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	09/15/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 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** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that an allegation involving abuse and neglect was documented completely in the clinical record for one resident (#11). The deficient practice could result in incomplete documentation in resident medical records and continued violation of resident rights.Findings include: Resident #11 was admitted to the facility on [DATE], with diagnoses that included pathological fracture of the right humerus, muscle weakness, dysphagia, systolic heart failure, hypotension, hypertensive heart disease, secondary malignant neoplasm of the liver, intrahepatic bile duct, lung, and brain, anxiety disorder, hyperlipidemia, anemia, and gastroesophageal reflux disease.A Medicare-5 Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment.A care plan focus initiated on September 12, 2025, revealed the resident was resistant to care related to her anxiety.A care plan focus initiated on September 12, 2025, revealed the resident had the potential for a behavior problem related to anxiety, evidenced by refusing care, yelling at staff, and hitting staff.A care plan focus initiated on September 12, 2025, revealed the resident had the potential to demonstrate physical behaviors related to anxiety, and that she hit and spat at staff. Review of Resident #11's clinical record revealed no evidence of documentation regarding an allegation of abuse by a staff member. A telephonic interview was conducted on September 15, 2025, at 11:03 a.m. with a Registered Nurse (RN/Staff#14) who stated that if an allegation of abuse were made to him, he would need to do a progress note with a time stamp, what was witnessed, who he notified, and what immediate interventions they had as per facility policy. An interview was conducted on September 15, 2025, at 11:24 a.m. with a Licensed Practical Nurse (LPN/Staff#21) who stated that if an allegation of abuse were made to him, he would need to document it in the progress notes as per facility policy. The LPN stated that the progress note would need to detail the time the incident happened, verbal allegations that came from the patient, what was said, what actions were taken, and who was notified. The LPN stated that it was important to document allegations of abuse in the clinical record to trace down patterns or record historical evidence of allegations of abuse to make sure they have full documentation for legal reasons. The LPN further stated that the risk of not documenting allegations of abuse in the clinical record could be that if there was an allegation that did occur and was not documented, they would not be able to further prevent other incidents or prove that the incident occurred, and abuse may continue. An interview was conducted on September 15, 2025, at 11:49 a.m. with the Director of Nursing (DON/Staff#48) who stated that her expectation of staff in documenting allegations of abuse in the clinical record would be to notify administration before documenting an incident. The DON stated that she would expect staff to document allegations of abuse in the progress notes, complete a Change of Condition, and management would update the care plan. The DON stated that the progress notes would need to detail what happened, the psychosocial well-being of the resident, what they were doing for the resident, and who was notified. The DON stated that an example statement of her expectation, which would be patient reports an allegation of abuse against family, staff, or other resident, administrator aware, family and physician notified, followed by any interventions they put in place. The DON stated that she did not put a progress note in the clinical record about the allegations against the nurse, and there is no documentation specifically about the incident in the clinical record. The DON further stated that a progress note would have been expected in this situation, and it did not meet her expectations regarding the actual incident and allegations. A review of a policy titled, Documentation and Charting, was conducted in October 2024 and revealed that it is the policy of the facility to provide a complete account of the resident's care, treatment, response to care, signs, symptoms, as well as the progress of the resident's care. The policy also revealed that the facility would provide nursing service personnel with a record of the physical and mental status of the resident, and a legal record that protects the resident, physician, nurse, and facility.