STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035159	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Post Acute and Rehabilitation Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure residents do not abuse other residents.Based on observations, interviews, record review, the facility failed to protect the resident's right (#1) to be free from physical abuse by another resident (#2). The deficient practice could result in further abuse of residents and appropriate action not taken.Findings include:Regarding Resident #1 (alleged victim) :Resident #1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, seizures, hypothyroidism, major depressive disorder, schizophrenia, anxiety disorder and muscle weakness.Review of Resident #1's quarterly minimum data set (MDS) assessment dated [DATE] revealed that the Brief Interview for Mental Status (BIMS) score was 15, indicating the resident is cognitively intact.Review of Resident #1's care plan revealed a focus for potential psychosocial well-being problem related to an altercation with another resident. The plan included to monitor for changes in mood/behavior, date initiated, October 21, 2025.-Regarding Resident #2:Resident #2 was admitted on [DATE] with diagnoses that included multiple sclerosis, major depressive disorder, and essential primary hypertension.Review of Resident #2's quarterly minimum data set (MDS) assessment dated [DATE] revealed that the brief interview for mental status (BIMS) score was 15, indicating the resident is cognitively intact.Review of Resident #2's care plan revealed a focus: potential to demonstrate verbally abusive behaviors related to ineffective coping skills, date initiated: 10/07/2023. Goal: Will verbalize understanding of need to control verbally abusive behavior through the review date. Target date: 12/30/2025. Another focus: Potential for a psychosocial well being problem related to incident with another resident PASRR level II referral submitted May 30, 2025. PASRR level II determination received June 5, 2025- Resident #2 does not meet criteria for PASRR level II and will remain PASRR level I. Date initiated May 19, 2025.A nursing progress note dated May 18, 2025 at 23:11 by licensed practical nurse (LPN)/Staff 9 stated that Staff #9 revealed Resident #2 was involved in an altercation with his roommate over noise in resident's room. Both parties were separated for individual safety.A nursing progress note dated October 21, 2025 at 19:11 by Director of Nursing Services (DON)/Staff #5 revealed Resident #1 had an incident with another resident. Both were immediately separated and assessed for injuries. Skin Concerns noted, treatment initiated, currently denies pain.A nursing progress notes dated October 21, 2025 19:35 by DON/ Staff #5 revealed that Resident #2 had an incident with another resident. Both were immediately separated and assessed for injuries. No skin concerns noted, currently denies pain. Change of condition initiated for mood/behavior changes. Police notified, resident arrested at this time related to domestic violence and taken to jail.A nursing progress note dated October 21, 2025 at 19:58 by DON Staff #5 revealed that the resident is on blood thinners and was offered to be sent to the emergency department, declines at this time.A Skin/Wound note dated October 22, 2025 at 13:06 by Licensed Practical Nurse (LPN)/Staff #6 revealed that Resident #1 had steri strips noted above left eye. Scratching and bruising to face, arms and chest.A telephonic interview was attempted on October 31, 2025 at 10:47 a.m. with certified nursing assistant (CNA)/ Staff #8. Staff #8 did not answer her phone, however a voice mail message was left to return the call. No call was returned by Staff #8. An interview was conducted on October 31, 2025 at 11:12 a.m. with (CNA) Staff #3 and revealed that she did not see the incident between Resident #1 and Resident #2, but stated when you see abuse that you report it to the abuse coordinator. Trainings are done when staff first start.An interview and observation was conducted on October 31, 2025 at 11:16 a.m. with Resident #1 revealed that Resident #2 started yelling, cussing and calling names and said something that he was going to f@&k me up and kill. He then came over and crashed into the over the bed table that was placed next to the curtain. Resident #1 did not want to hit him and Resident #2 started gouging his eyes. Resident #1 said some cuss words and told Resident #2 he could not hit. Then Resident #2 started punching Resident #1. Resident #1 then called Resident #2 a girl. Resident #2 then started punching Resident #1 with a black metal looking water cup (Resident #1 pointed to a bedside night stand where the black metal cup was at). Resident #1 pointed to his left side of face by his eye and eyebrow where white looking strips were placed, and stated Resident #2 scratched my face and ears. Resident #1 then pointed to his left shoulder and a dark colored bruise was noted on the ball of the shoulder, scratches on upper arm/shoulder, bruise to the antecubital area and more scratches to his lower arm. Resident #1 stated that he does have pain. The police came, pressed charges and took Resident #2 to jail. Resident #1 did not hit Resident #2 because Resident #2 was old.An interview was conducted on October 31, 2025 at 11:34 a.m. with assistant director of nursing (ADON) Staff #4 and revealed that she was