STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide notice as soon as practicable before transfer or discharge for 1 of 5 residents reviewed for admission, transfer, and discharge. (Resident #10)Resident #10's was transferred to another facility on 10/21/24 without required proper written documentation. This failure could place residents at risk of not receiving appropriate care and required notifications.Record review of Resident #10's face sheet indicated Resident #10, admitted to facility 06/09/24, was an [AGE] year-old female. Her diagnoses included dementia (An umbrella term for a group of conditions that cause a decline in mental ability severe enough to interfere with daily life affecting memory thinking and behavior) and generalized anxiety (a feeling of worry, nervousness, or unease about an uncertain outcome). Record review of Resident #10's Quarterly MDS, dated [DATE], indicated a BIMS score of 05 (indicating a severe impairment of cognitive abilities). Resident #10 used a wheelchair to propel self and had a wander guard bracelet. Record review of Resident #10's Care Plan dated 08/23/24, indicated Resident #10 had wandering behaviors related to dementia. Interventions include freedom of movement throughout facility/unit; always wear a wander guard bracelet; redirect from exit doors; re-direct if attempting to enter areas that are inappropriate; and use diversion and redirection. In addition, (dated 09/16/24) Resident #10 was unable to adjust to placement due to confusion and agitation. Unable to be distracted from agitation or confusion. Interventions included assisting with phone calls to family member. Record review of Resident #10's progress notes, dated 10/17/24 at 04:43 p.m., entered by the SW, read this SW informed that resident is having increasing confusion and exit seeking behavior. This SW contacted resident [family member] and discussed with her the concern and that resident would benefit from a memory care unit. Resident [family member] voiced understanding and that this SW could send referral to (sister facility). Referral sent to sister facility. This SW will follow up. Record review of Resident #10's progress notes, dated 10/21/24 at 2:15 p.m., entered by nursing, read late entry: Received report that resident was discharging to memory care unit. Medications and belongings packed by previous shift. Driver in facility for pickup. At 2:30 PM noted resident belongings left in room, but they did take medication. Notified receiving facility of belongings being left. Was informed that belongings would get picked up 10/22/24.Record review of a Referral packet sent to the sister facility on 10/17/24 at 3:49 p.m. and provided by the SW, contained the following for Resident #10:- face sheet,10/17/24;- physician note dated 09/23/24;-physician order report dated 09/17/24 - 10/17/24; and-nurse progress notes dated 07/23/24 - 10/12/24.Record review of Resident #10's clinical records from 09/17/24 - 10/21/24 did not document the following:-notification to resident or resident representative of transfer or discharge and the reasons for the move in writing;-notification of transfer or discharge notice to local ombudsman;-notice of transfer or discharge at least 5 days or 30 days before being transferred or discharged ;-signed consent from resident representative for transfer/discharge;-a discharge summary with a recapitulation of the resident's stay.Record review of an email exchanged with the ombudsman for the facility on 11/21/25, she said she did not recall being notified of Resident #10's transfer to sister facility and she did not have any documentation regarding transfer. During a phone interview on 11/18/25 at 09:30 a.m., the family member said Resident #10 had been transferred to the sister facility without her knowledge. The family member said she was visiting other facilities to seek placement and while at the sister facility, she was informed of the planned admission for that day to new facility. During an interview on 11/18/25 at 12:30 p.m., the SW said Resident #10 had not been given a 5 - day nor a 30-day discharge notice. She said she could not recall all the information as she was not a full-time employee at that time of Resident #10's transfer to a sister facility and was off when the resident had been transferred. During an interview on 11/18/25 at 12:45 p. m., the Administrator said she was not employed at the facility during the time of this incident. She said her expectations would be to put an exit-seeking resident on 1:1 supervision, and if necessary, initiate a 5-day or 30-day notice to resident and/or representative for a safer environment such as a memory care unit. She added expectations would include all the required documentation to be completed and given to appropriate entities. Record review of the undated facility's Discharge Summary and Plan policy read in part . 4. The discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and will include a) where there individual plans to reside; b) arrangements that have been made for follow up care and services; c)how the IDT will support the resident or representative in the transition to post-discharge care 6. The resident/representative will be involved in the discharge planning