STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375470	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Therapy & Living Center LLC	601 West 1st Street Chandler, OK 74834

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure prepared food items were labelled with preparation and use-by dates and food items were discarded after use-by date during 1 of 2 kitchen observations.The administrator identified 36 residents received nutrition from the kitchen.Findings:On 12/08/25 at 9:43 a.m., the following observations were made in the walk-in refrigerator located outside the building: a. a covered plastic pitcher labelled grape, 12/02/25,b. a covered plastic pitcher labelled noodles, 12/03/25,c. a covered plastic pitcher labelled unsweet, 12/06/25, and d. a covered plastic pitcher labelled oj, 12/07/25. On 12/08/25 at 9:48 a.m. a cardboard box was observed containing salad dressing packets with manufacturer use-by date of 9/25 in the dry storage area in the kitchen.An undated facility policy titled Date Marking and Food Safety, read in part, the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.An undated facility policy titled Date Marking for Food Safety, read in part, the discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest.On 12/08/25 at 9:44 a.m., the dietary manager stated they were not sure if the dates were prepared date or use-by date, but assumed the dates were the prepared date. On 12/08/25 at 9:50 a.m., the dietary manager stated they should have discarded and removed items that were expired from dry storage and placed in a trash receptacle.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure residents were free from abuse for 1 (#31) of 2 sampled residents reviewed for abuse.The administrator identified 37 residents resided in the facility.Findings:An undated Abuse Policy and Procedure, read in part, We will endeavor to protect our occupants from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of resident property. It recognizes resident rights to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints as defined by federal regulation.An incident report form, dated 12/08/25, showed on 12/08/25 Res #31 made an allegation of verbal abuse against CNA #1. The report also showed CNA #1 was suspended pending an investigation.An annual assessment, dated 09/29/25, showed Res #31 had a BIMS (a test for cognition) of 11 which was indicative of moderately impaired cognition. The assessment showed Res #31 had diagnoses which included diabetes mellitus and anxiety disorder. On 12/08/25 at 2:19 p.m., Res #31 stated CNA #1 was verbally abusive to them earlier in the day. Res #31 stated they had not reported the abuse.On 12/08/25 at 2:25 p.m., Res #31's allegation of verbal abuse was reported to the administrator.On 12/10/25 at 12:10 p.m., CMA #5 stated they had reported CNA #1 in the past for verbal abuse and was not sure if it was investigated.On 12/10/25 at 12:20 p.m., CNA #4 stated they had reported CNA #1 in the past for verbal abuse and does not know if it was investigated. On 12/10/25 at 3:00 p.m., the administrator stated during the investigation CNA #1 resigned. They also stated the facility had substantiated the allegation of abuse and they were reporting their findings to the nurse aide registry.

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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. Based on record review and interview, the facility filed to ensure allegations of abuse were reported to the OSDH for 1 (#21) of 2 sampled residents reviewed for abuse.The administrator identified 37 residents resided in the facility.Findings:An undated Abuse Policy and Procedure, read in part, All allegations of resident mistreatment, including neglect, physical abuse, mental abuse, sexual abuse, involuntary isolation, verbal abuse, injuries of unknown origin, and/or misappropriation of property, shall be promptly reported to the administrator and investigated by facility management. Administrator will immediately report the allegation to the Oklahoma State Department of Health and the local police.A quarterly assessment, dated 10/16/25, showed Res #21 had a BIMS score (a test for cognition) of 04, which was indicative of severe cognitive impairment. The assessment showed Res #21 had diagnoses which included anxiety and depression.An undated statement form, signed by CNA #4, showed Res #21 expressed suicidal thoughts and CNA #1 antagonized Res #21.An undated statement form, signed by CMA #5, showed Res #21 was yelling and CNA #1 was yelling back at Res #21.On 12/10/25 at 12:10 p.m., CMA #5 stated they witnessed CNA #1 shouting at Res #21 and wrote a statement about it and slid it under the administrator's door. On 12/10/25 at 3:15 p.m., CNA #4 stated on 10/04/25 they, along with CMA #1 and CMA #5, witnessed CNA #1 verbally abuse Res #21. CNA #4 stated the administrator was not in the building at the time of the incident, so they all wrote statements and slid them under the administrator's door. They stated the administrator was sent a text message to inform them of the situation.On 12/15/25 at 10:15 a.m., the administrator stated calling a resident names, cursing at a resident, or yelling at a resident, were all examples of verbal abuse. The administrator stated the incident involving Res #21 and CNA #1 was not reported to the OSDH or the local police.

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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. Based on record review and interview, the facility failed to ensure an allegation of abuse was investigated for 1 (#21) of 2 sampled residents reviewed for abuse.The administrator identified 37 residents resided in the facility.Findings:An undated Abuse Policy and Procedure, read in part, The administrator or administrative designee will conduct an immediate investigation of all alleged or actual incidents of abuse, neglect, or misappropriation of property.A quarterly assessment, dated 10/16/25, showed Res #21 had a BIMS score (a test for cognition) of 04, which was indicative of severe cognitive impairment. The assessment showed Res #21 had diagnoses which included anxiety and depression.An undated statement form, signed by CNA #4, showed Res #21 expressed suicidal thoughts and CNA #1 antagonized Res #21.An undated statement form, signed by CMA #5, showed Res #21 was yelling and CNA #1 was yelling back at Res #21.On 12/10/25 at 12:10 p.m., CMA #5 stated they witnessed CNA #1 shout at Res #21 and wrote a statement about it and slid it under the administrator's door. On 12/10/25 at 3:15 p.m., CNA #4 stated on 10/04/25 they, along with CMA #1 and CMA #5, witnessed CNA #1 verbally abuse Res #21. CNA #4 stated the administrator was not in the building at the time of the incident, so they all wrote statements and slid them under the administrator's door. They stated the administrator was sent a text message to inform them of the situation.On 12/15/25 at 10:15 a.m., the administrator stated calling a resident names, cursing at a resident, or yelling at a resident were all examples of verbal abuse. The administrator stated the incident which involved Res #21 and CNA #1 was not investigated because they did not think it was verbal abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a care plan was revised for 1 (#30) of 12 sampled residents reviewed for care plans.The administrator identified 37 residents resided in the facility. Findings: An undated medical diagnoses list showed Res #30 had diagnoses which included vascular dementia, bipolar, schizophrenia, muscle weakness, and abnormalities of gait. An undated incident list for Res #30 showed they had non-injury falls on 11/15/25, 11/24/25, 11/27/25, and 12/12/25. Res #30's record was reviewed, and the care plan had not been revised to show interventions after each fall. On 12/15/25 at 11:40 a.m., the DON stated the care plan should have been revised after each fall to show an intervention.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 (#6) of 4 sampled residents reviewed for medication administration. The administrator identified 37 residents resided in the facility.Findings:An undated medication administration policy showed residents should be identified by the photo in the medication administration record. The policy showed to follow the six rights of medication administration which included identifying the right resident.A quarterly assessment, dated 09/11/25, showed Res #6 had a BIMS score (a test for cognition) of 15 which was indicative of intact cognition. The assessment also showed Res #6 had diagnoses which included diabetes mellitus and anxiety disorder.An incident note, dated 09/25/25 at 11:44 a.m., showed Res #6 was given another resident's medication by mistake. The medications given in error were Lasix 20 mg (a diuretic), Colace 100 mg (a stool-softener), Mobic 7.5 mg (an anti-inflammatory), Prilosec 40mg (a proton pump inhibitor), Xanex 0.5 mg (an anti-anxiety medication), Cymbalta 30 mg (an anti-depressant medication), and oxycodone 10 mg (an opioid pain medication). On 12/15/25 at 9:05 a.m., CMA #2 stated residents should always be positively identified before medications were administered.On 12/15/25 at 9:25 a.m., CMA #1 stated on 09/25/25 they administered the wrong medication to Res #6 by mistake. On 12/15/25 at 9:45 a.m., the DON stated residents should always be identified before medication administration