

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Horizon Post Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4704 West Diana Avenue Glendale, AZ 85302	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</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

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure one resident was free from abuse from another resident, Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#100) was free from physical abuse from other residents (resident #200). The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #100 was admitted to the facility on [DATE], with diagnosis that Diabetes mellitus type 2, end stage renal disease, anemia, hyperlipidemia, heart disease and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A behavioral care-plan initiated May 5, 2025 showed the resident had the potential to demonstrate verbally aggressive behaviors related to poor impulse control and agitation, with a goal of will have zero episodes of verbally aggressive or agitation behaviors and a noted intervention of when resident becomes verbally aggressive, intervene before agitation escalates. -Resident #200 was admitted to the facility on [DATE], with diagnosis that include dementia, rheumatoid arthritis, anemia, depression, heart failure, and peripheral vascular disease. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. A behavioral care-plan initiated September 9, 2021 revealed the resident has the potential to demonstrate physical behaviors related to physical aggression towards other residents, with goals noted as will not harm self or others, and noted interventions of analyze key times, places, circumstances, triggers, and what de-escalated behaviors and document those, assess and anticipate resident's needs, and document observed behavior and attempted interventions. Review of information received from the SA complaint tracking system revealed that on July 18, 2025, at 5:45 a.m. a complaint incident was received that revealed that resident #200 had punched resident #100 with a closed fist. The complaint also states that the administrator was aware and had told the staff to keep quiet about the situation. A review of progress notes for resident #100 dated June 30, 2025 at 12:13 p.m. revealed resident #100 was alert and oriented to person, place and time. Able to communicate well, and had appropriate affect. A review of progress notes for resident #100 dated July 16, 2025 at 3:36 p.m. revealed Resident #100 has been observed bumping into walls and objects while independently wheeling himself in his manual wheelchair. Resident has a dx of legally blind due to Diabetes. Resident has been educated on the risks of ambulating independently. Resident became irate, became verbally aggressive and called is brother [NAME] on the phone. While on speaker, [NAME] asked to be transferred to another facility, his brother agreed and asked this write to facilitate a transfer. Brother was also educated on the risks of resident ambulating independently in his wheelchair and he demanded he continue with the wheelchair. An interview was conducted with resident #100 on July 22, 2025 at 1:45 p.m. The resident stated that he was running down the hallway and bumped into resident #200. He then stated he was shocked and said who was that? and stated that resident #200 got verbally aggressive and punched me in my face. He continued that he was just rolling down the hallway in his wheelchair and that he bumped into resident #200 on accident. The resident further stated that resident #200 was totally abusive. The resident concluded that a charge nurse identified as staff #15 broke it up, and didn't know if anyone else saw it. An interview was conducted with resident #200 on July 22, 2025 at 2:00 p.m. The resident stated that resident #100 ran into him on purpose, from behind. Resident #200 stated that there was all kinds of room on the side in the hallway resident #100 could have used instead of running into him, and pointed to the other side of the hall. Resident #200 stated that he pushed resident #100 away, and that resident #100 came straight at him. Resident #200 stated that resident #100 was trying to hit him and he told him to stop, and that resident #200 was just an asshole and was looking for it. Resident #200 concluded that yes he felt abused and stated that he was just trying to protect himself, and noted that he had a scratch on his arm from the incident. A roughly 1.5 long scratch that appeared to be healing was noted on resident #200's right arm during this interview, however review of skin notes and other documentation reviewed revealed nothing in the clinical record related to the injury. An interview was conducted with a Certified Nursing Assistant (CNA/staff #10) on June 23 2025 at 9:56 a.m. The CNA stated that she has been there a year and 11 months. When asked about the incident between the residents she stated that the incident happened on Wednesday, and that she doesn't work Wednesdays. The CNA concluded that she did hear about the incident involving resident #100 and resident #200 but did</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure a credible allegation of abuse was investigated. Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that their policy on abuse was followed. The deficient practice could result in more cases of resident to resident abuse not being investigated. Findings include: -Resident #100 was admitted to the facility on [DATE], with diagnosis that Diabetes mellitus type 2, end stage renal disease, anemia, hyperlipidemia, heart disease and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A behavioral care-plan initiated May 5, 2025 showed the resident had the potential to demonstrate verbally aggressive behaviors related to poor impulse control and agitation, with a goal of will have zero episodes of verbally aggressive or agitation behaviors and a noted intervention of when resident becomes verbally aggressive, intervene before agitation escalates. -Resident #200 was admitted to the facility on [DATE], with diagnosis that include dementia, rheumatoid arthritis, anemia, depression, heart failure, and peripheral vascular disease. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. A behavioral care-plan initiated September 9, 2021 revealed the resident has the potential to demonstrate physical behaviors related to physical aggression towards other residents, with goals noted as will not harm self or others, and noted interventions of analyze key times, places, circumstances, triggers, and what de-escalated behaviors and document those, assess and anticipate resident's needs, and document observed behavior and attempted interventions. Review of information received from the SA complaint tracking system revealed that on July 18, 2025, at 5:45 a.m. a complaint incident was received that revealed that resident #200 had punched resident #100 with a closed fist. The complaint also states that the administrator was aware and had told the staff to keep quiet about the situation. A review of progress notes for resident #100 dated June 30, 2025 at 12:13 p.m. revealed resident #100 was alert and oriented to person, place and time. Able to communicate well, and had appropriate affect. A review of progress notes for resident #100 dated July 16, 2025 at 3:36 p.m. revealed Resident #100 has been observed bumping into walls and objects while independently wheeling himself in his manual wheelchair. Resident has a dx of legally blind due to Diabetes. Resident has been educated on the risks of ambulating independently. Resident became irate, became verbally aggressive and called is brother [NAME] on the phone. While on speaker, [NAME] asked to be transferred to another facility, his brother agreed and asked this write to facilitate a transfer. Brother was also educated on the risks of resident ambulating independently in his wheelchair and he demanded he continue with the wheelchair. An interview was conducted with resident #100 on July 22, 2025 at 1:45 p.m. The resident stated that he was running down the hallway and bumped into resident #200. He then stated he was shocked and said who was that? and stated that resident #200 got verbally aggressive and punched me in my face. He continued that he was just rolling down the hallway in his wheelchair and that he bumped into resident #200 on accident. The resident further stated that resident #200 was totally abusive. The resident concluded that a charge nurse identified as staff #15 broke it up, and didn't know if anyone else saw it. An interview was conducted with resident #200 on July 22, 2025 at 2:00 p.m. The resident stated that resident #100 ran into him on purpose, from behind. Resident #200 stated that there was all kinds of room on the side in the hallway resident #100 could have used instead of running into him, and pointed to the other side of the hall. Resident #200 stated that he pushed resident #100 away, and that resident #100 came straight at him. Resident #200 stated that resident #100 was trying to hit him and he told him to stop, and that resident #200 was just an asshole and was looking for it. Resident #200 concluded that yes he felt abused and stated that he was just trying to protect himself, and noted that he had a scratch on his arm from the incident. A roughly 1.5 long scratch that appeared to be healing was noted on resident #200's right arm during this interview, however review of skin notes and other documentation reviewed revealed nothing in the clinical record related to the injury. An interview was conducted with a Certified Nursing Assistant (CNA/staff #10) on June 23 2025 at 9:56 a.m. The CNA stated that she has been there a year and 11 months. When asked about the incident between the residents she stated that the incident happened on Wednesday, and that she doesn't work Wednesdays. The CNA concluded that she did hear about the incident involving resident #100 and resident #200 but did not work that day. 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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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