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	05/13/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of records, observation, interviews, and a review of facility policies and procedures, the facility failed to ensure that one of 3 sampled residents (Resident #12), property was not misappropriated. The Universe was 145. The deficient practice could lead to resident's property to be misplaced or lost.Findings include:Resident #12 was admitted to the facility on [DATE], and discharged on [DATE], with diagnosis that included unspecified severe protein calorie malnutrition. A review of the MDS (Minimum Data Set) assessment dated [DATE], revealed no indication of BIMS (Brief Interview for Mental Status) score for Resident #12 as resident was in the facility for one day only.A progress admission notes dated [DATE], at 3:15 p.m. revealed that the Resident #12 was admitted for hospice respite. Further review of progress note indicated no indications of Resident #12 missing items.An inventory list dated [DATE], revealed that Resident #12 came with two rings and a chain with a cross.A facility Reportable Event Record / Report submitted to the State Agency on [DATE], revealed that on [DATE], around 12:30 p.m. revealed that daughter of Resident #12 alleged to the Administrator (staff # 179) that at time of admission on [DATE], her mother was wearing 2 rings and a crucifix necklace. Per report, Resident #12 had passed that evening and upon seeing her at the mortuary, the jewelry was not present. Per report, the facility initiated the investigation and staff and residents were interviewed. Per report, the allegation was inconclusive.An interview was conducted on [DATE], at 9:38 a.m. with a Social Service Supervisor (staff #74) who stated that when she received any grievances regarding missing items then the facility had 72 hours to resolve it. Staff #74 stated during a phone call that Resident's #12's daughter stated that her mother had 2 rings and a necklace were missing. Staff #74 then reviewed Resident #12 inventory list from [DATE], and the list indicated Resident #12 came with 2 rings and a necklace with a cross. The social services supervisor stated that she had spoken with her staff member (#202) and learned that the resident's daughter was present during the time the inventory was recorded. Social service supervisor stated that she was told by staff #202 that after the inventory was completed the resident's daughter said she would take the jewelry with her.An interview was conducted on [DATE], at 10:31 a.m., with Social Service team member (Staff #202) who stated that she does inventory for new admissions and she makes an offer to residents to assist them to get their valuables in a safe location. Staff # 202 stated that she had done the inventory for resident #12 in the presence of the resident's daughter and the staff member asked the daughter if she would like to put the residents personal items (jewelry, clothing, and blanket) in a safe place or keep them with the resident. Staff member #202 stated that the resident's daughter stated she would like to take the jewelry with her. Staff #202 further stated that she did not see the daughter leave with the jewelry. Staff #202 stated that regarding Resident # 12's missing items, the staff member notified the administrator, asked nurses, and searched the residents room for these items. Staff #202 said that video was also reviewed.An interview was conducted on [DATE], at 10:51 a.m. with a Licensed Nursing Assistant (LNA, Staff # 184) who stated that she works Monday through Wednesday from 6 p.m. to 6 a.m., and provided care to residents including transfer, personal hygiene, and oral care. This LNA stated that she recalled Resident #12 was a hospice patient and was in the facility for one day and then passed away on the same day. The LNA (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 LNA then stated that she would consider the incident as misappropriation of property because someone took property from the resident.An interview was conducted on [DATE], at 10:55 a.m. with Resident's #12 ?s daughter who stated that her mother came to the facility on [DATE], wearing 2 gold rings with diamonds, and a gold necklace. Per daughter her mother (Resident #12) wanted to keep jewelry with her and wear it all the time. Per daughter, she was in the facility with her mother all day on [DATE], and left the facility around 10 p.m.An interview was conducted on [DATE], at 11:36 a.m. with a Registered Nurse (RN, staff #99), who stated that she works Wednesday and Thursday from 6 p.m. to 6 a.m. RN stated that she was aware of Resident #12. The RN recalled taking Resident#12's vitals and checking with her daughter inquiring if she needed anything. The RN recalled that she saw a ring on the right hand of Resident#12. The RN did not recall a necklace. The RN stated that after Resident #12 passed away that she notified the mortuary and the hospice. The RN stated that after the mortuary left, the LNA (staff #184) handed her a zip lock bag containing a ring and another piece of jewelry. The RN stated that she placed the bag on the computer on station two and then handed it over in the morning to the day Licensed Practical Nurse (staff #76). During this interview the RN stated misappropriation of property means unauthorized, intentional, and unlawful use or taking of someone else's assets, funds, or property for personal gain for an unintended purpose. The RN further stated that she would consider this incident as misappropriation because jewelry was not in the resident's possession.A review of the facility investigation revealed the LPN (staff #76) took the zip lock bag from the RN (Staff #99). The LPN noted the bag had a ring and necklace but did not recall if there were one or two rings. The LPN stated that she then placed it underneath the computer tray on station 2 with the intention of giving the bag to social services when they got in. She stated that she forgot to turn them into social services before she left.An interview was conducted on [DATE], at 1:54 p.m. with the Administrator (staff # 179) who stated that there are different types of abuse are verbal, physical, emotional, and financial. Per Staff #179, the facility process for any allegation of misappropriation of property would be that the staff report immediately to the Administrator and then the administrator reports the incident to the police, family, Arizona Department of Health services (AZDHS), Adult Protected Services (APS), and Ombudsman within 2 hours, and continue to do the investigation. The Administrator stated that Resident #12 came to the facility with the daughter on [DATE], and was on hospice. The administrator stated that Social Service staff #202 welcomed the Resident #12 and the family to complete the admission agreement and inventory list. The Administrator stated that the Resident #12's inventory list included 2 rings and a chain with cross. Social Service then offered to keep items locked up in a safe location and the resident's daughter stated she was going to take it with her. The Administrator stated that Resident #12 expired on the same day she was admitted and about a week later the family reported the jewelry missing and the administrator then filed a report to police, AZDHS, APS and started the investigation. The Administrator stated that the resident's daughter stated that she wanted to take the jewelry home but the resident wanted to wear her jewelry while at the facility. The Administrator stated that he called the hospice company and mortuary regarding the inquiry of jewelry and they stated that they did not have any jewelry. The Administrator then stated that he interviewed the LNA (staff #184) who stated that mortician handed her a ziplock bag containing a ring with 4 stones and a crucifix chain.Per the administrator the LNA (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	then stated that she handed the ziplock bag to the night shift nurse (RN, staff # 99).The Administrator stated that the night shift RN (staff #99) placed the ziplock bag containing jewelry by her computer and reported it to the dayshift nurse. LPN (staff #76) stated that Resident #12 had inventory that the mortuary took off. The Administrator stated that the dayshift LPN(staff #76) forgot to hand it over to Social Service or locked it in her cart. The Administrator further stated that the video footage revealed that both nurses exchanged the ziplock bag near the nurse station and confirmed that the jewelry was in the facility possession but not sure if it was trashed or shredded. The Administrator further stated that he called the family and offered $2500.00 for the loss. The resident's daughter was appreciative but refused the offer and wanted to keep looking for the jewelry. The Administrator further stated that the outcome of the investigation was inconclusive because they were unable to determine misappropriation of property.Review of the facility titled Admission/Transfer/Discharge inventory of personal effects, revised on January, 2026, revealed that it is the policy of the facility to take reasonable steps to protect the personal property of the residents. The policy further revealed that when a resident is admitted to the facility, an inventory of the resident's personal effects shall be done by a staff member of the facility and that the inventory should include the recording of all personal clothing, valuable articles, etc. which are brought into the facility with the resident and retained by the resident. personal effects shall be recorded on the Inventory of Personal Effects form.