STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035101	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Post Acute and Rehabilitation	2121 West Elgin Street Chandler, AZ 85224

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited: 1Based on observations, record review, staff interviews, review of facility documents, policy, [NAME] Nursing Drug Book, and Medlineplus.gov website, the facility failed to ensure medications for one resident (#14) were administered as ordered by the physician and according to accepted standards of clinical practice. The deficient practice could place residents' safety at risk.Findings include:Resident #14 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, hypoglycemia, and Post-Traumatic Stress Disorder.The care plan dated December 7, 2023, revealed the resident had Diabetes Mellitus. The interventions included diabetes medication as ordered.A physician order dated February 6, 2024 revealed an order for Metformin Hydrochloride (HCL) 500 MG tablet give one tablet by mouth with meals for diabetes. And, another physician order with a revision date of July 16, 2024 revealed an order to OK to crush and combine crushable medications and mix with applesauce/pudding or drink.On December 11, 2025, at 6:20 AM, a medication administration observation was conducted with a Licensed Practical Nurse (LPN/Staff # 468). Staff #468 prepared Metformin 500 milligram (MG) one tablet. Staff #468 crushed the Metformin tablet and mixed it with a spoon of pudding in the medication cup, and then administered the medication to Resident #14 in her room.A review of the Medication Administration Record (MAR) for December 2025, revealed Metformin HCL 500 MG tablet give one tablet by mouth with meals for diabetes with an order date of February 6, 2024 and a scheduled time of 7:00 AM was transcribed in the MAR. Per the MAR, the medication Metformin HCL 500 MG was administered to Resident #14 on December 11, 2025, without a breakfast meal despite an order to give the medication with meals. According to the facility's meal times schedule, the breakfast tray cart for the behavioral unit was scheduled for 7:10 AM.While waiting for additional medication administration observation with Staff #468, an interview was conducted on December 11, 2025 at 6:22 AM with Staff #468. Staff #468 stated that there was only one medication cart in the behavioral unit and the medication storage is shared with the west side unit. He stated that Resident #14 preferred taking her medication with a pudding and her water was located at bedside. Staff #468 stated that he administers medication one hour before and one hour after the schedule time. He said that breakfast trays in his unit are delivered between 7:00 AM to 7:15 AM. An interview was conducted on December 11, 2025, at 11:00 AM with an LPN (Staff #493). Staff #493 stated that a physician order such as give medication with meals meant give medication with meals. He stated that in the computer system for documenting medication, the medications scheduled to give with meals were scheduled according to scheduled meal times, and as long as the resident can eat. He stated that a pudding in a medication cup mixed with the resident's pill was not considered a meal, and he stated that it was just the way the residents take their medication.Another interview was conducted with an LPN (Staff # 482) on December 11, 2025 at 11:38 AM. She stated that a medication with an order to give with meals such as with a medication like Metformin would be given with a meal. She stated that it mostly meant to give with the meal coming, or give it when the meal was getting delivered. She stated that an apple sauce or a pudding with medication could be due to a swallowing issue or due to swallowing a big pill, and the apple sauce or a pudding with the medication was something to take it with.A follow up interview was conducted on December 11, 2025 at 12:28 PM with LPN (Staff #468). Staff #468 stated that an order to give with meals meant to be given with meals such as breakfast, lunch, or dinner. He stated that a spoonful of pudding was not a meal. He stated that regarding Resident #14's Metformin medication to give with meals, he stated that he gave the metformin medication at 7:00 AM, he stated that the common practice for the resident was refusing meals, and today the resident refused breakfast and she received her metformin medication. He stated that he would still administer the resident's Metformin medication for a resident with diabetes who refuses a meal. He stated that he would call a physician to clarify an order if there was a conflict found in the order. He stated that he would generally call the physician if a resident refused to take the medication. He stated that he would not call a physician for Metformin ordered with meals, and would not call the physician because sometimes residents don't take their medication related to their behavior.In an interview conducted on December 12, 2025 at 12:16 PM with the Director of Nursing (DON/Staff # 301). The DON stated that the process and expectation regarding medication administration would be that she expects the nurse to follow the physician's orders, and the process is to follow the physician's orders. She stated that the impact if an order was not followed would depend on the type of the order and the risk for the residents

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, staff interviews, facility documents, and policy, the facility failed to ensure several residents' rooms were equipped with a working communication system to call for staff assistance. The deficient practice could place residents' safety at risk.Findings include:An observation in the behavioral unit was conducted on December 9, 2025 at 10:50 AM and revealed the call light in one room (#1) was on the floor behind the resident's bed and was out of reach.An observation of another room (#2) in the behavioral unit was conducted on December 9, 2025 at 1:33 PM, and there was no call light available for resident use. In a later observation of room (#1) conducted on December 9, 2025 at 3:20 PM, the same room (#1) continued to have the call light out of the resident's reach. The call light was on the floor behind the resident's bed.During a medication administration observation conducted on December 11, 2025, at 6:22 AM, an interview was conducted with a Licensed Practical Nurse (LPN/Staff #468) who stated that the behavioral unit was staffed with 1 nurse and 3-4 certified nursing assistants (CNAs) for 16 residents in the unit. He stated that when providing care to nonverbal residents, the staff do regular checks by rounding every 15 minutes and more often for residents with higher acuity. He stated that for residents who can verbalize their needs, the residents can use their call lights for assistance.An observation of resident rooms in the behavioral unit to check on the call lights was conducted with a CNA (Staff #459) on December 11, 2025 at 6:46 AM. In the bathroom of one resident room, the call light string was approximately 12 inches from the wall. The CNA stated that the bathroom call light was a short string; and, if the resident had a fall in the bathroom and was on the floor, the resident could not reach the call light string to alert staff for assistance. The CNA then proceeded to another bathroom of another resident room, and pulled the call light string; however, the light on the hallway outside of the resident's room was not lit up to indicate that the call light in the bathroom was pulled. The call button on the wall by the resident's bed in the same resident room was pushed. The light on the hallway outside of the same resident's room did not turn on. The CNA stated that the call lights were not working, and that, the light outside the room did not turn on. She further stated that if the call lights were not working, the residents would be in trouble. The CNA said that she will inform the maintenance staff that the call lights were not working on these 2 resident rooms.In an interview with the administrator (staff #300) conducted on December 12, 2025, at approximately 6:00 PM, the Administrator provided a Work Order document dated December 11, 2025, and another document with room numbers and a hand written note on top of the page that read, all call light strings and lights audited and corrected.Review of facility's policy titled Fall Management System, reviewed on September 2025, revealed that the facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible, through providing the resident with adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.