident. *She stated that the regular medication cards are in the medication cart, per each resident's name, and	F0760		

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F0760 SS = E	Continued from page 3 separated by a.m., p.m., and HS shift. She could have seen if a medication was not administered if the medication had not been punched out for that date. The medication would have been left in the bubble pack for that date. The medication would have been left in the bubble pack for that date. She had reported a concern regarding medications left in a bubble pack in the past to the DON, but she had not seen that happen again. She stated she was not sure if that person still worked at the facility, as she didn't know who had done it. 4. Interview on 2/19/26 at 2:20 p.m. with DON B and administrator A, revealed: *DON B stated she was not currently auditing bubble cards for medication errors. *She stated she had not had problems with medications that had been signed off in the EMAR and left the medication in the bubble cards before the incident of 9/8/25 and 9/9/25. *She stated that that LVN J had been blocked immediately from all of their facilities, and the contract agency had been notified. *LVN J had started on 9/5/25 and had only worked one day and that was the was the date of the incident 9/8/25. *She stated she gets calls or text messages from her staff all the time. She stated that, depending on the situation she would have decided if that situation warranted her to come in right away. She had come in later that morning after receiving report regarding the patch. She stated she then discovered the HS medication cards were not moved to the back of the medication cards which indicated the medications had not been given for the HS on 9/8/25 and the morning on 9/9/25. She would run reports so that she could tell if medications had been missed because they would be in red. LVN J had signed them out on the EMAR that they had been given but the medications were still in the medication cards. *DON B and Administrator A agreed that the dose of Fentanyl that was given to the incorrect resident (2) was a lot. The DON stated that due to that dose, the resident had been monitored a lot after that with no negative outcome. 5. Review of the resident's (EMR) who had medication	F0760		

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F0760 SS = E	Continued from page 4 errors on 9/8/25 and 9/9/25 by by LVN J revealed: *Resident 2 was admitted to the facility on 2/16/22. -She had a Brief interview for mental status (BIMS) score of 3, which indicated severely impaired cognition. -She had a physician's medication order for a Fentanyl (pain medication absorbed through the skin) Patch 12 MCG/HR (micrograms/hour) every 72 hours and had received the wrong dose of 25 MCG on 9/8/25. -She had no documented negative outcomes. *Resident 3 was admitted to the facility on 9/30/24. -She had a BIMS score of 6 that indicated severe cognitive impairment. -She had a physician's order for Dilantin (antiseizure), Terazosin (blood pressure), Calcium (supplement), Olanzapine (antipsychotic), Oxcarbazepine (antiseizure), Depakote (seizures), Hydralazine (blood pressure), Seroquel (antipsychotic), and Lactulose (lower ammonia levels) that she had not receive d on 9/8/25, but had been signed out on the EMAR as given. -She had no documented negative outcomes. *Resident 4 was admitted to the facility on 9/5/25. -She had a BIMS score of 15 that indicated her cognition was intact. -She had medication orders for Protonix (reflux), Crestor (lower cholesterol), Venlafazine (antidepressant), Buspar (anxiety), Eliquis (blood thinner), Sulfasalazine (ulcerative colitis), Calcium (supplement), and Loperamide (chronic diarrhea). She had not received those medications, but they were signed out on her EMAR as given. -She had no documented negative outcomes. *Resident 5 was admitted to the facility on 6/19/25. -He had a BIMS score of 2 that indicated his cognition was severely impaired. -He had physicians' medication orders for Donepezil (manage cognitive symptoms), Tamsulosin (decrease frequent urination), Trazodone (depression), and Metformin (lower blood sugars) that he had not	F0760		

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F0760 SS = E	Continued from page 5 received, but were signed out on his EMAR as given. -He had no documented negative outcomes. *Resident 6 was admitted to the facility on 3/28/24. -He had a BIMS score of 10 that indicated he had moderately impaired cognition. -He had physicians' medication orders for artificial tears (dry eyes), Melatonin (regulates body's sleep – wake cycle), and Trazodone (depression) that he had not received, but they were signed out on his EMAR as given. -He had no documented negative outcomes. *Resident 7 was admitted to the facility on 5/30/24. -He had a BIMS score of 11 that indicated he had moderately impaired cognition. -He had a physician's medication order for Tamsulosin (decrease frequent urination) and Trazodone (depression) that he had not received, but they had been signed out on his EMAR. -He had no documented negative outcomes. *Resident 8 was admitted to the facility on 4/16/26. -She had a BIMS score of 00 that indicated she had severe cognitive impairment. -She had a physician's medication order for Gabapentin (nerve pain medication) that she did not receive, but it was signed out on the EMAR as given. -She had no documented negative outcomes. *Resident 9 was admitted to the facility on 3/3/25. -He had a BIMS score of 12 that indicated his cognition was moderately impaired. -He had a physician's medication order for Synthroid (treat low thyroid hormone), Flonase (nasal spray for nasal congestion), Prilosec (treats heartburn), and Tylenol (pain reliever) that he did not receive but they were signed out on his EMAR as given. -He had no documented negative outcomes. *Resident 10 was admitted to the facility on 8/1/25.	F0760		

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F0760 SS = E	Continued from page 6 -He had a BIMS score of 7 that indicated he had severe cognitive impairment. -He had a physician's medication order Synthroid (treat low thyroid hormone), Tamsulosin (treat frequent urination), Trazodone (depression), Clonazepam (treat panic disorders), and Fluticasone (treat itchy, runny/stuffy nose) that were signed outon the EMAR as given. -He had no documented negative outcomes. *Resident 11 was admitted to the facility on 7/25/24. -He had a BIMS score of 00 that indicated he had severe cognitive impairment. -He had physicians' medication orders for Depakote (treat seizures), Hydroxyzine (antihistamine), Melatonin (regulates sleep/wake cycle), and Trazodone (treat depression) that he had not received, but they were signed out on his MAR as given. -He had no documented negative outcomes. *Resident 12 was admitted to the facility on 12/6/24. -She had a BIMS score of 15 that indicated her cognition was intact. -She had physicians' medication orders for Gabapentin (nerve pain reliever), Protonix (treat reflux), and Synthroid (treat low thyroid hormone) that she had not received, but they were signed off on her EMAR as given. She had no documented negative outcomes. *Resident 13 was admitted to the facility on 1/29/25. -She had a BIMS score of 2 that indicated her cognition was severely impaired. -She had a physician's medication order for Prilosec (treat heartburn) that she had not received, but it was signed off on her EMAR as given. -She had no documented negative outcomes. 6. Review of the provider's undated Medication Administration Policy revealed:	F0760		

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F0760 SS = E	Continued from page 7 *"B. Administration" *"2) Medications are administered in accordance with written orders of the prescriber." *"15) Medications supplied for one resident are never administered to another resident." *"D. Documentation (including electronic)." *"1) The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. *"6) If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other that the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is [initialed and circled]. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. An explanatory note is entered on the reverse side of the record. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response."	F0760		
F0803 SS = J	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F0803	"Past Noncompliance - no plan of correction required"	

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F0803 SS = J	Continued from page 8 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure a physician orders for a therapeutic pureed (blended food) diet was followed for one of one sampled resident (1) who had a diagnosis of dysphagia (difficulty swallowing) and received a snack from one of one certified nursing assistant (CNA) (D) that was not the right texture and then required life-saving measures through use of the Heimlich maneuver after the food became lodged in his throat. On 2/18/26 at 12:59 p.m., an Immediate Jeopardy was identified for a facility reported incident (FRI) related to the quality of care and treatment that occurred on 2/11/26 at 12:59 a.m. for a resident who was served the wrong diet and required life-saving measures in an attempt to dislodge the food he choked on. The investigation revealed verbal and written education was initiated on 2/11/26 for the staff, and the resident's dietary information was changed to the correct diet on the snack cart for staff to follow. Those implemented processes allowed for the immediacy to be removed. Substantial compliance was confirmed on 2/19/26 at 2:58 p.m. after review of the provider's Quality Assurance and Performance (QAPI)/Quality Assessment and Assurance (QAA) minutes, documented staff education, audit information, observation of the kitchen, changes made to the snack cart and clipboards with the snack carts. Continued observations of the dining service, observations of resident meal tickets, and interviews with staff. The provider was found to	F0803		

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F0803 SS = J	Continued from page 9 have past non-compliance at F803 related to the provider's failure to ensure a physician-ordered resident diet was followed which required staff to perform the Heimlich maneuver [life-saving measure used to clear a blocked airway] on resident 1. On 2/19/26 at 3:50 p.m. the Immediate Jeopardy template was electronically emailed to administrator A for reference and review. After the immediacy was removed on 2/19/26 at 2:58 p.m. the scope and severity was lowered from a J to a G. Findings include: 1. Review of the 2/11/26 SD DOH FRI regarding resident 1 revealed: *On 2/11/26 at 12:56 a.m. resident 1 was walking in the main lobby and stated he was hungry. *Certified nursing assistant (CNA) D had him sit down at a table by the nurse's station and handed him an Uncrustable sandwich (a prepackaged peanut butter and jelly sandwich without the crust). *Resident 1 had taken three bites and at 12:59 a.m. resident 1 set the Uncrustable sandwich on the table and stood up. *CNA D went to resident 1 and asked him if he was choking, resident 1 did not respond. *CNA D had given resident 1 back blows and called licensed practical nurse (LPN) E for assistance. *LPN E immediately came and began administering the Heimlich maneuver to resident 1. *Resident 1 was assisted to sit in a chair at 1:01 a.m. and LPN E continued to administer the Heimlich maneuver until he took a couple gasps of air. *At 1:04 a.m. resident 1 was transferred to the floor and laid on his side, he made a noise and began spitting phlegm. *CNA D was able to visualize food in his mouth. *She reached into his mouth and was able to grasp remnants of the Uncrustable sandwich and pulled them	F0803		

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F0803 SS = J	Continued from page 10 out of his mouth. *Resident 1 was assisted by LPN E to sit up and take sips of thickened liquid. *At 1:12 a.m. resident 1 was assisted to a dining room chair. *His vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse and respiration rate) were taken. His temperature was 96.9, pulse 64, respirations 20, blood pressure 158/76 and his oxygen saturation (percentage of oxygen in the blood) was 95 percent. *Resident 1's voice was a little raspy, he was assisted to the bathroom and then returned to the dining area to a recliner chair for further monitoring. *Resident 1's family, physician, and hospice program were notified of the incident. *CNA D and LPN E were suspended pending investigation for not providing resident 1 with the correct diet texture food. 2. Review of resident 1's electronic medical record (EMR) revealed: *His 11/24/25 Brief Interview for Mental Status (BIMS) assessment score was 0 indicating severe cognitive impairment. He was dependent upon the staff to ensure his physician orders were followed for his safety and well-being. *He was admitted to the facility on 1/31/24. *He was admitted to hospice services on 11/18/25. *His diagnoses included: Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body function), restlessness and agitation, delusional disorder, and depression. *A 11/22/25 quarterly nutritional assessment indicated he was on regular puree textures with thin liquids diet, had dysphagia, and had coughing or choking during meals or when swallowing medications. *A 11/24/25 physician's code status order for DNR (do not resuscitate)/DNI (do not intubate).	F0803		

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AVANTARA LAKE NORDEN	803 PARK STREET POST OFFICE BOX 139, LAKE NORDEN, South Dakota, 57248

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F0803 SS = J	Continued from page 11 *On 11/28/25 a physician-order was entered and his diet for regular, puree (level 1) texture remained the same, but his liquids were changed to nectar-thickened liquids. 3. Interviews on 2/18/26 at 10:35 a.m. and again on 2/19/26 at 10:49 a.m. with dietary manager (DM) H regarding the 2/11/26 FRI revealed: *She was notified on 2/11/26 at 8:30 a.m. of the choking incident with resident 1. *She added designated bins for puree and mechanical soft texture diet to the snack cart. *She added a posted list in the kitchen on the wall by the snack cart. *She updated the clipboard (contains diet information for residents) for the snack cart that now contains the correct diet texture. *She also added the allowable and not allowed foods education to the clipboard for the mechanical soft and puree diet textures. *Uncrustable sandwiches were not sent out on the snack cart. *Staff must go into the kitchen and get Uncrustable sandwiches from the refrigerator when requested. *She had completed education since the above incident occurred on 2/11/26, and all dietary staff had completed the education also on 2/11/26. *She completed audits regarding if the meal ticket was left with the meal, did the ticket and the meal match for diet ordered, was the meal the right texture, were the liquids the correct consistency, and was the correct adaptive equipment in place, at least weekly. *She audited to ensure there were back up bins in the refrigerator for snacks, labeled properly. She had ensured dietary staff had completed education on 2/11/26 regarding the new bins being used, and ensuring textures of the diets ordered for residents through her performed audit. 4. Interview on 2/18/26 at 11:30 a.m. and 2/19/26 at 10:30 a.m. with LPN E revealed:	F0803		

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F0803 SS = J	Continued from page 12 *She had worked the overnight shift on 2/10/26 at 6:00 p.m. until 2/11/26 at 7:00 a.m. *Resident 1 is awake most nights. *CNA D had given resident 1 an Uncrustable sandwich at the table. *LPN E had known that resident 1's ordered diet was regular puree texture with nectar-thickened liquids. *CNA D had reported to her that resident 1 was choking, and LPN E started the Heimlich maneuver on him while standing, then sat him in a chair while continuing the Heimlich maneuver. *Before finally placed resident 1 on the floor and switched to chest thrusts. *Resident 1 had made a noise, *LPN E and CNA D could see a piece of sandwich and CNA D performed a finger sweep, and removed the sandwich piece from his mouth. *LPN E continued to remove more small remnants after the first piece was removed. *CNA D had gone into the kitchen and got the Uncrustable sandwich for resident 1. *She had been aware that CNA D was giving resident 1 the Uncrustable sandwich because CNA D had asked if it was okay, and she had not answered CNA D. *Resident 1 had eaten the Uncrustable sandwiches before without problems. *She had been a nurse for thirty years, she was thankful she performed the Heimlich maneuver, and it was successful. *She had received a lot of education since the 2/11/26 incident on what a mechanical diet and puree diet consists of. She also received education on changes to the kitchen snack cart. That education included that it now had labeled bins with items safe for puree texture and mechanical soft texture diets, and allowable and not allowed list attached to the clipboard that is on the snack cart. All the residents were listed with their diets. diet texture and fluid consistency. *She monitored resident 1 in the sitting area by the nurse's station the remainder of her shift. No other	F0803		

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F0803 SS = J	Continued from page 13 interventions were initiated. *She had completed Basic Life Support training on 2/17/25. *She had notified administrator A and director of nursing (DON) B on 2/11/26 at around 7:00 a.m. via text message. *She had notified family representative and physician on 2/11/26 at 6:49 a.m. 5. Interview on 2/18/26 at 1:30 p.m. with CNA D revealed: *She worked the overnight shift on 2/11/26. *She had asked LPN E what to get resident 1 for a snack and she suggested the Uncrustable sandwich. *After giving resident 1 the Uncrustable sandwich, she observed him stand-up from the table. *She had asked him if he was choking. *Resident 1 did not answer, and she gave back blows. *LPN E came over and started the Heimlich maneuver on resident 1. *She thought resident 1 might have passed out so they placed him on the floor, then LPN E completed abdominal thrusts. *She saw a chunk of the sandwich in resident 1's mouth and removed it. *She had given resident 1 Uncrustable sandwiches before the above incident and he had no problems with eating it. *She was aware resident 1's diet was regular puree texture with nectar thickened liquid. *She was able to find resident diet orders on the Kardex (a report of the resident's care needs and interventions). *She received education on 2/11/26 at 3:30 p.m. from assistant director of nursing (ADON) F, and there are signs in the kitchen about what is acceptable for residents who have mechanical soft texture and puree texture diets.	F0803		

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F0803 SS = J	Continued from page 14 *She had completed Obstructive Airway-Choking training on 12/4/25. *She had received a disciplinary warning and signed an acknowledgement of the required education following the above incident. 6. Interview on 2/19/26 at 9:58 a.m. with speech language pathologist (SLP) H revealed: *She had seen resident 1 from 9/12/25 through 10/2/25. *He was on a mechanical soft texture diet at that time. *Resident 1 was unresponsive to cues and so his diet was downgraded to regular puree diet with nectar thickened liquids. *She had not received a request from the facility for further evaluation after the 2/11/26 choking incident. *The facility might not have requested further evaluation due to resident 1 already being regular puree diet with nectar thickened liquids. *She agreed that resident 1 should not be eating Uncrustable sandwiches as that is mechanical soft texture consistency. 7. Interview on 2/19/26 at 11:03 a.m. with assistant director of nursing (ADON) I revealed: *She was notified of resident 1's choking incident on 2/11/26 at 9:30 a.m. when she arrived at the facility. *She ensured that the family and physician had been notified. *She started initial verbal education for staff working, after receiving additional information by email communication with administrator A on 2/11/26 at 10:12 a.m. and the education was completed before 12:00 p.m. when lunch was served to residents. *Education for all staff was started after 12:30 p.m. following further communication from the corporate meeting. *All staff were given the required education on 2/11/26 at a 2:00 p.m. staff meeting.	F0803		

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F0803 SS = J	Continued from page 15 *Staff who were unable to attend were sent the education materials and documents via text message and had to acknowledge receipt of the education. *Two as needed (PRN) staff were sent a letter containing the information by certified mail. 8. Interview on 2/19/26 at 2:48 p.m. with DON B revealed: *She and administrator A were the primary contacts for emergencies. *She would then notify other staff needing to be notified of incidents. *She and administrator A were notified via text message on 2/11/26 at 7:15 a.m. by LPN E of resident 1's choking incident. *LPN E should have called as soon as resident 1's choking incident happened. *LPN E had received disciplinary action after the incident. *She had not asked for a speech evaluation following resident 1's choking incident because he had one that was completed one month before. His diet order was regular puree diet with nectar-thickened liquids, and he was on hospice and comfort care already. *Neither she nor administrator A was in the building on 2/11/26. *Education to all staff started 2/11/26 around 10:12 a.m. with an email to ADON I regarding dietary changes and what to include in initial education for mechanical soft and puree diets for staff. *Information was added to the snack cart clipboard about allowable and not allowable food items for mechanical soft and puree texture diets. *Staff know resident diet orders by looking at the Kardex, meal tickets, care plans and the resident diet order. *She and administrator A were in contact with the corporate office on 2/11/26 at 12:30 p.m. and notified ADON I of the final education for staff and the added dietary changes on the snack cart clipboard.	F0803		

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F0803 SS = J	Continued from page 16 *The first interventions were put in place on 2/11/26 at 12:00 p.m. before the noon meal to protect all residents before their lunch was served by ADON I. *She and administrator A both completed QAPI for the facility. *Through QAPI audits will be reviewed: -How many were completed. -The retraining needs of staff. -What corrections are needed. *Audits were to continue until full compliance is obtained and were to continue for at least three months. *The audits will be re-evaluate and adjusted if non-compliance within the audits is found. *Further steps included re-education of staff, with audits completed every time they work. 9. Review of the provider's Pureed diet policy revealed: *"General Information: This modification is designed for people who have severe chewing and /or swallowing problems. Properly pureed foods eliminate the chewing phase. Pureed diet menus follow the foods on the regular menu as closely as possible and differ primarily in consistency. Puree all foods to smooth, lump-free, Extremely Thick consistency (not firm or sticky). Use an appropriate recipe. This diet is also appropriate for Dysphagia Pureed (Level1)." *"Transitional foods are NOT allowed unless assessed and ordered by the SLP and/or a physician." *A detailed plan of action was completed by the facility on 2/11/26 related to resident 1's choking incident. The plan was based on Root Cause Analysis of the FRI and resulted in the development of multiple performance improvement plans. -These plans include systemic changes and actions with all staff's education and re-training. Audits on staff	F0803		

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F0803 SS = J	Continued from page 17 awareness of resident diet textures as ordered by physicians. Updated snack cart clipboard with diet texture information for staff, allowable and not allowed foods for mechanical soft texture and puree texture diets. Labeling of new bins with stocked approved snacks for snack carts for mechanical soft and puree texture diets. Back-ups bins in refrigerator in kitchen which will be audited by DM H. The changes and actions were confirmed on 2/19/26 through observation, interview and review of the Provider's Plan of Correction documentation. Based on the above information, non-compliance at F803 occurred on 2/11/26. Based on the provider's implemented plan of correction for the deficient practice confirmed on 2/19/26, the non-compliance is considered past non-compliance.	F0803		