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	11/01/2024

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	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Base on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to monitor and ensure that resident (#34) was administered pain and psychotropic medications as per the orders and medications were left with the resident unsupervised. The deficient practice could result in the pain and anxiety not being managed. Findings include: Resident #34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included post traumatic disorder, anxiety, major depression, low back pain, and chronic pain syndrome. The care plan dated May 26, 2023 revealed that the resident is on pain medication therapy related to pain. Interventions included to administer medication as ordered. Review of the care plan dated May 29, 2023 revealed that the resident is on anti-anxiety mediation due to anxiety as evidenced by restlessness. Interventions included to give anti-anxiety medications as ordered by the physician. The minimum data set (MDS) dated [DATE] included that the resident's memory is okay and she is able to make decisions independently. The order summary revealed: -April 10, 2024, Gabapentin capsule 400 mg give 2 capsules by mouth every 6 hours for neuropathy. Hold from October 11, 2024 to October 14, 2024. -April 12, 2024, Xtampza ER oral capsule ER 12 hour abuse-deterrent 27 mg (Oxycodone) give 1 capsule by mouth two times a day for pain. -April 14, 2024, monitor behavior every shift for anti-anxiety episodes as evidenced by target behavior, restlessness. -June 14, 2024, Oxycodone HCl oral tablet 15 mg (Oxycodone HCl) give 1 tablet by mouth every 6 hours for pain. Hold from October 11, 2024 to October 14, 2024. (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	An interview was conducted on November 1, 2024 with (RN/staff #33), who stated that he had provided care for resident #33 on prior occasions. He went to her room to administer her morning medications between 8:00 and 9:00 a.m. He stated that he received a report that the resident receives her medication in pudding, but she wanted to see the medications, so she could identify them and choose which medications that she wanted to take, but they were already dissolving, so they were not recognizable. He stated that the resident told him that she is usually given her medication on the side with the pudding and he told the resident that was fine, but he could not pull the narcotics again, so she would have to take the medications in the pudding. He stated that a certified nursing assistant (CNA/staff 8#) was in the resident's room when he left to get the resident some water, but the resident normally takes the medications just with pudding, and when he returned the CNA told him that the resident had thrown the pudding with the medications on the floor, so he had to throw it all away. He stated that he did not know if the resident was allowed to take her medication without supervision, but based on his training, he is supposed to watch the resident take the medication to verify that it was taken and to ensure that the resident doesn't aspirate. He stated that once the medications were on the floor, he told the resident that she would have to wait until the next time that the medications were scheduled to be administered and this included the pain and anti-anxiety medication. He stated that there is a risk of continued pain and withdrawal when pain medications are not administered as ordered, and there is a risk of agitation if anti-anxiety medications are not administered as per orders. He thought that the pain medication and anti-anxiety medication was due again sometime in the evening. He stated that he didn't contact the physician right away, but continued to monitor the resident, and around mid afternoon, the resident complained of pain, removed her oxygen, became aggressive and was still upset about not receiving her medications in the morning. He stated that he contacted the physician around 1:00 p.m.; the physician was in the facility and told him that he would come by and see the resident. He stated that it is not within his purview to decide if a resident should get medication or not and the normal process would be to call another nurse to witness the medications being thrown away and pull more pain and anti-anxiety medication for the resident, but the medication had dissolved, so another nurse would not be able to identify the medications to witness that the medication was thrown away. He stated that he did not contact the ADON or DON because he was the charge nurse that day. During a second interview with (RN/staff #33) conducted on November 1, 2024 at approximately 11:15 a.m., he reviewed the medication administration record (MAR) dated October 2024 and stated that the resident refused all medications on the morning of October 27, 2024 when he wouldn't pull another Xtampza ER oral capsule for pain and Alprazolam for anxiety. He stated that the resident did not receive any medication on the morning of October 27, 2024, and if he documented that the resident did receive a medication, it is a documentation error. An interview was conducted on November 1, 2024 with a certified nursing assistant (CNA/staff #8), who stated that the resident's call-light was on and she was walking towards the resident's room when she heard raised voices. She stated that she could hear (RN/staff #33) and the resident were both yelling, so she didn't go into the room. Staff #33 came out of the room and said, I am not dealing with her anymore, and then the pudding cup with the medications came flying out of the room into the hallway and landed on the floor. She cleaned up the pudding on the floor and when she went into the resident's room, the resident told her that she doesn't take her medications like that and kept asking to speak with the charge nurse, but the charge nurse had called off that day, so (RN/staff #33) was the acting charge nurse. The resident was upset throughout the day and there wasn't anyone there to help the resident with her problem. The resident was asking to talk to someone throughout the day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 1, 2024 at 12:25 p.m. with resident #33, who stated that she takes her medication with yogurt/pudding because she has trouble swallowing them. She stated that the nurse brought her medications in the yogurt and she was not able to identify the medications and told staff #48 that she needed to see the pills to make sure that she was getting the right medications, and he told her that he was not pulling the medications again. He left the yogurt with the medications on her table and walked out of the room, so she threw the cup of yogurt with the medications out the door into the hallway. She stated that the nurse normally waits until she takes the medications before leaving the room. She stated that she asked the nurse to call her doctor. An interview was conducted on November 1, 2024 at 12:49 p.m. with the Director of Nursing (DON/staff #1), who stated that resident #34 is not allowed to take medication unsupervised because she has a history of pocketing medications. She stated that the resident was given her pain medication that afternoon and received her evening medications. She stated that (RN/staff #33) should have followed the process when medication is wasted; he could have called a nurse from another hall to witness him throwing the medications away. She stated that staff #33 should have also notified the physician right away about the resident not getting her medications to make sure that there were no issues, but the resident has other orders for pain medication, so the resident did not go without pain medication. The facility policy, Professional Standards states that it is the policy of this facility that services provided by the facility meet professional standards of quality and be provided by qualified persons in accordance with each resident's care plan. The facility policy, Self-Administration of Medications states that if a resident desire to participate in self administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status.