

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Sante of Chandler		STREET ADDRESS, CITY, STATE, ZIP CODE 825 South 94th 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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on interview and review of facility records, policy, and procedure, the facility failed ensure payroll based journal was submitted according to federal requirement. The deficient practice could lead to inability of a third party to audit the facility's staffing. Review of Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing data report dated April 1 - June 30, 2025, revealed the facility failed to submit staffing data for the quarter. An interview was conducted with the facility administrator (Staff #6) on February 18, 2026, at 9:43 a.m. who stated that the facility's process for submitting the PBJ staffing data is through electronic submission, and to submit it by a deadline date. The administrator stated that for the quarter April 1 - June 30, 2025, that the facility tried to submit the staffing data but missed the deadline. The administrator stated that the facility's new process moving forward is to submit the PBJ staffing data a week early to ensure the deadline is not missed. Review of the facility policy titled Reporting Direct-Care Staffing Information (Payroll-Based Journal), dated October 2017, revealed staffing and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Policy interpretation and implementation included: 1. Beginning with the fiscal quarter of 2016 (beginning July 1, 2016), direct-care staffing and census information will be reported electronically to CMS through the Payroll-Based Journal (PBJ) system. 2. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees. 3. Providers who are employed by the facility (including physicians) are included in direct-care staffing information; providers who bill Medicare directly are not included. 4. For auditing purposes, reported staffing information is based on payroll records, or other verifiable information. 5. Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both. 6. The PBJ system is accessed through the QIES at https://www.qtso.com/.</p>		

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Sante of Chandler		STREET ADDRESS, CITY, STATE, ZIP CODE 825 South 94th 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, staff interviews and review of the clinical record, the facility failed to ensure that services met professional standards of quality by failing to prepare medications according to provider orders, requiring surveyor intervention prior to medication administration to one of six sampled residents (#21). The deficient practice has the potential for the resident not receiving the appropriate treatment and for additional errors in treatment administration. Findings include: During medication administration observation conducted on February 19, 2026 at 9:23 a.m., a Licensed Practical Nurse (LPN/staff #118) was observed to review Resident #21's order in the electronic medical record (EMR) and then place two Buspirone HCL 15mg (milligram) tablets in a clear medication cup for Resident #21. The LPN proceeded to remove a medication card out of the medication cart, and began to place the medication into the same medication cup with the two Buspirone. At this time, the surveyor stopped the LPN and asked for clarification of the order for Buspirone. The LPN reviewed the order and stated that the resident was ordered 1/2 of a 30 mg tablet, which would be 15 mg. She stated that she had not read the order accurately and placed two 15mg Buspirone tablets in the medication cup, which would total 30mg. The LPN immediately removed one of the 15mg Buspirone tablets and placed it in the waste receptacle. An interview was conducted on February 19, 2026 with the LPN (staff #118) at 9:40 a.m. directly after administration of Resident #21's medications. The LPN stated that she would have administered the Buspirone medication in error if the surveyor had not intervened. She stated that this did not follow the facility policy, and that the expectation is to follow physician orders as written. She stated that she did not follow the orders or the facility policy for medication administration. An interview was conducted with the Assistant Director of Nursing (ADON/staff #1) on February 19, 2026 at 11:18 a.m. She stated that medications should be administered following physician orders, exactly as the provider ordered. She stated that the risk of administering Buspirone outside of physician orders could result in side effects that may include sleepiness/tiredness. The ADON reviewed Resident #21's medical record and stated that there was an order dated January 21, 2026 for Buspirone HCL Oral tablet 30 mg, to give 1/2 tab twice a day at 8:00 a.m. and 2:00 p.m., which would be 15 mg twice a day. She stated that if the nurse placed two 15mg tablets in a medication cup to administer to the resident then that would be a medication error variance. She stated that this would not meet the facility policy for medication administration. A policy titled, Administering Medications, revealed that medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders. The individual administering medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p>		