

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Chandler Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility documents and policy, the facility failed to ensure that a medication was administered following the physician ordered parameters for one resident (#135). The deficient practice resulted in hospitalization due to lowered blood pressure. Findings included: Resident #135 was admitted to the facility on [DATE]. Review of the hospital records revealed the resident #135 had a past medical history of urinary tract infection (UTI), Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea (OSA), Hypertension, and Cerebrovascular Disease (CVA). The admission progress note dated November 10, 2025 included the resident arrived at the facility; and that the resident was alert, oriented x 4, awake and able to make needs known. The care plan dated November 10, 2025 included interventions to administer medications/treatments as ordered, to monitor/document for side effects and effectiveness and to report occurrences to the physician. A review of the order summary report revealed that a physician order dated November 10, 2025 for Losartan Potassium (antihypertensive) 50 mg (milligrams), give two tablets by mouth one time a day for hypertension; and to hold for SBP (systolic blood pressure) of less than 130. This order has a start date of November 11, 2025. This order was transcribed onto the MAR (medication Administration record) for November 2025 and was scheduled to be administered at 8:00 a.m. The blood pressure summary report on November 10, 2025, at 8:00 p.m. revealed a BP (blood pressure) of 120/76 mmHg (millimeters Mercury); and, at 11:59 p.m., her BP was 131/78 mmHg. The eMAR (electronic medication administration record) note dated November 11, 2025 at 1:17 a.m., the resident was on a change of condition for new admit, oral antibiotic therapy for UTI (urinary tract infection). per the documentation, the resident was alert, oriented x 4, was able to make needs known and was on antibiotic for UTI and had a PRN (as needed) narcotic medication. The eMAR note dated November 11, 2025 at 6:36 a.m. revealed the resident was sitting in the bed with no complaint of pain or discomfort. A review of Blood Pressure Summary record revealed that on November 11, 2025, at 7:04 a.m., Resident #135's blood pressure was 90/55 mmHg. Review of the MAR entry for November 11, 2025 revealed the resident's BP reading recorded at 8:00 a.m. was 103/65. Despite having a SBP of less than 130, the documentation in the MAR revealed Losartan was administered on November 11, 2025 at 8:00 a.m. scheduled time. The clinical record revealed no documentation why Losartan was administered outside of the physician ordered parameters; and that the physician was notified. The Blood Pressure summary report revealed that on November 11, 2025 at 8:40 a.m., the resident's blood pressure was 103/65 mmHg. The therapy progress note dated November 11, 2025 at 9:27 a.m. revealed the resident had a blood pressure of 63/39 mmHg and had visual and auditory hallucinations. Per the documentation, the resident reported feeling yucky; and that, the therapist immediately notified the registered nurse (RN) who confirmed resident had an extremely low blood pressure. The nursing progress note dated November 11, 2025 at 9:46 a.m. revealed that the resident's blood pressure was (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035101	Facility ID: 035101 If continuation sheet Page 1 of 24

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F 0684 Level of Harm - Actual harm Residents Affected - Few	parameters, staff must follow those parameters. She said that if a medication needs to be held, the nurse should notify the provider of the reason and document it in the clinical record. She stated that if a blood pressure medication with hold parameters is not followed, the resident's blood pressure could either increase or decrease. For medications such as Losartan, the DON stated that if there was a blood pressure parameter order, staff were expected to take the resident's blood pressure. She said that blood pressures were usually taken by certified nursing assistants (CNAs) around 7:00 a.m. or earlier, and the nurse then has one hour before or one hour after the scheduled 8:00 a.m. medication time to administer the medication. She stated that blood pressure readings were expected to be documented in the electronic record; and, if the nurse takes the blood pressure, it should be documented at the time of medication administration or before giving the medication when parameters apply. The DON also stated that medications such as Losartan can lower blood pressure. During the interview, a review of the clinical record was conducted with the DON who stated that Resident #135 had an order for Losartan with instructions to hold the medication if the systolic blood pressure was less than 130 mmHg. She further stated that on November 11, 2025, the resident's blood pressure was 103/65, and Losartan was administered. The DON stated that progress notes indicated Resident #135 went to physical therapy and began hallucinating. She further stated that the resident was sent to the hospital for hypotension. A review of the facility policy titled Physician Orders, revised in September 2025, revealed that it is their policy to accurately implement medication orders only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care; and, drugs shall be administered only upon the order of a person duly licensed and authorized. The facility policy on Medication Administration-Oral, revised in September 2025, revealed that it is their policy to accurately prepare, administer, and document oral medications, and when administering unit doses, identify resident eMAR orders, take vital signs if required, and hold drugs if indicated. The policy also included to no medication is to be administered without a physician's written order.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, observations, interviews, facility documentation, and policy, the facility failed to ensure hand hygiene was performed and PPE was appropriately applied for one resident (Resident #9) , and infection control measures were implemented for a resident with a urinary catheter (Resident #71) and during a dressing change (Resident #166). This deficient practice can result in contamination and spread of infection. Findings include: Regarding Resident # 71 Resident #71 was admitted to the facility on [DATE], with conditions that included encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg above knee, long-term (current) use of anticoagulants, need for assistance with personal care, generalized muscle weakness, and cognitive communication deficit, hypertension, wound infection, and diabetes mellitus. A review of the admission Minimum Data Set (MDS) accepted November 30, 2025, revealed the resident had a Brief Interview Mental Status Score (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS also revealed the resident had an indwelling catheter, and was on antibiotic therapy. A review of the facility list of all current residents with catheter orders, revealed resident # 71 with an active order for catheter drainage bag was allowed to be changed every 12 hours as needed for standard of care if soiled or leaking. An observation was conducted on December 11, 2025, at 12:13 p.m., with Licensed Practical Nurse (LPN/Staff #417) of a urinary catheter contained in a privacy bag that was in direct contact with the floor while the resident was sleeping in bed. An interview was conducted on December 11, 2025, at 12:16 p.m. with LPN/Staff #417. The LPN stated that the urinary catheter drainage bag should never be placed on the floor and should be hung on the bed frame below bladder level or placed in a basin. The LPN stated that direct contact with the floor increases the risk of infection transmission and did not meet facility expectations. The LPN stated that at the time of observation, there was no basin or other barrier in place to prevent the catheter drainage bag from touching the floor. An interview was conducted on December 12, 2025, at 3:13 p.m. with Certified Nurse Assistant (CNA/Staff #442). The CNA stated that training on catheter care and infection prevention was provided upon hire, and that training included completion of a skills checkoff to ensure proper technique. The CNA stated that catheter drainage bags should never be allowed to touch the floor, as the floor is considered contaminated at all times; if the drainage bag contacts the floor, it is considered contaminated. The CNA stated that if a drainage bag touches the floor, it is thoroughly cleaned with alcohol, before it is rehung on the bed frame below the level of the bladder. The CNA (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that once the bag is properly secured, the nurse is immediately notified. The CNA revealed sometimes wash basins are used to help keep catheter drainage bags off the floor. The CNA stated that facility policy requires catheter drainage bags to be kept off the floor and below bladder level to promote urine flow and reduce the risk of infection. The CNA stated that there are typically no significant barriers to maintaining proper bag placement within the facility. However, the CNA stated that catheter clips do not always grip the bed frame securely, which can occasionally interfere with correct positioning. The CNA stated that improved or additional catheter clips would help prevent future catheter bag securement issues. A follow-up interview was conducted on December 12, 2025, at 3:20 p.m. with Licensed Practical Nurse (LPN/Staff #417). The LPN stated that they were not aware of any issues with catheter drainage bag clips. The LPN stated that the facility provides resident education on the importance of not lowering the bed in order to help keep the catheter drainage bag from contacting the floor. An interview was conducted on December 12, 2025, at 3:26 p.m. with the Infection Preventionist (IP/Staff #456). The IP stated that catheter drainage bags should be hung below the level of the bladder and must not touch the floor in order to reduce the risk of infection. The IP stated that if a drainage bag is touching the floor, a basin would be placed underneath the bag. The IP stated that the resident is independent with bed controls, which may have contributed to the drainage bag coming in contact with the floor. The IP stated that the facility had begun staff in-services earlier in the day to address catheter care and proper drainage bag placement. The IP stated that there have been no increasing trends in catheter-related infections at the facility. An interview was conducted on December 12, 2025, at 3:38 p.m. with the Director of Nursing (DON/Staff #301). The DON stated that the resident raises and lowers the bed independently. The DON stated that both the resident and staff were educated to ensure a basin is placed under the catheter drainage bag to prevent it from touching the floor. The DON stated that if a catheter drainage bag does touch the floor, it must be replaced to reduce the risk of infection. In regards to cleaning the drainage bag with alcohol, the DON was not able to answer the question, due to the need to review catheter drainage bag instructions. The DON stated that facility expectations for catheter care include strict adherence to infection control guidelines to prevent complications. Regarding Resident # 166 Resident # 166 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, unspecified, need for assistance with personal care, muscle weakness (generalized), and abdominal aortic aneurysm, without rupture, unspecified. A review of the Minimum Data Set (MDS), dated [DATE] revealed the resident entered the facility from a Short-Term General Hospital, with an admission date of December 5, 2025. The facility was within the window for Completion of the admission MDS. A review of the order summary revealed an active order start date of December 6, 2025 for the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's right lower arm skin tear to be cleansed with Normal Saline, patted dry, apply xeroform and covered with a hydrogel dressing every day shift and as needed for if soiled or dislodged. Further review of the order summary did not reveal orders for enhanced barrier precautions. A review of the care plan revealed no focus or interventions for enhanced barrier precautions. A wound care observation was conducted on December 11, 2025 at 1:23 p.m. for a right lower arm skin tear with Wound Care Nurse (WCN/Staff # 478). The Staff #478 prepared the necessary items, including a folded pink absorbent pad, 4 x 4 gauze placed in a medicine cup and saturated with normal saline spray, one 5x9 petrolatum gauze cut in half, and a hydrogel dressing. Staff #478 gathered supplies from the wound care cart and placed the items on the tray table without first cleaning or sanitizing the tray table. The pink absorbent pad remained folded, with the dressing change supplies sitting on top of the absorbent pad. The old dressing was removed and placed in the trash, Staff #478 was observed with gloves and no protective gown. Staff # 478 washed hands again, and donned a yellow protective gown and fresh gloves before returning to the resident to complete the procedure. The wound was cleansed with Normal Saline, patted dry, petrolatum gauze was applied, and covered with a hydrogel dressing An interview was conducted on December 11, 2025, at approximately 1:30 p.m. with the Wound Care Nurse (WCN). Staff #478 reported experiencing significant nervousness during the wound care observation and stated that several steps were inadvertently missed. Staff #478 acknowledged that a protective gown should have been worn during removal of the prior dressing and throughout the new dressing change. Staff # 478 also admitted to forgetting to disinfect the table prior to placing the dressing change supplies and stated that this lapse constituted a break in infection control policy, which could contribute to the spread of infection. An interview was conducted on December 12, 2025 at 3:13 p.m. with CNA/Staff # 442. The CNA revealed that if a dressing falls off, it is the CNA's responsibility to notify the nurse. The CNA stated that when assisting with dressing changes they are expected to wear PPE, in order to decrease the chance of infection. An interview was conducted on December 12, 2025 at 3:20 p.m. with LPN/Staff # 417. The LPN stated the type wound to determine if a full gown is needed during the dressing change, such as contact precautions. The LPN continued that once dressing change supplies are gathered, the bedside table should be cleaned and sanitized, prior to laying down the barrier pad, and supplies. An interview was conducted on December 12, 2025 at 3:26 with the IP/Staff # 456. The IP stated infection control standards are to be maintained throughout the entire dressing change, which includes proper use of PPE. The IP explained that PPE is to protect everyone, and if a resident has an open wound, staff are expected to wear PPE based on the type of enhanced barrier precautions. The IP also stated that while preparing for a dressing change, the bedside table has to be cleared, cleaned, and sanitized with approved wipes in order to decrease the risk of contamination and spread of illness. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on December 12, 2025 at 3:38 p.m. with the DON/Staff # 301. The DON stated the facility expectation for dressing changes include following the provider orders, donning appropriate PPE, and maintaining infection control practices while handling dressing supplies. -Regarding Resident #9 Resident #9 was initially admitted on [DATE], and re-admitted on [DATE], with diagnoses that included gastrotomy, anoxic brain damage, anxiety, and dementia. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #9's cognitive skills for daily decision-making were severely impaired. The MDS further revealed that Resident #9 has a nutritional approach via feeding tube. A care plan initiated on June 01, 2024, revealed a focus area for risk for infections related to an indwelling device. The goal indicated to mitigate the risk of pathogen transmission. Intervention included Enhanced Barrier Precautions (EBP) during the provision of close contact care. A physician's order dated August 08, 2025 prescribed EBP related to the PEG (Percutaneous Endoscopic Gastrostomy) tube. An incontinence care observation was conducted on December 09, 2025, at 9:33 AM. During the observation, Licensed Practical Nurse (LPN/Staff # 452) used the same gloves from the brief change to put on Resident #9's shirt. Further observation revealed that when Certified Nursing Assistant (CNA/Staff #445) assisted /Staff #452), gown was not completely covering his pants , which made contacted with Resident #9's mattress. An observation was conducted on December 12, 2025, at 9:55 AM. During the observation, a CNA (Staff # 471) repositioned the resident back to bed without wearing a gown. Additionally, staff #471 was not observed performing hand hygiene prior to and after Resident #9 was repositioned Staff #471 was observed touching another resident's wheelchair when she finally sanitized her hands. An interview was conducted on December 12, 2025, at 9:48 AM with a Certified Nursing Assistant (CNA/Staff #471) who stated that Resident #9 has bilateral soft mittens and abdominal covering to prevent him from pulling out his G-tube (Gastrostomy tube). Per Staff #471 staff need to sanitize their hands and wear PPE prior to entering residents' room to provide direct care. She noted that since Resident #9 has a G-tube, staff need to wear a gown and gloves during incontinence care. She admitted that when she repositioned Resident #9 back to bed, she did not wear a gown because the resident's stomach was not exposed and there was no direct care provided. An interview was conducted on December 12, 2025, at 2:10 PM with the Infection Control Preventionist (IP/Staff #306), who stated that during infection control meetings with staff, they discuss topics such as: Hand Hygiene, Enhanced Barrier Precautions (EBP), and Transmission-Based Precautions (TBP). She indicated that the type of precaution a resident is placed on is displayed on the side of the resident's door. She said that EBP is used for indwelling devices. Per Staff #306 staff should sanitize their hands before and after leaving a resident's room. Furthermore, when a task (continued on next page)		

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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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Chandler Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 West Elgin Street Chandler, AZ 85224	
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 one resident (#9) and/or the resident representative were informed of the risks and benefits of restraints prior to usage of abdominal binder, waist/seat belt restraint and bilateral mitt restraints. The deficient practice could result in residents and/or resident representatives not being aware of the benefits and risks of restraints. The census was 109. Findings include: Resident #9 was initially admitted on [DATE], and re-admitted on [DATE], with diagnoses that included gastrostomy, anoxic brain damage, anxiety, and dementia. A behavior progress note dated October 22, 2022 revealed that a binder was placed over the resident's peg tube to prevent him pulling the peg tube out. Review of progress notes dated October 22, 2022 through February 24, 2025 revealed no evidence of a consent for the use of a binder from the resident's representative, or acknowledgement of risks/benefits. A care plan initiated on February 25, 2024, revealed a focus for physical restraints that included behaviors of putting self on floor, pulling at PEG tube, and history of pulling out PEG tube and PICC line. Interventions included abdominal support to secure feeding tube and prevent dislodgement, abdominal support belt to secure feeding tube and prevent dislodgement. Further review of progress notes dated February 25, 2024 through September 2, 2024, revealed no evidence of a consent for the use of an abdominal binder from the resident's representative, or acknowledgement of risks/benefits. A Restraint/Enabling Device/Safety Device Evaluation dated September 3, 2024, revealed that abdominal support garment was recommended to protect feeding tube and prevent dislodgement related to resident unintentionally removing feeding tube due to lack of awareness. The evaluation indicated that the abdominal support garment was a restraint. The evaluation further relayed that the benefits for the restraint related to potentially protecting the resident from injury, removing his feeding tube. The evaluation also indicated that consent was obtained from the resident's family member. A change of condition note, dated January 31, 2025, revealed that the G-tube was replaced per orders received from Nurse Practitioner. The note included that family was present on unit and aware of occurrence with good understanding, and the new abdominal binder was placed over site. A physician progress note dated February 10, 2025 revealed that an abdominal binder was in place. A behavioral progress note dated February 13, 2025, indicated that a G-tube was replaced, a new hand mitts and binder placed. Review of progress notes dated February 26, 2024 - August 24, 2025 revealed no evidence of Resident and/or Resident Representative consent for bilateral soft mitts, abdominal binder or seatbelt restraints. A March 4, 2025 behavior note revealed that the resident had been restless and agitated, posey mitts were in place and abdominal binder to protect G-tube site. A care plan initiated on May 21, 2025, revealed a focus for physical restraints that included the use of the bilateral soft wrist mittens related to Traumatic Brain Injury. Interventions included the use of a fastened seatbelt in a wheelchair, abdominal support to secure feeding tube and prevent dislodgement, ongoing evaluation for restraint risk/benefits, alternatives, and ongoing use. A May 21, 2025 Medication Administration Note was written to remove bilateral soft wrist mittens every 2 hours for 10 minutes for skin checks, check circulation, and ROM. An Assistive Device consent dated July 15, 2025, revealed consent for the use of restraints including an abdominal binder, bilateral soft mitts, and a seatbelt, related to behaviors of unintentionally removing the feeding tube, and impaired safety awareness. The potential benefits on the consent were listed as enhanced self-independence with transfers/bed mobility and increased feeling of safety and security. The potential risk on the consent was documented as accidental injury from the device. However, the risks/benefits listed on the consent form did not (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurately reflect the risks/benefits of these restraints. Continued review of the clinical record revealed no evidence that the risk and benefits were explained to the resident and/or responsible party from July 16, 2025 through August 25, 2025. A behavior progress note dated April 16, 2025, revealed that resident was observed to be severely agitated, with increased incidents of pulling on feeding tube, and abdominal binder reinforced. A physician's order dated August 26, 2025, revealed the following orders: OK to have a seatbelt while in a wheelchair. Bilateral soft wrist mittens to prevent removal of medical device: Peg tube every shift A Restraint/Enabling Device / Safety Device Evaluation form dated August 26, 2025, revealed no evidence of all measures tried before implementing the recommended device. The device recommended portion of the evaluation, revealed that furniture was removed from the room and his mattresses were on the floor, specialized pro wheelchair with seatbelt, bilateral soft wrist mittens. The evaluation included that the device was considered a restraint, and placed due to the resident unintentionally removing the feeding tube, impaired safety awareness, inability to seat still related to traumatic brain injury, as the resident was unaware of what he was doing. The risk and benefits portion of the evaluation regarding what the device will enable the resident to do included, potentially protect resident from injury and enabled the resident to maintain proper body positioning/alignment. The benefits listed on the evaluation included improved mobility, improved comfort/safety and security, decreased anxiety, prevention of falls, improved posture/alignment, enhanced dependence, greater self-sufficiency, medical treatment allowed to proceed without resident interference, and decreased falls. However, the risks/benefits on this evaluation were not the same risks and benefits that were listed on the Assistive Device consent dated July 15, 2025. The evaluation did include that consent was obtained from the resident's family. Further review of the evaluation revealed no evidence of the risks related specifically to the use of the wrist and seatbelt restraints related to increased agitation, pressure ulcers, accidental injuries, loss of independent mobility, withdrawal/depression, death by strangulation, and suffocation. An annual IDT (interdisciplinary team) Care Plan Review dated September 2, 2025, revealed that the POA (power of attorney) was not present during the meeting for consent. The review included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints. However, further review of the evaluation revealed documentation that the resident and/or Resident Representative agreed with the established plan of care, despite documentation that the Resident Representative was not present for the meeting. A September 17, 2025 Physician Progress note, revealed that bowel sounds were present in all four quadrants of the abdomen. the note did not include evidence regarding the use of the hand mitts or seat belt restraints. A Physician Progress Note dated October 20, 2025, revealed that abdominal bowel sounds were present in all four quadrants, and abdominal binder was in place, g-tube noted. However, the note did not include evidence regarding the use of the hand mitts or seat belt restraints. A Physician Progress Note dated November 5, 2025, revealed that abdominal bowel sounds were present in all four quadrants, and abdominal binder was in place. However, the note did not include evidence regarding the use of the hand mitts or seat belt restraints. A Quarterly Data Set Minimal Data Set (MDS) assessment dated [DATE], revealed no BIMS (brief interview of mental status) score; however, it did reveal that Resident #9's cognitive skills for daily decision-making were severely impaired. The MDS further revealed the resident's upper extremity was impaired on one side and that a wheelchair was used for mobility. The assessment revealed no evidence of restraint use In-chair or out-of-bed for trunk restraints and limb restraints, and no evidence of a trunk restraint (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used In-bed. A Restraint/Enabling Device / Safety Device Evaluation form dated November 25, 2025. The device recommended portion of the assessment revealed that furniture was removed from the room and his mattresses were on the floor, specialized pro wheelchair with seatbelt, bilateral soft wrist mittens. The evaluation included that the device was considered a restraint, and placed due to the resident unintentionally removing the feeding tube, impaired safety awareness, inability to seat still related to traumatic brain injury, as the resident is unaware of what he is doing. The risk and benefits portion of the evaluation regarding what the device will enable the resident to do included, potentially protects resident from injury and enables the resident to maintain proper body positioning/alignment. The benefits listed on the evaluation included improved mobility, improved comfort/safety and security, decreased anxiety, prevention of falls, improved posture/alignment, enhanced dependence, greater self-sufficiency, medical treatment allowed to proceed without resident interference, and decreased falls. However, the risks/benefits on this evaluation were not the same risks and benefits that were listed on the Assistive Device consent dated July 15, 2025. The evaluation did include that consent was obtained from the resident's family. Further review of the evaluation revealed no evidence of the risks related specifically to the use of the wrist and seatbelt restraints related to increased agitation, pressure ulcers, accidental injuries, loss of independent mobility, withdrawal/depression, death by strangulation, and suffocation. The evaluation revealed no evidence to indicate all measures that had been tried Before Implementing Recommended Device.A Physician Progress Note dated November 28, 2025, revealed that abdominal bowel sounds were present in all four quadrants, and abdominal binder was in place. However, the note did not include evidence regarding the use of the hand mitts or seat belt restraints.A Treatment Administration Record (TAR) dated December 2025, revealed evidence that bilateral soft wrist mittens and seatbelt were placed as ordered. However, there was no evidence on the TAR that the abdominal binder was placed, despite observations of an abdominal binder placed on the resident.A December 2, 2025 quarterly IDT Care Plan Review, revealed that the POA was present for the review for consent. not part of the review. However, the review indicated that the resident and/or Resident Representative agreed with the established plan of care, despite documentation revealing that the POA was not present during the IDT meeting. The review included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints.An observation was conducted on December 09, 2025, at 9:13 AM. The resident was observed reclining in a wheelchair with bilateral soft mitts (limb restraint) applied to hands, an abdominal binder (trunk restraint) around the waist, and a seat belt (rising prevention restraint) fastened across his waist/lap. Another observation was conducted on December 11, 2025, at 7:02 AM. The resident was observed to be sitting in a reclining wheelchair with a seatbelt fastened around the resident's waist/lap, and bilateral mitts in place on his hands. Further observation of the resident was conducted on December 11, 2025, at 11:14 AM in the dayroom. The resident was observed to be wearing bilateral mitts on his hands, a seatbelt was fastened across his waist/lap while he was reclining in a wheelchair.An observation was conducted on December 12, 2025, at 3:21 PM with the Director of Nursing (DON). The resident was observed lying on his bed with bilateral mitts applied to his hands. At this time the DON asked the resident if he was able to take off the mitts, and the resident attempted to remove the mitts, but was unable to remove them from his hands.An interview was conducted on December 12, 2025, at 10:04 AM with a Licensed Practical Nurse (LPN/Staff # 417), who stated that Resident #9 started using bilateral soft mittens on August 26, 2025, because he tends to pull the G-tube. He (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that the seat belt on the wheelchair was used to prevent the resident from falling. He also stated that the Assistive Device Consent form had not been updated to show the benefits and risks of the current restraints. He then stated the benefit of the abdominal binder and soft mitt use was to prevent the resident from removing the G-tube, and to allow the resident to receive nutrition through the tube feeding. He further stated that the benefit of using a fastened seatbelt in a wheelchair would include the prevention of falls. The LPN further stated that the risk of using the restraints could result in the resident pulling on the G-tube causing trauma and possible return to the hospital. He stated that there was no documentation that the family were informed/educated before the consent was obtained. An interview was conducted on December 12, 2025, at 2:49 PM with the Director of Nursing (DON/Staff #30), who stated that the Assistive Device form was discussed with Resident #9's family who was aware. A policy titled, Informed Consent, revised May 2025, revealed that it is the facility policy that resident rights are not violated and a copy of these rights are made available to the resident and to any representative of the resident. The policy indicated that the rights included the right to receive in advance all information that is material to a decision to accept or refuse treatment. A policy titled, Restraints, Physical/Safety Devices, revised May 2025, included that it is the policy of the facility that the resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to that the resident's medical symptoms. The policy relayed that a physician's order is necessary for the use of a physical restraint. The policy also relayed that the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy, the facility failed to ensure that monitoring and evaluation were conducted for the least restrictive alternatives for the least amount of time and conduct ongoing evaluations of the need for physical restraints for one resident (Resident #9). The deficient practice could result in the resident not able to use a less restrictive alternative. The census was 109. Findings include:Resident #9 was initially admitted on [DATE], and re-admitted on [DATE], with diagnoses that included gastrostomy, anoxic brain damage, anxiety, and Dementia.A behavior progress note dated October 22, 2022 revealed that a binder was placed over the resident's peg tube to prevent him pulling the peg tube out.A nursing progress note dated October 23, 2022, revealed the patient tried to pull out a PICC line and tube feeding while he was in a geri-chair and he required 1-2 staff members to be with him just to keep him safe.A physician progress note dated February 10, 2025 revealed that an abdominal binder was in place.Review of progress notes dated February 25, 2024 - August 24, 2025 revealed no evidence of Resident and/or Resident Representative consent for bilateral soft mitts, abdominal binder or seatbelt restraintsA behavioral progress note dated February 13, 2025, indicated that a G-tube was replaced, and new hand mitts and binder placed.A March 4, 2025 behavior note revealed that the resident had been restless and agitated, posey mitts were in place and abdominal binder to protect G-tube site.A December 2, 2025 quarterly IDT Care Plan Review, revealed that the POA was present for the review for consent. not part of the review. However, the review indicated that the resident and/or Resident Representative agreed with the established plan of care, despite documentation revealing that the POA was not present during the IDT meeting. The review included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints.A Care Plan initiated on May 21, 2025, revealed a focus for physical restraints that included the use of the bilateral soft wrist mittens related to Traumatic Brain Injury. Interventions included the use of a fastened seatbelt in a wheelchair, abdominal support to secure feeding tube and prevent dislodgement, ongoing evaluation for restraint risk/benefits, alternatives, and ongoing use.A physician's order dated August 26, 2025, revealed the following orders:OK to have a seatbelt while in a wheelchair.Bilateral soft wrist mittens to prevent removal of medical device: Peg tube every shiftA Restraint/Enabling Device/Safety Device Evaluation form dated August 26, 2025, included a device recommended portion of the evaluation, which revealed that furniture was removed from the room and his mattresses were on the floor, specialized pro wheelchair with seatbelt, bilateral soft wrist mittens. The evaluation included that the device was considered a restraint, and placed due to the resident unintentionally removing the feeding tube, impaired safety awareness, inability to seat still related to traumatic brain injury, as the resident was unaware of what he was doing. However, the evaluation revealed no evidence that alternatives were attempted, prior to the use of the wheelchair seat belt and bilateral soft mitt restraints. An annual IDT (interdisciplinary team) Care Plan Review dated September 2, 2025, included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints.A Quarterly Data Set Minimal Data Set (MDS) (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chandler Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 West Elgin Street Chandler, AZ 85224	
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment dated [DATE], revealed no BIMS (Brief Interview of Mental Status) score; however, it did reveal that Resident #9's cognitive skills for daily decision-making were severely impaired. The MDS further revealed the resident's upper extremity was impaired on one side and that a wheelchair was used for mobility. The assessment revealed no evidence of restraint use In-chair or out-of-bed for trunk restraints and limb restraints, and no evidence of a trunk restraint used In-bed.A Restraint/Enabling Device/Safety Device Evaluation form dated November 25, 2025, included that the device was considered a restraint, and placed due to the resident unintentionally removing the feeding tube, impaired safety awareness, inability to seat still related to traumatic brain injury, as the resident is unaware of what he is doing. However, the evaluation revealed no evidence that alternatives were attempted, prior to the use of the wheelchair seat belt and bilateral soft mitt restraints. A December 2, 2025 quarterly IDT Care Plan Review, included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints.An observation was conducted on December 09, 2025, at 9:13 AM. The resident was observed reclining in a wheelchair with bilateral soft mitts (limb restraint) applied to hands, an abdominal binder (trunk restraint) around the waist, and a seat belt (rising prevention restraint) fastened across his waist/lap. Another observation was conducted on December 11, 2025, at 7:02 AM. The resident was observed to be sitting in a reclining wheelchair with a seatbelt fastened around the resident's waist/lap, and bilateral mitts in place on his hands. Further observation of the resident was conducted on December 11, 2025, at 11:14 AM in the dayroom. The resident was observed to be wearing bilateral mitts on his hands, a seatbelt was fastened across his waist/lap while he was reclining in a wheelchair.An interview was conducted on December 12, 2025, at 10:04 AM with a Licensed Practical Nurse (LPN/Staff # 417), who stated that Resident #9 started using bilateral soft mittens on August 26, 2025, because he tends to pull the G-tube. He stated that there have not been any other alternatives to minimize the use of the abdominal binder and the bilateral mitts. An interview was conducted on December 12, 2025, at 2:49 PM with the Director of Nursing (DON/staff # 30), who stated that the Interdisciplinary Team (IDT) consists of: Medical Director, Unit Manager, Minimum Data Set (MDS) Coordinator, Wound Nurse, and Administrator. She further stated that the (IDT) will review the need for the restraints. She further stated that there were no alternative measures used for the restraint documented in the Restraint/Enabling Device/Safety evaluations dated May 21, 2025, July 15, 2025, August 26, 2025, and November 25, 2025.A policy titled, Restraints, Physical/safety Devices, revised May 2025, revealed that the facility must explain alternatives to restraint use. The policy included that medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedure review, the facility failed to ensure a thorough investigation of an allegation of neglect was completed for one resident (#9). The census was 109. The deficient practice could result in incomplete investigations of allegations of abuse. Findings included: Resident #9 was initially admitted on [DATE], and re-admitted on [DATE], with diagnoses that included gastrotomy, anoxic brain damage, anxiety, and dementia. A Comprehensive Data Set Minimal Data Set (MDS) assessment, dated November 04, 2022, revealed no BIMS (Brief Interview of Mental Status) score; however, it did indicate that Resident #9's cognitive skills for daily decision-making were severely impaired. A change in condition note dated November 06, 2022, at 16:59 revealed that Resident #9 made multiple attempts to put himself on the ground from his geri (geriatric) chair. The note further revealed that the resident had mats in his room and a helmet on for his safety. The note also revealed that he was restless. A behavioral note dated November 07, 2022, at 0:43 revealed that Resident # 9 made multiple attempts to roll out of his geri chair, rolled around his mat, crawling around his room. A behavioral note dated November 09, 2022, at 1:14 revealed that Resident #9 was restless in bed and crawled around his room. Review of clinical records revealed that Resident #9 obtained a fracture with unknown date; and that, in the facility's investigation no resident interviews were conducted, or the location suspected to have occurred. A Transfer Out note dated November 17, 2022, at 22:25 revealed that resident had an X-ray done on the left hand due to swelling. The note further revealed that he had a fracture of the distal radial metaphysis and new orders for him to be sent out to the hospital for evaluation and treatment. A physician's progress note dated November 18, 2022, at 15:46 revealed that Resident #9's X-ray showed a left distal radius fracture; and that, Resident #9 had fall due to behaviors, and underlying anoxic brain injury. A 5-day investigation dated November 18, 2022, revealed that seven nursing staff members, consisting of Certified Nursing Assistant (CNA) and Licensed Practical Nurse (LPN), were interviewed. This 5-day investigation further revealed there were no resident that were interviewed as potential witnesses. This 5-day investigation did not indicate where or how the resident fractured the distal radial metaphysis. An interview was conducted on December 12, 2025, at approximately 10:00 AM with the Administrator (Staff #300), who confirmed that he was the facility's abuse coordinator. Staff #300 stated that the residents in the behavioral unit have a diagnosis of Alzheimer's, dementia, and schizophrenia. Staff #300 stated he was not administrator at the time of the incident, however that the residents in this unit have cognition status varieties, for example, some residents are able to hold a conversation, while others are not able to. He then stated that the process during an investigation is to make sure that the residents are safe, conduct interviews with potential witnesses, and staff members who have worked with the residents. Staff #300 stated that the provider, family, and other state agencies would be notified. He then stated that in the behavioral unit, there isn't much interviewing conducted with the resident because of their mental judgment. He further stated that if the residents can hold a conversation and are witnesses to the incident, then they would be interviewed. He then stated that the investigation for this complaint included the staff members and family interviews. He then stated that it seems as though the incident happened in the residents' room, and there was no witness, so that's why residents' interviews were not conducted. He then stated that in their policy, it states that they should interview witnesses, residents, and the person affected. A policy title Abuse: Prevention of the prohibition against was revised in September 2024 and revealed that An interview with the person(s) reporting the incident and an interview with resident(s).		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that on residents Minimum Data Set (MDS) assessment regarding restraints was accurate. The deficient practice could result in inaccurate documentation of the resident's medical history and needs. The census was 109. Findings include:Resident #9 was initially admitted on [DATE], and re-admitted on [DATE], with diagnoses that included gastrotomy, anoxic brain damage, anxiety, and dementia. A behavioral progress note dated February 13, 2025, indicated that a G-tube was replaced, a new hand mitts and binder placed.A March 4, 2025 behavior note revealed that the resident had been restless and agitated, posey mitts were in place and abdominal binder to protect G-tube site.A Care Plan initiated on May 21, 2025, revealed a focus area for physical restraints documenting the use and the bilateral soft wrist mittens related to traumatic brain injury. This care plan also revealed an intervention placed for the use of a fastened seatbelt in a wheelchair. This care plan revealed an intervention for abdominal support to secure the feeding tube and prevent dislodgement. A physician's order dated August 26, 2025, revealed an order for OK to have a seatbelt while in a wheelchair.A physician's order dated August 26, 2025, revealed an order for removal of bilateral soft wrist mittens every 2 hours for 10 minutes for skin check, check circulation, and range of motion (ROM). An annual IDT (interdisciplinary team) Care Plan Review dated September 2, 2025, included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident's cognitive skills for daily decision-making were severely impaired. The MDS also revealed that the mobility device used by the resident was a wheelchair. The assessment revealed no evidence of restraint use In-chair or out-of-bed for trunk restraints and limb restraints, and no evidence of a trunk restraint used In-bed. A Restraint/Enabling Device / Safety Device Evaluation form dated November 25, 2025. The device recommended portion of the assessment revealed that furniture was removed from the room and his mattresses were on the floor, specialized pro wheelchair with seatbelt, bilateral soft wrist mittens. The evaluation included that the device was considered a restraint, and placed due to the resident unintentionally removing the feeding tube, impaired safety awareness A Treatment Administration Record (TAR) dated December 2025, revealed evidence that bilateral soft wrist mittens and seatbelt were placed as ordered.A December 2, 2025 quarterly IDT Care Plan Review, revealed that the review included person-centered comprehensive care planning related to restraint, enabling device, safety device. Additional nursing plan of care notes in the review, included to continue with current plan of care, care plan updated. However, the review did not include specific changes to the resident's current restraints, or implementing less restrictive restraints.An observation was conducted on December 09, 2025, at 9:13 AM. The resident was observed to be in a reclining wheelchair with bilateral soft mitts, an abdominal binder, and a seat belt. An observation was conducted on December 11, 2025, at 7:02 AM. The resident was observed to be in a reclining wheelchair with a seatbelt and wearing bilateral mittens. An observation was conducted on December 11, 2025, at 11:14 AM in the dayroom. Resident # 9 was observed to be wearing bilateral mitts and had a fastened seat belt in the reclining wheelchair.An observation was conducted on December 12, 2025, at 3:21 PM. While in bed, Resident # 9 was unable to take off his shirt and bilateral soft mitts. An interview was conducted on December 12, 2025, at 9:06 AM with the MDS Coordinator (Staff #313), who stated that the information used to complete the MDS includes (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chandler Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 West Elgin Street Chandler, AZ 85224	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments, notes, and the Assessment Reference Date (ARD). She then stated for the MDS for the Restraints and Alarms section, Used in chair or out bed for Truck restraints, it was marked Not used and should be marked daily. She further said that the MDS dated [DATE], was inaccurately completed regarding the use of the abdominal binder and bilateral soft mitts. An interview was conducted on December 12, 2025, at 2:49 PM with the Director of Nursing (DON/staff # 301), who stated that the Interdisciplinary Team (IDT) consists of: medical director, unit manager, (MDS) coordinator, wound nurse, and administrator. She further stated that IDT will review the need for restraints. She then stated that Resident #9 had bilateral mites and an abdominal binder because he pulled out his g-tube. She further stated that Resident #9 has a seat belt on while in a wheelchair so that he does not harm himself. She also stated that she would expect the MDS to be accurate. A policy titled, Resident Assessments and Associated Processes, revised or reviewed December 2024, included that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. revealed that it refers to the Long-Term Care Facility Resident Assessment instrument 3.0 User's Manual Version 1.18.22 October 2023. The Centers for Medicare & Medicaid Services' Long Term Care Facility Resident Assessment Instrument (RAI), dated October 2023 revealed that the Federally mandated MDS is the basis for an accurate assessment of nursing home residents.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the state mental health authority was notified of a resident's change in mental condition for one resident (#37). The deficient practice could result in residents not receiving the proper level of care to meet their needs. Findings Include: Resident #37 was admitted to the facility on [DATE] with diagnosis that included atherosclerotic heart disease, bipolar disorder, and colostomy status. A Level 1 Pre-admission Screening and Resident Review (PASARR) dated February 25, 2025 was completed with no referral was necessary for PASARR Level 2. Further review of the PASRR revealed that the Bipolar Diagnosis was not included. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated that the resident was congenitally intact. Further review of the MDS revealed no psychiatric or mood disorders and special treatment which included Hospice therapy. A Level 1 PASRR dated April 7, 2025 was completed including the Bipolar Disorder (Manic Depression) diagnosis. An e-mail dated April 14, 2025 from the state mental health authority revealed that Resident #37 met the terminal illness exemption and did not require a Level 2 PASARR due to a terminal illness with life expectancy of less than 6 months and also received hospice care. A Quarterly MDS assessment dated [DATE], revealed a diagnosis of Bipolar disorder with no psychological services, The MDS also revealed that Resident #37 continued to be on Hospice services. A Hospice discharge-transfer summary dated July 21, 2025, revealed that Resident #37 was discharged from hospice care on July 18, 2025 due to extended prognosis. A Nursing Progress note dated August 3, 2025 revealed that Resident #37 was refusing medications the last few days. The progress note goes on to reveal that the Resident became teary eyed that weekend, refusing some meals. Resident # 37 continued to cry and ask why do you treat me like this? It was documented in the Progress note that the nurse had another staff member in the room because resident would make false accusations. A review of the comprehensive care plan initiated on August 4, 2025 revealed that Resident #37 had a potential for a behavior problem related to bipolar disorder, resistive to care, and making false accusations against staff. A Significant Change of Condition MDS assessment dated [DATE], revealed an active diagnosis of Bipolar disorder, no psychological services and no Hospice Care. Multiple medication administration notes on August 13, 2025 revealed that Resident #37 started refusing to take her medication stating If the Holy Spirit wants to heal me he will or I will go home. It was also revealed that the resident's primary care physician was notified and psychological services were notified. An order for psychological services was given on August 13, 2025 for psychological services. A psychiatric note dated August 13, 2025 revealed that Resident #37 did have a urinary tract infection which could be contributing to her recent change in behavior and delusional thinking. A psychiatric note dated August 22, 2025 revealed a recommendation for a mood stabilizer such as lamotrigine to treat bipolar depression which Resident #37 declined. There was no evidence in the resident's clinical records of an updated Level 1 PASARR Screening following being discharged from Hospice on July 18, 2025, or the Significant Change of Condition on August 8, 2025 with unstable behavioral symptoms noted on August 13, 2025. An interview was conducted on December 12, 2025 at 10:12 a.m. with the Social Services Director (Staff # 311) who stated that every patient should have an admission PASSR when they enter and then they continue to monitor changes in behaviors and medications and adjust the care plan as needed. She goes on to reveal that it is the Interdisciplinary team to go over the review of medication and behavior (continued on next page)		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes and then update then Staff #311 would update PASARR as needed. After reviewing Resident #37's chart Staff #311 stated that a PASARR was done on April 7, 2025 and it was determined that the resident did not need PASARR 2 because she was on hospice. Staff #311 reviewed the chart further and stated that Resident #37 was no longer on Hospice as she was discharged on July 18, 2025. Staff #311 indicated that as a change of condition and stated that she should have resubmitted the PASARR for a change of condition determination. Staff #311 revealed that she did not know what it was not resubmitted for PASARR 2 determination. An interview was conducted with the Director of Nursing (DON/Staff # 301) on December 12, at 1:43 p.m. who stated that all residents get a PASSAR screening done in the hospital when they are admitted and around 30 days into their stay we do another PASARR determination and after that if there no recommendation for a PASARR level 2 we would do one if there is a change of condition. The DON also stated that if we determine there is a change of condition physically or behaviorally then Social Services would resubmit the PSARR with the change of condition for determination of PASARR level 2. The DON reviewed Resident #37's chart and stated the resident was screened on April 7, 2025 and it was determined that the resident did not need PASARR level 2 services because she was considered terminal and on hospice with under 6 months to live. The DON revealed that Resident #37 was no longer under as of July 18, 2025. The DON stated that no longer being on Hospice would be a change of condition in the MDS world. The DON also revealed that it is her expectation is what ever the facilities policy is regarding PASARR submission. Review of a policy titled, Resident Assessment PASRR, reviewed May 2025, revealed that it is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. The policy also revealed that the facility will refer to the state's AHCCCS PASSAR policy. Review of a policy titled, AHCCCS Medical Policy Manual - Pre-admission Screening and Resident Review (PASRR), revealed that a request for PASRR Level 2 evaluation is not required for individuals with a terminal illness and has a life expectancy less than six month, and there is not a current risk to self or others and behaviors/symptoms are stable. The policy also revealed that the facility was required to request Resident Reviews for individuals experiencing a Significant Change in condition as specified in Section 1919(e)(7)(B)(iii) of the Social Security Act. The policy revealed that the facility was required to submit a new Level 1 Screening to AHCCCS or DES/DDD within 14 calendar days after the facility determined through the MDS assessment that there had been a Significant Change in the resident ' s mental condition (42 CFR 483.20). The policy revealed that the submitted documentation would be reviewed to determine if another PASRR Level 2 evaluation was needed.		

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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** Number of residents sampled: Number of residents cited: 1 Based 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 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 would be possible side effects. The DON stated that the process and expectation for an order with an instruction to give medication with meals meant that nursing staff administer the medication with the meal or directly following a meal. She considered breakfast, lunch, or supper a meal, a spoon of applesauce or a pudding would not be a meal, and a resident receiving their medication with applesauce or pudding would be due to swallowing disorder or a resident's preference, and she would not consider it as a meal. Regarding Resident #14, the DON stated that the order for Metformin was to give with meals. According to [NAME] Nursing Drug Handbook, Metformin is used for management of type 2 diabetes mellitus. Regarding administration and handling, give with meals to decrease gastrointestinal (GI) upset. The medlineplus.gov website last revised on February 15, 2024, Metformin is used alone or with other medications, to treat type 2 diabetes. Metformin helps to control the amount of glucose (sugar) in your blood. It decreases the amount of glucose you absorb from your food and the amount of glucose made by your liver. The regular tablet is usually taken with meals two or three times a day. Metformin may cause side effects such as diarrhea, nausea, stomach discomfort, gas, indigestion, constipation. A review of the facility policy titled Physician Orders, revised in September 2025, revealed that it is the policy of the facility to accurately implement medication orders only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. Another review of the facility policy titled Medication Administration-Oral, revised in September 2025, revealed that it is the policy of the facility to accurately prepare, administer, and document oral medications, and when administering unit doses, identify resident eMAR orders, take vital signs if required, and hold drugs if indicated.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and the facility's policy and procedures, the facility failed to ensure that food items were properly stored and dated to meet safety standards. The deficient practice could result in loss of nutritive value and increase the risk of foodborne illness. Findings include: An initial kitchen observation was conducted on December 9, 2025, at 8:20 a.m. with the Dietary Supervisor (Staff/#308). The following were observed in the walk-in refrigerator: Salad bag opened, exposed to air, and labeled with open and use by dates of 12/6-12/12/21lb ground beef, without an open or use-by date Employee lunch bag on the shelf Boiled eggs container opened, exposed to air 9 unlabeled and undated juice cups 1lb bag of green beans opened, exposed to air bag of lettuce opened and exposed to air During a follow-up Kitchen Observation conducted on December 11, 2025, at 6:26 a.m., two sheet cake pans were observed uncovered on the prep counter. A tray line temperature check and observation conducted on December 11, 2025, at 11:46 am revealed the following: 12/11/2025 11:40 AM cake dessert - 52 degrees Fahrenheit (F) 12/11/2025 11:42 AM cake dessert #2 - 55 degrees F 12/11/2025 11:43 AM milk - 46 degrees F 12/11/2025 11:43 AM milk #2 - 47 degrees F 12/11/2025 11:43 AM apple juice - 45 degrees F 12/11/2025 11:43 AM diced peaches - 48 degrees F 12/11/2025 11:44 AM applesauce - 48 degrees F 12/11/2025 11:44 AM watermelon - 48 degrees F 12/11/2025 11:45 AM mechanical soft/moist pears - 56 degrees F During an observation conducted on December 11, 2025, at 11:54 AM, a Dietary Aide (Staff #488) was observed placing a personal water bottle on the bottom shelf of the food prep table. An observation of the unit refrigerators was conducted on December 11, 2025, at 1:41 p.m. with (Staff/#308). The unit refrigerator's posted cleaning schedule documented that it was not cleaned on December 10, 2025. Additionally, the fridge contained a paper plate covered with a napkin containing a half-eaten sandwich. (Staff/#308) identified the sandwich as an employee's lunch. Per staff #308, staff stated lunches should not be placed in the unit refrigerators with medications and that they know better. (Staff/#308) noted that the risks of placing personal food in the unit refrigerators is that it can cause cross-contamination. Further observation of the unit refrigerator revealed juice spills located on the shelves and the bottom of the unit refrigerator. An interview was conducted on December 12, 2025, at 1:07 PM with the Dietary Supervisor (Staff/#308). Staff #308 stated that the facility's process for storing food is to label and date all food items and to ensure all food items are properly closed. Staff #308 stated she is responsible for ensuring staff label and date food items. However, there is no set schedule for conducting these observations. Staff #308 stated that she randomly conducts observations of the refrigerator, freezer, and dry storage. Staff #308 stated that the risk of not properly storing or dating food items is that it places residents at risk for food-borne illness from bacterial growth that can cause stomach issues or diarrhea. Staff #308 stated that staff should place their food items in the designated refrigerator for staff located in the break room to prevent cross-contamination. Staff #308 stated that milk should have been at 40 degrees, cold desserts and juices should have been at 42 degrees and under. Per staff #308, the risks of higher temperatures for these foods are bacterial growth, which can cause residents to get sick from it or cause diarrhea. Review of the facility policy titled Food Storage and Date Marking states that sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry, and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross-contamination. e. TCS (Time/Temperature Control for Safety) foods should be covered, labeled, and dated if stored and not (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for immediate use. All foods will be checked to assure that foods (including leftovers) will be consumed by their use-by dates, or frozen (where applicable), or discarded, at the end of the day. Use-by dates for TCS foods are 7 days or less from the prep date.		