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	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Post Acute and Rehabilitation Center	4704 West Diana Avenue Glendale, AZ 85302

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, review of the clinical record, facility documentation and policy, the facility failed to ensure that a code status was accurate and consistent in the medical record for one (Resident #28) of twenty-seven residents. The deficient practice could result in residents not receiving care consistent with the signed advanced directive. Findings include: Resident # 28 was admitted on [DATE] for surgical aftercare following surgery on skin and subcutaneous tissues. Additional diagnoses included local infection of the skin and subcutaneous tissue, open wound of lower back and pelvis without penetration into retroperitoneum, unspecified open wound of right buttock, unspecified open wound of left buttock, chronic kidney disease, stage 3, hypertensive chronic kidney disease or unspecified chronic kidney disease, unspecified atrial fibrillation, and orthostatic hypotension. A review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, suggesting that the resident had no cognitive impairment. A review of the resident dashboard, located in the electronic health record and verified by physician order review revealed a code status of cardiopulmonary resuscitation (CPR) as CPR/Full Code, however the resident's Advanced Care Directive form dated [DATE] indicated that resident preferance as do not resuscitate (DNR) status refusing resuscitation measures including but not limited to: CPR, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation and related emergency procedures. The form stipulated that if checked, the orange prehospital medical directives form must be completed. The attached orange pre-hospital directive indicated that in the event of cardiac or respiratory arrest, the resident refused any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures. The facility Advance Health Care Directives form indicated the resident had elected DNR code status, however the baseline care plan revealed no entry notating the presence of specific treatment of healthcare choice, whether full-code or DNR. An interview with the resident (#28) was conducted on [DATE] at 09:07 AM who confirmed that she had elected DNR status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 08:40 AM with staff #152 Certified Nursing Assistant (CNA). The CNA stated that resident code status is identified using the code arrest book that is located in the nursing station. If a code arrest occurs and the resident is identified as a full code, the facility has a radio system that is used to call for help. If the code is successful, the resident is taken to the hospital. An interview was conducted on [DATE] at 10:07 AM with staff #151 social service supervisor. The social service supervisor revealed advanced directives are confirmed by the nurse during the admission process with the resident or their representative. The nurse confirms and adds the advance directive to the physician orders which are reviewed and signed by the provider. She stated that if a resident who was identified as a full code had a code on the unit, a code would be called using the facility radio system. Responding staff would begin cardiopulmonary resuscitation, using the automated external defibrillator (AED) available on the unit and 911 emergency response would be activated. She stated that if the code is successful, the resident would be transported to the hospital for further care. An interview was conducted on [DATE] at 08:35 AM with staff #101, registered nurse (RN). The RN stated that the staff check the code book at the nurses' station to verify resident code status in conjunction with the electronic health record dashboard to confirm code status. If the resident had elected DNR status, the prehospital directive (orange card) would be placed on the top of the record in the code book at the nurses' station for ease of verification. The RN obtained the book from the nurse's station and verified that resident #28 had both advanced directive and prehospital directives in the record indicating election of DNR status. The RN stated that if there was a noted a discrepancy between the information in the dashboard of the electronic health record and the book on the unit, the RN would report it through the chain of command to the Director of Nursing. The RN obtained the code book from the nursing station and verified that resident #28 had completed advanced directives that indicate DNR status which were in conflict with the notation of full code on the electronic health record dashboard. The RN identified the risk of this discrepancy as a possibility of resuscitating someone who did not want to be resuscitated. Staff #101 stated that this did not meet her expectation, as the code status in the electronic health record and the code arrest book in the nurse's station should all match what is ordered by the physician. An interview was conducted on [DATE] at 10:01 AM with staff #232, Nurse Practitioner (NP) who stated that the advanced directives are typically reviewed with the residents and or representatives if they do not have the capacity to make decisions. Staff #232 stated that he would explain the options and would refer to case management to complete the necessary forms. The NP stated that orders would be placed in the in the medical record if updates or changes were indicated. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 10:48 AM with staff #109 Director of Nursing (DON), who reviewed the DNR process. She reported that nurses review the consent packet with residents and/or their representatives upon admission to the facility and advanced directives are included in the discussion. When resident's choice is confirmed, the resident or responsible party sign the required forms, the signature is witnessed by facility staff and the documents are scanned and placed in the Electronic Health Record. She stated that medical records staff review the documents and organize them into 'code books' that are located at each nursing station. The DON reported that the medical records department does a weekly review of these resources and if a resident changed their advanced directives, the 'code book' would be updated and new forms scanned into the medical record. The DON stated that corresponding physician orders are entered into the electronic health record. She stated that in the event of a resident emergency, staff confirm code status by accessing the advanced directives on the book at the nurses' station or review of the Kardex in the electronic health record whichever is closer. She stated that this did not meet her expectations and stated that the risk of discrepancy between the book and the electronic health record would be that a resident's elected DNR wishes would not be followed. The DON reviewed the resident's Kardex, electronic health record and 'code book' from the unit and confirmed that there was a discrepancy on the Kardex indicating that the patient had elected full-code status which conflicted with the signed Advanced Care Directive Form dated [DATE]. She confirmed the expectation that the code book and the clinical record match. She identified the discrepancy, that if there is an error, someone who opted not to be coded could be and their wishes may not be followed. The DON stated that she would confirm the resident's advanced directives and follow with a facility-wide audit to ensure accuracy. A review of the facility policy/procedure entitled Advance Directives in Section Care and Treatment reviewed [DATE], revealed that advance directives will be recognized and respected by the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** -Regarding Resident #37: Resident #37 was originally admitted to the facility on [DATE] and most recently re-admitted on [DATE], with diagnoses that included, other psychotic disorder due to a substance or known physiological condition, chronic pain, depression and anxiety. A Pre-admission Screening and Resident Review (PASRR) Level I Screening dated September 12, 2024 completed prior to admission, revealed that it was left mostly blank. A care plan initiated on September 12, 2024 included the following focus: -Psychotropic medications use related to schizoaffective disorder -Ineffective coping related to substance abuse -Potential for a psychosocial well-being problem with interventions that included to consult with psych services and social services. -Potential for mood problem An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment also revealed diagnoses that included a psychotic disorder other than schizophrenia, anxiety disorder and depression. A PASRR Level I Screening dated October 14, 2024 revealed that Resident #37 had mental disorders to include anxiety and depression and had a substance related disorder. A level II screening was deemed necessary for mental illness only. A care plan focus of potential for mood problem revealed a PASRR level II was submitted on October 14, 2024. A PASRR Level II referral response was sent and a note, dated October 16, 2024, from the State PASRR Program-AHCCCS (Arizona Health Care Cost Containment System) relayed that the resident did not meet the criteria for a Level II PASRR evaluation. The letter stated that if their condition changed in the future to submit a new Level I screening tool if needed. A physician order dated February 17, 2024 included an order to administer Olanzapine (antipsychotic) 10 milligrams (mg) for schizoaffective disorder aeb (as evidenced by) striking out. A Review of a PASRR Level I Screening dated February 18, 2025, after the resident had been in the hospital revealed the Mental illness, symptoms and medication sections were left blank, despite the February 17, 2025 diagnosis of schizoaffective disorder. The box was marked that stated no referral necessary for any Level II . (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychologist provider progress note, dated March 6, 2025 revealed a diagnosis of schizoaffective disorder. A modified quarterly Minimum Data Set (MDS) assessment dated [DATE] included active diagnoses of schizophrenia, anxiety and depression. The assessment also included a Brief Interview of mental status (BIMS) score of 15, which indicated intact cognition. Review of the nursing care plan, initiated May 13, 2025, included that the resident was receiving psychotropic medications for schizoaffective disorder. Despite documentation that the resident had a new diagnosis of schizoaffective disorder, no evidence was found that the facility referred the resident to the appropriate state-designated mental health or intellectual disability authority for review or why the resident was not referred. During an interview conducted with the Social Services Assistant (SSA/staff #151) on May 15, 2025 at 8:56 AM, she stated the social services department reviews the face sheet upon admission and completes a PASRR prescreening. She also stated, after that a 30-day PASRR is conducted that included a review of medications, diagnoses and psychiatric notes. She stated that if there were diagnoses such as: anxiety, depression, schizophrenia, any mental diagnosis or psychoactive substance abuse, they would recommend a level II PASRR. The SSA (staff #151) further stated that if a resident had a previous declination of a level II by the State, but then went to the hospital or had a new diagnosis, they would need to be reassess with a Level I PASRR and go through the process again. The SSA stated she was not aware of the schizoaffective disorder diagnosis for Resident #37 and therefore she did not complete a 30-day review or send the referral for a Level II PASRR. An interview was conducted with the MDS Coordinator (staff #41) on May 15, 2025 at 11:02 AM. The MDS Director stated she received information regarding Resident #37's new diagnosis of schizoaffective disorder from a provider progress note dated March 6, 2025. She stated other management team members were aware of the new diagnosis and that a PASRR should have been completed. An interview was conducted with the Social Services Director (staff #45) on May 16, 2025 at 11:02 AM. The Social Services Director stated she and her assistant were not made aware of the new schizoaffective diagnosis in March 2025 for Resident #37. She relayed that Resident #37 should have had a new Level I PASRR completed and it should have been referred to the State for a Level II PASRR, and that this did not occur related to the new diagnosis of schizoaffective disorder. A policy titled, PASRR, reviewed May 2025, revealed that each resident would be properly screened using the PASRR specified by the State. Based on clinical record review and staff interviews, the facility failed to ensure two residents' PASARR screenings (#3, #37) were completed accurately and referred to the appropriate state-designated mental health or intellectual disability authority for review. The deficient practice could result in necessary specialized services not being provided for residents who need it. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, mood affective disorder, and convulsions. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Arizona Pre-admission Screening and Resident Review (PASSAR) level one screening tool, completed October 19, 2010, revealed that the resident met the criteria for a thirty-day convalescent care stay. At this time, no referral was deemed necessary for a level two PASARR evaluation. Review of Resident #3's diagnoses revealed that she was diagnosed with major depressive disorder, single episode, on February 15, 2014. Resident #3 was then diagnosed with mood disorder due to known physiological condition on August 7, 2019. She was diagnosed with anxiety disorder on July 20, 2021, and she was diagnosed with dementia on October 1, 2022. Record review revealed no evidence that a new PASARR was completed until August 12, 2019. Review of the PASARR level one screening tool, completed August 12, 2019, revealed that Resident #3 was documented to have no serious mental illnesses (SMI) and had no mental disorders or suspected mental disorders. The PASARR indicated that no referral was necessary for a level two PASARR evaluation. Review of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had active diagnoses which included anxiety disorder, depression, bipolar disorder, and mood affective disorder. Review of the physician orders revealed an order, dated May 8, 2025, revealed that Resident #3 was prescribed Mirtazapine 7.5mg for depression. Despite documentation that the resident had diagnoses of major depressive disorder, mood disorder, bipolar disorder, and anxiety disorder, no evidence was found that the facility referred the resident to the appropriate state-designated mental health or intellectual disability authority for review or why the resident was not referred. Interview was conducted on May 16, 2025 at 10:25AM with the Case Manager (Staff #45) and the Social Services Supervisor (Staff #151), who stated that the purpose of a PASARR is to ensure that residents are getting the psychiatric care needed. The staff members stated that in order to determine if Resident #3's 2019 PASARR was completed accurately, they would need to refer to the diagnoses and Medication Administration Record (MAR) from that time. However, the staff members stated that the PASARR completed for Resident #3 in 2019 was not reflective of Resident #3's active diagnoses, and a new one should have been completed. Interview was conducted on May 16, 2025 at 12:32PM with the Director of Nursing (DON/Staff #109), who stated that she would expect all residents to get a PASARR level one screening on admission to determine if a referral for level two services is necessary. She also stated that if a resident remained in the facility after thirty days, she would expect social services to complete a new PASARR. The DON reviewed the PASARRs completed for Resident #3 and agreed that she would expect Resident #3's diagnoses to have been reflected on the PASARR level one screening. The DON identified the purpose of completing an accurate PASARR would be to determine if the resident was safe in the facility or needed a higher level of care. She explained that if a resident was considered to have serious mental illness and required level two services, then the resident's psychiatric needs could not be met in the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and policy review, the facility failed to ensure the medication error rate was not 5% or greater, by failing to administer medications as ordered for three of four residents (#58, #25, #103). The deficient practice could result in adverse effects and further medication errors. Findings Include: Six medication administration errors were identified out of 38 opportunities during medication administration observation. The medication error rate was 15.79% -Regarding Resident #58 Resident #58 was admitted to the facility on [DATE] with diagnoses that included viral hepatitis, anxiety disorder, depression, and schizophrenia A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Provider orders revealed an order for Senna Plus 8.6/50 mg (milligrams), take 1 tablet by mouth in the morning. The medication was scheduled to be administered at 8:00 AM. A medication administration observation was conducted with a Licensed Practical Nurse (LPN/staff #138) on May 15, 2025 at 7:00 AM for Resident #58. The LPN (staff #138) was observed to take a bottle of Senna 8.6 mg out of the medication cart and place one tablet in the cup with the other medications. The resident was observed to swallow the Senna 8.6 mg. An interview was conducted with the LPN following the administration, regarding administering Senna instead of Senna Plus. The LPN acknowledged that she mistakenly administered the wrong type of Senna to the resident. -Regarding Resident #103 Resident #103 was admitted to the facility on [DATE], with diagnoses that included coronary artery disease, hypertension, Diabetes mellitus, thyroid disorder, and depression. An annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Provider orders for Resident #103 revealed the following orders to be administered at 8:00 AM: -Amlodipine 10 mg, give 1 tablet by mouth -Carvedilol 12.5 mg, give 1 tablet by mouth -Losartan Potassium 50 mg, give 1 tablet by mouth (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Levetiracetam 1000 mg, give 1 tablet by mouth -Metformin 500 mg, give 1 tablet by mouth A medication administration observation was conducted with a Licensed Practical Nurse (LPN/staff #153) on May 15 at 9:25 AM for Resident #10. The LPN was observed administering the medications at 9:30 AM, with the resident observed swallowing the medications at 9:31 AM. An interview was conducted with the LPN (staff #153) following the administration. She acknowledged that the medications were administered late according to the provider order and facility policy. She stated medications are considered late if administered more than 1 hour after the scheduled time. The LPN stated she usually finished her 8:00 AM medication pass around 10:30 AM and that she typically administers medications to 27-30 residents. She stated she has brought her concerns regarding late medications to the attention of the Director of Nursing. -Regarding Resident #25 Resident #25 was re-admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare, absence of left toes, and Type 2 Diabetes mellitus with hyperglycemia. A quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, which indicated intact cognition. During a medication observation with another LPN (staff #153), who stated that she had 5 more residents to administer medications. The LPN (staff #153), was observed in a resident's room, administering insulin. Upon exiting the room, the LPN stated she was administering sliding scale insulin to Resident #25. Upon review of Resident #25's orders, an order for blood sugars to be assessed and Humalog sliding scale to be administered before meals. Resident #25's blood sugar was assessed after he had eaten breakfast and the insulin was administered late. An observation of the morning medication pass was conducted on May 16, 2025 at 9:30 AM. One LPN (staff #54) stated that she had 5 more residents to administer medications to at that time. She also stated she had expressed concern to the DON regarding not being able to get medications administered on time. It was observed at this time that the resident had already eaten breakfast. An interview was conducted with the Director of Nursing (DON/staff #109) on May 15, 2025 at 10:16 AM, who stated that medications are considered administered on time if they are administered one hour before to one hour after the scheduled time. She stated nurses have been instructed to communicate with their supervisor if they were not able to administer medications on time. She stated nurses have not communicated any issues to their supervisors. She acknowledged the late medications administered during the observed medication passes and stated the risk of late medications could be adverse effects of medications given too close together. An additional interview was conducted with LPN (staff #138) on May 15, 2025 at 1:02 PM. The LPN stated that she had informed the DON that nurses are not able to complete their medication passes within the one-hour time frame and that medications were therefore being administered late. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional interview was conducted with the DON on May 16, 2025 at 10:25 AM. She acknowledged the medication errors and stated they are working on a process to address the issue. She stated the medication errors could lead to negative outcomes. A facility policy titled, Administration of Drugs, dated May 2025, revealed that medications shall be administered as prescribed by the attending physician. If a medication is given other than at the scheduled time, the documentation will be reflected in the clinical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure that medications were not left at the bedside for one resident (#448). The deficient practice could result in harm to the residents, and/or visitors who have access to medications. Findings Include: Resident #448 was admitted on [DATE], diagnosis included displaced fracture of surgical neck of left Humorous, anemia, retention of urine, hypokalemia, chronic pain syndrome, alcohol abuse, and anxiety disorder. The Admissions Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that resident was cognitively intact. Review of care plan revealed no evidence that Resident #448 was able to self-administer medication. Review of the physician's orders revealed no orders to self-administer medications. Review of the assessments revealed not assessed to self-administer medications. Review of progress note revealed no interdisciplinary meeting for self-administering medication. Further review of the Physicians orders revealed no orders for Omeprazole delayed release capsule, 20 mg acid reducer (proton pump inhibitor). An observation conducted on May 13, 2025 at 08:50 AM revealed Resident #448 was laying in her bed awake, table on the side of her bed which had water and purple medication bottle with a cap on her table. Resident #448 stated that this is her over the counter medication for heart burn. An interview was conducted on May 13, 2025 at 8:54 AM with Certified Nurse Assistance (CNA/staff #200), who identified this medication was Omeprazole 20mg acid reducer for heat burn and it is not supposed to be left on the bedside. She stated there are risk posed to have medication left the bedside where the resident can overdose and cause diarrhea because it is for acidity. CNA took the medication and called the nurse; additionally a doctor came into the room. An interview was conducted on May 13, 2025 at 08:56 AM with the Physician (staff #178), who stated that over the counter medication are not allowed to be on bedside. An interview was conducted on May 13, 2025 at 08:58 AM with the Licensed Practical Nurse (LPN/staff #145), who identified the medication was an over the counter medication Omeprazole 20 mg for acid reflux. She stated that she was not aware that resident #448 had this medication. She stated that medication was not allowed to be on beside. She stated there are risk of this medication left on beside such as resident can overdose, can cause dizziness, vomit, or have abdominal pain. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 16, 2025 at 12:18PM with Director of Nursing (DON/ Staff #109), who stated that no one is allowed to have any over the counter medication left on beside even if it is Omeprazole. She also stated strictly no medication can be allowed on beside. She stated that resident is not allowed to self-administer medication unless they have been assessed. She stated if they are assessed and able to self-administer - then the resident would be given knowledge on how safely administer medication and knowledge of the medication, then physician orders the medication, and it will be care planned. She stated that risk of having omeprazole or medication left on bedside the staff member would not know what medication the resident is taking or interaction with the medication that the facility was providing. Reviewed the policy titled Self-Administration of Medications Revised date May 2025 revealed that to participate in self-administration drugs, the interdisciplinary team will assess and periodically re-asses the resident based on change in the resident's status. If resident is a candidate for self-administration of medication, a physician's order for self-administration of medications or for specific medication. Review of policy titled Quality of Life revised April 2025 revealed avoid leaving in the resident's room any medication that might cause harm.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** -Resident #545 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included urinary tract infection, adult failure to thrive, gastrostomy status, chronic kidney disease stage 3, obstructive and reflux uropathy and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #545 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS assessment further revealed that the resident had a Foley catheter and an intravenous catheter (IV). A Nursing Care Plan, dated May 10, 2025, indicated Resident #545 had an indwelling catheter, a Peripherally Placed Central Catheter (PICC) and a feeding tube. Physician orders, dated May 10, 2025, revealed the following: -Check for Foley catheter privacy bag every shift, -Catheter [Foley] care every shift -Check placement of G-tube (feeding tube) every shift, -Cleanse G-tube with warm soap and water or normal saline (NS), pat dry, every shift, -Jevity 1.5 at 80 milliliters per hour (ml/hr) via G-tube continuous via pump x 20 hours per day. Start at 12:00 PM and turn off at 8:00 AM and -PICC line flush with 10 ml NS and 5 ml heparin every shift. An initial observation of Resident #545 was conducted on May 13, 2025 at 12:05 PM. The resident was observed to have a Foley catheter in place. The Foley catheter drainage bag was observed directly on the floor under the resident's bed. A privacy bag was not observed covering the Foley catheter drainage bag and the emptying spout was observed directly touching the floor of the resident's room. An interview was conducted with a Licensed Practical Nurse (LPN/staff #57) on May 13, 2025 at 12:10 PM. The LPN admitted had observed the foley catheter bag sitting on the floor, under the resident's bed. She stated the bag should not be touching the floor and should be in a privacy bag. The LPN was observed to raise the resident's bed to a higher position. Upon raising the bed, it was discovered that the Foley catheter bag was not attached to the bed, but was sitting directly on the floor. The LPN picked up the Foley catheter bag, put a privacy bag over it and hung it from the bed railing. (continued on next page)

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	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Post Acute and Rehabilitation Center	4704 West Diana Avenue Glendale, AZ 85302

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made of an LPN (staff #138) performing feeding tube and PICC management care on May 15, 2025 at 12:18 PM. The LPN was observed to don a gown outside of Resident #545's room, as the LPN entered the room she donned gloves. The LPN was not observed to sanitize her hands before donning the gloves. The LPN repositioned the resident in his bed, closed the door to his room and doffed her gloves. She then donned new gloves. The LPN did not sanitize her hands in between glove changes. The LPN was observed cleaning the two PICC line ports with an alcohol wipe. She was then observed to administer 10 cubic centimeters (cc) of NS into each port, followed by 5 cc of Heparin (an anticoagulant). The LPN placed an alcohol cap onto each port. She doffed her gloves, threw them into a garbage can and donned new gloves. The LPN did not sanitize her hands in between glove changes. The LPN was then observed to write the date on a bottle of Jevity (tube feeding formula) and hang it on an IV pole. She connected the tubing to the Jevity and to a bag of water that was hanging from the IV pole. The LPN programmed the pump to 80 cc/hr. At that time, the resident had requested a pain pill, so the LPN doffed her gloves and removed her gown. She left the room and came back with a pain pill, after donning a new gown and gloves. She did not sanitize her hands. The LPN was observed to check the placement of the feeding tube, checked for any residual and flushed the tube with 20 cc of water. She administered the crushed pain pill, mixed with water and then flushed again with 30 cc of water. The LPN then secured the feeding tube tubing to the port on the resident and began the feeding. She then removed her gown, doffed her gloves and threw them into the garbage can. She did not sanitize her hands. An interview was conducted with the LPN, following the procedure. She acknowledged that she should have sanitized her hands between donning and doffing gloves and when she removed gloves following the procedures. An interview was conducted with the Director of Nursing (DON/staff #109) on May 16, 2025 at 10:09 AM. The DON stated that the LPN (staff #138) should have sanitized her hands before she began the procedure, before and after donning/doffing gloves and at the end of the procedure. She stated the risk of not doing so could be cross contamination from one to another. Review of the facility policy titled, IPCP Standard and Transmission-Based Precautions (revised October 2022), revealed that Enhanced Barrier Protection (EBP), which referred to the use of gown and gloves during high-contact resident care activities, is indicated when contact precautions do not otherwise apply for residents with wounds and/or indwelling medical devices, regardless of MDRO colonization. The policy also defined wound care as an activity requiring the usage of PPE for residents on EBP. A policy titled, Infection Control/Procedure/Catheter care, reviewed July 2024, revealed that drainage bags were to be kept in privacy bags. It also explained that when performing catheter care, staff should wash hands, put gloves on, perform the task, remove gloves and wash hands. A policy titled, Tube feeding-Nasogastric or Gastrostomy, revised May 2025, revealed staff were to wash hands before performing cares with the feeding tube. Based on clinical record review, observation, and staff interviews, the facility failed to ensure appropriate infection control practices were implemented and followed for two residents (#64, #545). The deficient practice could result in a spread of preventable illness to residents and staff. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #64 was admitted to the facility on [DATE] with diagnoses that included dementia, reduced mobility, and aphasia. Review of the care plan revealed a focus, initiated May 28, 2020, which revealed that the resident had actual or potential for pressure injury development related to tube feeding and history of pressure injury over the right heel, left lateral ankle, right medial great metatarsal head, and sacrum/upper buttocks. The focus also revealed that on December 2, 2024, the resident had a pressure injury to the left plantar great metatarsal head. Interventions in place for this focus included the usage of Enhanced Barrier Precautions (EBP). Review of physician orders revealed an order, dated January 10, 2025, which instructed the usage of enhanced barrier precautions, related to enteral feeding and wound care. Review of the Minimum Data Set (MDS), dated [DATE], revealed that Resident #64 had one stage four pressure ulcer, which was present upon admission, and one unstageable pressure ulcer, which was not present upon admission. An observation of wound care was conducted on May 15, 2025 at 2:12PM for Resident #64's left platar great metatarsal head wound and the scar tissue on the resident's ankle. Observation in Resident #64's room during the wound care revealed signage for Enhanced Barrier Precautions (EBP) on the wall behind the resident's bed. The wound care was provided by a Registered Nurse (RN/Staff #11) and a Licensed Practical Nurse (LPN/Staff #105). Prior to interacting with the resident, both staff members performed hand hygiene and donned gloves. Both staff members failed to don gowns prior to beginning the wound care. During the wound care, the staff properly removed the soiled dressings and applied new dressing, but gowns were not utilized in any point during the wound care. An interview was conducted on May 15, 2025 at 2:23PM with the Registered Nurse (RN/Staff #11) who had provided the wound care, stated that gown and gloves would be required during wound care for residents with chronic wounds, who would usually be on contact precautions. She explained that if a resident had a lot of drainage in the wound, this would warrant the resident to be put onto contact precautions, which would then require the use of a gown and gloves. The RN stated that Resident #64 did not have a lot of drainage in her wound, so she did not need to use a gown and gloves during her wound care. Interview was conducted on May 16, 2025 at 12:32PM with the Director of Nursing (DON/Staff #109), who stated that staff should don gown and gloves any time they are providing direct care for residents with orders for Enhanced Barrier Precautions (EBP). The DON identified the purpose of EBP to be to decrease the risk for infection, especially for residents that may have chronic open wounds.