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	11/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to report an allegation of sexual abuse of one resident (#10) to mandated entities within 2 hours. The deficient practice could result in ongoing abuse, leading to physical and/or psychosocial harm of a resident. Past non-compliance was identified for this citation:These findings represent past non-compliance with this regulatory requirement. There was sufficient evidence the facility corrected the non-compliance as of November 17, 2025 and three were no other occurrences of the same deficient practice. At the time of the survey, the facility was in substantial compliance with this regulatory requirement and, therefore, does not require a plan of correction. The facility conducted an in-service regarding Abuse Prevention and Reporting Policy (documentation was included at the time of the request), to include immediate separation of residents, safety, assessment of involved parties, timely notifications and documentation. The facility also conducted a full-house resident questionnaire to ensure no residents observed or felt resident-to-resident abuse. All residents reported feeling safe in the facility with no abuse concerns identified. Grievance logs, 24-hour reports and documentation will be review four times a week for the next four weeks and the monthly. Staff will follow abuse prevention and reporting policy, until compliance is met and ensure all allegations of abuse are addressed properly. Any issues observed will be followed up on immediately and 1 on 1 education will be provided. -Findings include:Resident #10 was admitted to the facility on [DATE], with diagnoses that included myoneural disorder, other toxic encephalopathy, dysphagia, ataxia, and post-traumatic stress disorder.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #10 had a brief interview for mental status (BIMS) assessment score of 15, indicating intact cognition. Additionally, the assessment revealed Resident #10 had no hallucinations or delusions.A physician order dated August 26, 2025, indicated for a chest x-ray for leukocytosis.An additional physician order dated October 1, 2025, indicated for a stat chest x-ray for shortness of breath.A Nursing Note dated October 16, 2025, revealed that Resident #10 was discharged from the facility to the hospital.A police report initiated October 18, 2025, revealed that Resident #10 (alleged victim) reported that an unknown male that conducted x-rays allegedly committed sexual abuse by touching Resident #10's breast, while she was receiving medical care at the facility. The report additionally revealed that a description of the male was provided by Resident #10, and that Resident #10 stated that she had reported the allegation to a nurse at the facility, and that the nurse stated that the alleged perpetrator had left the building. The report also revealed that a police officer assigned to the case arrived at the facility on October 23, 2025, and discussed the case with the Assistant Director of Nursing (ADON / Staff #12). The report revealed that Staff #12 identified the x-ray technician as the possible perpetrator, and additionally provided police with information about Resident #10's room number and previous roommate. Additionally, Staff #12 provided information to the police that the only dates that Resident #10 had received x-rays were August 27, 2025, and October 1, 2025. The report revealed that Staff #12 spoke with her boss (Administrator / Staff #66), who would be in the office the following day to assist with any video footage needed. The report revealed that on October 24, 2025, the police officer returned to the facility to meet with Staff #66, and that the police officer was notified that Staff #66 was out of state, and that the video camera footage that was requested was not available.Review of the facility's list of self-report incidents revealed no evidence of an allegation of sexual abuse of Resident #10.Review of the State Agency database revealed no evidence that the facility submitted a self-report for an allegation of sexual abuse of Resident #10.An interview was conducted with Resident #10's former roommate on November 17, 2025, at 9:46 A.M. The roommate stated that a detective came and talked to her in October 2025, and asked her if she had witnessed anything between Resident #10 and an x-ray technician.An interview was conducted with a Licensed Practical Nurse (LPN / Staff #29) on November 17, 2025, at 9:56 A.M. Staff #29 stated that if she saw or heard any allegation of abuse of a resident, that she would first ensure the resident is safe, then report the allegation immediately to the abuse coordinator (Staff #66). Staff #29 stated the importance of immediately reporting an allegation of abuse is to protect against continued abuse of a resident, and that witnesses may have memory problems, so staff would need to act right away to take witness statements.An interview was conducted on November 17, 2025, at 10:00 A.M. with an LPN and ADON (Staff #12), who stated that if staff see or hear an abuse allegation, the expectation is to first ensure the safety of the resident, and then to contact Staff #66 immediately. Staff #12 stated if staff cannot reach Staff #66, then the process

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to investigate an allegation of sexual abuse of one resident (#10). The deficient practice could result in ongoing abuse, leading to physical and/or psychosocial harm of a resident. Past non-compliance was identified for this citation:These findings represent past non-compliance with this regulatory requirement. There was sufficient evidence the facility corrected the non-compliance as of November 17, 2025 and three were no other occurrences of the same deficient practice. At the time of the survey, the facility was in substantial compliance with this regulatory requirement and, therefore, does not require a plan of correction. The facility conducted an in-service regarding Abuse Prevention and Reporting Policy (documentation was included at the time of the request), to include immediate separation of residents, safety, assessment of involved parties, timely notifications and documentation. The facility also conducted a full-house resident questionnaire to ensure no residents observed or felt resident-to-resident abuse. All residents reported feeling safe in the facility with no abuse concerns identified. Grievance logs, 24-hour reports and documentation will be review four times a week for the next four weeks and the monthly. Staff will follow abuse prevention and reporting policy, until compliance is met and ensure all allegations of abuse are addressed properly. Any issues observed will be followed up on immediately and 1 on 1 education will be provided. -Findings include: Resident #10 was admitted to the facility on [DATE], with diagnoses that included myoneural disorder, other toxic encephalopathy, dysphagia, ataxia, and post-traumatic stress disorder.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #10 had a brief interview for mental status (BIMS) assessment score of 15, indicating intact cognition. Additionally, the assessment revealed Resident #10 had no hallucinations or delusions.A physician order dated August 26, 2025, indicated for a chest x-ray for leukocytosis.An additional physician order dated October 1, 2025, indicated for a stat chest x-ray for shortness of breath.A Nursing Note dated October 16, 2025, revealed that Resident #10 was discharged from the facility to the hospital.A police report initiated October 18, 2025, revealed that Resident #10 (alleged victim) reported that an unknown male that conducted x-rays allegedly committed sexual abuse by touching Resident #10's breast, while she was receiving medical care at the facility. The report additionally revealed that a description of the male was provided by Resident #10, and that Resident #10 stated that she had reported the allegation to a nurse at the facility, and that the nurse stated that the alleged perpetrator had left the building. The report also revealed that a police officer assigned to the case arrived at the facility on October 23, 2025, and discussed the case with the Assistant Director of Nursing (ADON / Staff #12). The report revealed that Staff #12 identified the x-ray technician as the possible perpetrator, and additionally provided police with information about Resident #10's room number and previous roommate. Additionally, Staff #12 provided information to the police that the only dates that Resident #10 had received x-rays were August 27, 2025, and October 1, 2025. The report revealed that Staff #12 spoke with her boss (Administrator / Staff #66), who would be in the office the following day to assist with any video footage needed. The report revealed that on October 24, 2025, the police officer returned to the facility to meet with Staff #66, and that the police officer was notified that Staff #66 was out of state, and that the video camera footage that was requested was not available.Review of the facility's list of self-report incidents revealed no evidence of an allegation of sexual abuse of Resident #10.Review of the State Agency database revealed no evidence that the facility submitted a 5-day investigation report for an allegation of sexual abuse of Resident #10.An interview was conducted with Resident #10's former roommate on November 17, 2025, at 9:46 A.M. The roommate stated that a detective came and talked to her in October 2025, and asked her if she had witnessed anything between Resident #10 and an x-ray technician. The roommate also stated that facility staff did not ask her any questions related to the allegation.An interview was conducted with a Licensed Practical Nurse (LPN / Staff #29) on November 17, 2025, at 9:56 A.M. Staff #29 stated that if she saw or heard any allegation of abuse of a resident, that she would first ensure the resident is safe, then report the allegation immediately to the abuse coordinator (Staff #66). Staff #29 stated the importance of immediately investigating an allegation of abuse is to protect against continued abuse of a resident, and that witnesses may have memory problems, so staff would need to act right away to take witness statements.An interview was conducted on November 17, 2025, at 10:00 A.M. with an LPN and ADON (Staff #12), who stated that if staff see or hear an abuse allegation, the expectation is to first ensure the safety of the resident, and then to