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 02/26/2026

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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical record, and review of policy and procedure, the facility failed to ensure a resident's (#2) rights were honored regarding emergent transfer to the hospital. The deficient practice could result in a resident being unable to make choices about their health, and could cause physical or psychosocial harm to a resident.-Findings include:Resident #2 was admitted on [DATE], with diagnoses that included type 2 diabetes mellitus, hypertensive heart disease, chronic kidney disease, peripheral vascular disease, pulmonary hypertension, anemia, and acquired absence of the left leg below the knee.A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #2 had a brief interview for mental status (BIMS) assessment score of 13, indicating intact cognition.The clinical record revealed no evidence that Resident #2 had a medical power of attorney or any other court-appointed entity to make medical decisions on the resident's behalf.A care plan initiated July 30, 2025, revealed Resident #2 had hypertension, with interventions that included to monitor for side effects such as orthostatic hypotension and increased heart rate, and to obtain blood pressure readings.Another care plan initiated August 14, 2025, included Resident #2 had a potential fluid deficit, with a goal that the resident would be free from symptoms of dehydration, and with interventions that included to monitor vital signs as ordered and record, and to notify the medical provider of significant abnormalities.A Nurse Practitioner / Physician Assistant (NP / PA) progress note dated February 11, 2026, included that the resident had worsened renal function, pending labs that day. The note included that the resident needed nephrology follow-up, and that an order was placed.A physician's order dated February 11, 2026, included to make follow up appointment with nephrology as soon as possible due to worsened renal function.An NP / PA progress note dated February 12, 2026, included that Resident #2 was complaining of tiredness, and the note revealed this was secondary to suspected acute kidney injury uremia, acute on chronic kidney disease, stage III, with metabolic acidosis, and suspected pre-renal acute tubular necrosis dehydration. Again, the note included for the resident to follow up with nephrology ASAP (As Soon As Possible), and that this was discussed with administration and nursing.A physician's order dated February 12, 2026, with a start date of February 14, 2026, included a basic metabolic panel (BMP) laboratory order.A physician's order dated February 13, 2026, and with a start date of February 14, 2026, included for sodium bicarbonate oral tablet 640 mg to give 1 tablet by mouth three times a day for metabolic acidosis.The clinical record revealed no evidence of any nursing progress notes completed on February 14, 2026, and no evidence of a nursing assessment done for Resident #2 for a request from the resident to go to the hospital on February 14, 2026. Additionally, the record revealed no evidence of any of Resident #2's concerns or any interventions done regarding his concerns on February 14, 2026.Physician's orders dated February 14, 2026, included: -Place foley catheter for outlet obstruction versus neurogenic bladder -Set up urology appointment due to partial obstructive uropathy versus neurogenic bladderThe clinical record revealed no evidence that any vital sign assessments of blood pressure, oxygen saturation, pulse, respiration rate, or temperature were assessed and recorded on February 14, 2026 (the date that Resident #2 requested to go to the (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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The note included that the resident refused to have the foley catheter inserted and instructed the nurse to contact his attorney. The note included that the physician was notified.Another physician's order dated February 15, 2026, included a BMP laboratory order in the morning for acute kidney injury (AKI).Despite the physician orders for laboratory tests, for the start of a medication (sodium bicarbonate) for metabolic acidosis, and the order for a new foley catheter, there was no evidence of a change of condition monitoring for February 14-15, 2026.Review of the clinical record revealed no active physician orders for February 14 or 15, 2026, specifying how often or when to assess vital signs of blood pressure, oxygen saturation, pulse, respiration rate, or temperature.Despite the physician order on February 11, 2026, to set up nephrology appointment as soon as possible, review of the clinical record on February 26, 2026, revealed no evidence that a nephrology appointment was set up.A Nursing note dated February 17, 2026, revealed that a nurse entered Resident #2's room to administer medications, and the resident appeared unresponsive and not breathing. The nurse immediately re-assessed the resident, and confirmed lack of vital signs, and do not resuscitate (DNR) status, and retrieved a second nurse to confirm, and the resident was pronounced deceased .An interview was conducted with a licensed nursing assistant (LNA / Staff #21) on February 26, 2026, at approximately 11:15 a.m., who stated that she was familiar with Resident #2, and that she had never experienced the resident having any behaviors, and that the resident did not seem like the type to overreact.An interview was conducted with a certified nursing assistant (CNA / Staff #9) on February 26, 2026, at 11:37 a.m., who stated that she was very familiar with Resident #2 and worked with him frequently, and that the resident was not behavioral, and that when she had worked with the resident, that he never seemed upset with staff or his care.An interview was conducted with a licensed practical nurse (LPN / Staff #34) on February 26, 2026, at 11:42 a.m. who stated that she was not the resident's assigned nurse, but that she recalled on Saturday, February 14, 2026, she had seen the resident, and observed he had a peripheral IV in his arm, and that the resident appeared pale compared to his normal appearance.A telephonic interview was conducted with a CNA (Staff #54) on February 26, 2026, at 12:27 p.m., who stated that she was familiar with Resident #2, and that she was one of his assigned CNAs in the days before his passing, and that she had noticed the resident was not presenting as usual. Staff #54 stated she noticed that the resident normally did not complain of pain when staff helped to turn and move him in the bed, and that during the days before he passed away, Resident #2 was complaining of pain when staff assisted the resident with rolling and turning over in the bed. Staff #54 stated that she was not sure if the floor nurse was aware of the resident's new complaint of pain, but that Staff #54 believed so.An interview was conducted with an LPN (Staff #70) on February 26, 2026, at 12:31 p.m., who stated that she was familiar with Resident #2, and that the resident had not been doing well for several days before his passing. Staff #70 stated that the resident had lab work drawn often in the days before his passing, and the resident's renal function had plummeted.A telephonic interview was conducted with an LPN (Staff #18) on February 26, 2026, at 1:04 p.m. who stated that she was familiar with Resident #2, and that the resident never really asked for much, so that when he did ask for something, Staff #18 knew it was serious.A telephonic interview was conducted with a friend of Resident #2 on February 26, 2026, at 1:20 p.m. who stated that he received a phone call from Resident #2 on February 14, 2026, at 10:34 a.m. The friend stated that Resident #2 was very upset and said that he was not feeling well, and stated he felt that the facility was not doing enough to address his (continued on next page)

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The friend said that he was informed by the fire department that they could not just pick up Resident #2 out of the facility and take him to the hospital. The friend stated that this incident had an upsetting effect on Resident #2, and that the resident was so riled up, that Resident #2 had requested the friend to contact his attorney. At the conclusion of the interview, the friend was requested to review his phone call log on his phone to confirm the dates and times of the phone calls. The friend reviewed his phone call log and stated Resident #2 had called him on February 14, 2026, at 10:34 a.m., and that the friend had called 911 five minutes later at 10:39 a.m.A telephonic interview was conducted with an LPN (Staff #66), on February 26, 2026, at 1:33 p.m. who stated she was familiar with Resident #2, and had cared for the resident at times before the resident passed away. Staff #66 stated that she had never seen any behaviors from the resident. Staff #66 also stated that she recalled one incident recently when the resident stated that he wanted to go to the hospital and felt that nothing was being done to address his medical issues. Staff #66 stated that she told the resident that he had an IV and was on medication, and that he did not meet the criteria to be sent to the hospital. Staff #66 stated that shortly after that, a friend of Resident #2 called and spoke with Staff #66 on the phone, and said to Staff #66 that Resident #2 was unhappy and felt nothing was being done for his medical issues, and requested that the resident go out to the hospital via 911. Staff #66 stated that she informed the friend that we can't call 911 for this patient because he did not meet the criteria, but stated to the resident's friend that if Resident #2 or the friend wanted to call 911, then they could do so themselves. When asked what the criteria included, Staff #66 stated that there are two ways a resident is transferred to the hospital emergently via 911; the first way included that a medical provider would write a physician order to transfer the resident emergently to the hospital, and the second way included that the nurse would assess the resident, and if the resident were having a medical emergency, then the nurse would call 911 to have the resident sent to the hospital urgently. Regarding the incident with Resident #2, Staff #66 continued to explain that shortly after she had spoken with the resident's friend on the phone, she received a call from the fire department asking about the welfare of Resident #2. Staff #66 stated that she told the fire department that there was not a physician order to send the resident to the hospital, and that he did not meet criteria to send to the hospital, and the fire department then cancelled their response to the facility. Staff #66 stated that she then went back to check on the resident, and that the resident was upset about the situation, and also stated that the resident said at that time that he did not like the food, and that Staff #66 gave him some sandwiches, and that she did not hear any further complaints from the resident that day. After the incident, Staff #66 stated she relayed the resident's concern to the resident's provider.A telephonic interview was conducted on February 26, 2026, at 1:49 p.m. with a nurse practitioner (NP / Staff #3) who stated that she was one of Resident #2's medical providers and was familiar with the resident. Staff #3 stated that in the week before Resident #2 passed, she was seeing the resident more frequently, and that she was treating the resident for several conditions, including worsening kidney function, acute kidney injury, and dehydration, and was attempting to diagnose a possible urological issue. Staff #3 stated that she had received a message from the resident's floor nurse on February 14, 2026, that revealed that the resident had wanted to go to the hospital, and that the fire department was called by the resident's friend, and that the nurse spoke to the fire department and then the fire department cancelled the response to the facility. Staff (continued on next page)

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Staff #15 stated that a nurse would complete a nursing assessment, and it would be up to nursing judgment to determine if the resident needed emergent transfer to the hospital, and that the medical provider would also be contacted to determine if the resident needed to be sent out. Staff #15 stated that if a resident requested to be sent out emergently to the hospital, then that is the resident's right to make that decision, and she would send the resident to the hospital via 911.An interview was conducted with an LPN (Staff #26) on February 26, 2026, at 2:29 p.m., who stated that there was not a list or set of criteria that a resident would have to meet in order to be sent to the hospital. Staff #26 stated that the situation would rely on nursing judgment, and if the resident was experiencing a change of condition, and the nurse and provider deemed transfer to the hospital necessary, then the resident would be sent to the hospital. Additionally, Staff #26 stated that if a resident requested to go to the hospital via 911, then she would assess the resident, determine why the resident wanted to go, and see if she could meet the resident's needs. Staff #26 said if the resident still wanted to go, then she would walk the resident through the process of calling 911. Additionally, Staff #26 stated that she did not think she was allowed to help a resident call 911.An interview was conducted with an LPN (Staff #39) on February 26, 2026, at 2:36 p.m., who stated that she is not allowed to decide whether a resident is sent to the hospital or not. Staff #39 stated that the decision to send a resident to the hospital has to go through upper management and the provider. Staff #39 stated she is not allowed to call 911 to send a resident to the hospital. Staff #39 stated she did not know if there would be any risk or impact on a resident who wanted to be sent urgently to the hospital and did not get their choice honored.An interview was conducted with the Assistant Director of Nursing (ADON / Staff #90) on February 26, 2026, at 3:25 p.m., who stated that there was not a list or set of criteria that a resident had to meet in order to qualify to be sent out to the hospital. The ADON stated that the decision to send a resident to the hospital is made by first assessing the resident, then contacting the doctor, and a decision is made whether the resident needs to be sent out to the hospital. The ADON stated that the nursing assessment would include observation of the resident, and assessment of vital signs, and any other specific assessments that would be needed to determine the status of the resident. The ADON stated that if the resident was adamant about going to the hospital, and the nursing assessment revealed that the resident needed to go, then the resident would be sent to the hospital. The ADON stated that the nursing assessment would be documented in the clinical record because it would be important for anybody who needed to review, including the provider. Regarding any impact it may have on a resident if the resident chose to go to the hospital, and did not have their choice honored, the ADON stated that she did not know what kind of impact it would have because typically, the facility staff would send the resident to the hospital. Additionally, the ADON stated that the resident always has a choice. Regarding Resident #2, the ADON stated that she was not aware of any situation where the resident requested to go to the hospital, nor was she aware of any situation where the fire department was contacted to send the resident to the hospital.A telephonic interview was conducted with the Director of Nursing (DON / Staff #2) on February 26, 2026, at 3:48 p.m., who stated that there was not a set of criteria that a resident would need to meet to be sent to the hospital. If a resident requested to go to the hospital, the nurse would assess what their concern was and talk to the provider. The DON stated that if the resident was adamant about going to the hospital, it would be the resident's right to make the choice to be sent to the hospital. The DON stated that if the resident were stable, she would not assume there would be a risk to the resident if the resident's choice to go to the hospital was not honored. The DON stated she familiar with Resident #2 and that (continued on next page)

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The resident has the right:To be encouraged and assisted throughout his or her stay in the facility to exercise theseResident Rights as well as those which Residents are entitled as a U.S. citizen.To voice grievances regarding treatment or care or recommend changes in facility policies and services without fear of reprisal, restraint, interference, coercion ordiscrimination, and to have prompt efforts undertaken by the facility to resolve them.To choose a personal attending physician (and be informed how to contact him or her), [NAME] fully informed in advance about care and treatment, and, unless adjudicatedincompetent or otherwise found incapacitated under state law, participate in planningmedical treatment.Review of the facility policy titled Change of Condition Reporting, revised July 2015, revealed it is the policy of this facility that all changes in resident condition will be communicated to the physician and resident representative and documented. For a Life-Threatening Change:1. Licensed nurse will initiate appropriate first aid measures until emergency responsepersonnel arrive on the scene.2. Licensed nurse will inform the primary physician (alternate physician or MedicalDirector) of resident status as soon as possible once resident needs have been met andimmediacy of nursing care is completed.3. Licensed nurse will inform family/ resident representative of change of condition anddocument notification.4. All nursing actions, physician contacts, resident representative, and resident assessmentinformation will be documented in the nursing progress notes.For Acute Medical Change: 1. Any sudden or serious change in a resident's condition manifested by a marked change inphysical or mental behavior will be communicated to the physician with a request forphysician visit promptly and/or acute care evaluation. The licensed nurse will notify thephysician.2. If unable to contact attending physician or alternate physician timely, notify MedicalDirector for follow-up to change in resident condition.3. The resident representative will be notified that there has been a change in the resident'scondition and what steps are being taken.For Routine Medical Change: 1. Unusual signs and symptoms will be communicated to the physician promptly. Routinechanges are minor changes in physical and mental behavior, abnormal laboratory and xrayresults that are not life threatening.2. The nurse is responsible for notification of physician prior to end of assigned shift when asignificant change in resident's condition is noted.3. If unable to reach physician, all calls to physicians or exchanges requesting callbacks willbe documented on the nursing progress notes.4. If the physician has not returned the call by the end of the shift, the on-coming nurse willbe notified for follow-up.5. If unable to contact attending physician or alternate timely, notify Medical Director forresponse and follow-up to change in resident status.6. Document resident change of condition and response in nursing progress notes andupdate resident Care Plan, as indicated.7. All attempts to reach the physician and responsible party will be documented in thenursing progress notes. Documentation will include time and response.8. The nurse will notify the resident representative and document the notification.Review of the facility policy titled Vital Signs, Weight, and Height, revised May 2007, revealed the resident's vital signs shall be recorded as the physician's orders indicate, or as frequently as the resident's condition warrants. Vital signs shall be taken and recorded in accordance with the resident's condition and current treatment plan, and as prescribed by the attending physician. This may vary with certain factors such as residents on cardiac medications may warrant daily pulses, those on blood pressure medications may warrant daily or weekly blood pressures, residents involved in a possible head injury incident may warrant neuro-checks every 15 minutes for a period of time, etc.Review of federal regulation 42 CFR S 483.10 revealed the resident has a right to a dignified existence, self-determination, and communication with and access to (continued on next page)

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