

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	

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 - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on resident and staff interviews, clinical record reviews, and review of facility documentation, the facility failed to protect the rights of four residents (#2, #4, #6, #8, and #10) to be free from physical abuse by another resident (#2 and #10). The deficient practice could result in residents subjected to continued abuse.</p> <p>Findings include:</p> <p>Regarding residents #2 and #4:</p> <p>-Resident #2 was admitted to the facility on [DATE] with diagnosis including major depressive disorder, recurrent severe without psychotic features, generalized anxiety disorder, Alzheimer's disease, unspecified, unspecified dementia, unspecified severity, with other behavioral disturbance.</p> <p>A behavioral treatment care plan dated January 30, 2025 revealed current behaviors for resistance to care, self-isolation and physical aggression. Past behaviors included Refusal of care, withdrawn, self-isolation, worry, restless, somatic delusions, and moody. Interventions included staff should approach resident #2 with a calm, reassuring demeanor to minimize physical aggression. Use a gentle tone, slow movements, and clear, simple communication to reduce confusion and agitation. Identify potential triggers, such as discomfort, frustration, or overstimulation, and adjust the environment accordingly. If aggression occurs, avoid confrontation, provide space, and allow her time to regulate</p> <p>A care plan revised on May 6, 2024 revealed a focus for behavior problems. Interventions included administering medications as ordered, intervening as necessary to protect the rights and safety of others, approach and speak to the resident in a calm manner, divert their attention, remove from situation and take to alternate location as needed.</p> <p>The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating resident had intact cognition. Further review of the MDS revealed the resident had no indicators for mood or behaviors.</p> <p>A behavior progress note dated March 22, 2025 revealed resident #2 upset with roommate, resident #4 for not closing the bathroom door. Resident #2 was yelling at resident #4 in Spanish to shut the bathroom door. Demanding and verbally aggressive with resident #4. Staff Would continue with frequent rounding.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	
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 - Some</p>	<p>A behavior progress note dated March 25, 2025 revealed that a staff nurse witnessed resident #2 had altercation with roommate, resident #4 at 5:45am inside residents' room.</p> <p>A psych follow-up note dated March 25, 2025 revealed nurse practitioner presented for an urgent psychiatric follow-up with resident #2. She recently experienced a conflict with her roommate that escalated over prolonged use of the bathroom and resulted in a physical altercation. Following the incident, Resident #2 refused hospitalization and displayed verbal and physical aggression towards the staff. Consequently, she is now under 1:1 supervision. Despite her agitation, resident #2 refused her morning medications but was willing to take her afternoon dose, although her compliance remains intermittent.</p> <p>-Resident #4 was admitted to the facility September 23, 2029 with diagnosis including paranoid schizophrenia, post-traumatic stress disorder, unspecified, age-related osteoporosis without current pathological fracture.</p> <p>A behavioral treatment care plan dated October 20, 2024 revealed current behaviors for delusional beliefs, medication refusal, verbal aggression/inappropriate gestures, ADL care refusal and hoarding of cups. Known triggers are patients or staff entering her personal space. Past behaviors included hitting and biting staff, throwing items at staff, pulling the fire alarm, and throwing self on the floor. Interventions included redirecting inappropriate behaviors, attempt to focus on activity or reality-based subject, keep distanced from other residents when irritable or attempting to instigate and ask to calm down in her room.</p> <p>A care plan-initiated September 7, 2022 and revised on April 23, 2024 revealed a focus for behavior problems related to paranoid schizophrenia. Interventions include administer medications as ordered, monitor behavior episodes and attempt to determine underlying cause, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to alternate location as needed.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 suggesting moderate cognitive impairment, further review of the MDS revealed the resident had no indicators for mood or behaviors.</p> <p>A behavior progress note dated March 25, 2025 revealed that a staff nurse witnessed resident #2 had altercation with roommate, resident #4 at 5:45am inside residents' room.</p> <p>A progress note dated March 28, 2025 revealed after altercation a head to toe assessment was completed, no abnormalities or injuries noted/reported. Resident refused vital [NAME], denied pain/discomfort, no needs at this time.</p> <p>Review of the facility investigation with discover date of March 25, 2025 included that resident #4 was interviewed. Per the documentation, resident #4 reported had taken longer than usual in the bathroom and resident #4 was tempted by the devil to strike me so she did and the nurse witnessed it. Continued review of the facility investigation included that the facility identified the incident as one resident hitting the other. The facility substantiated the resident to resident abuse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	
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 - Some</p>	<p>An interview was conducted April 1, 2025 with Licensed Practical Nurse (LPN/Staff #22) on April 1, 2025 at 3:05 pm. Staff #22 stated the incident between resident's #2 and #4 happened near the bathroom. Staff #22 stated resident #2 was upset, using hand gestures indicating the bathroom door-Staff #22 stated she opened up the bathroom door as resident #4 was coming out the bathroom in her wheelchair, Staff #22 stated resident #2 was standing near the door and as resident #4 came out, resident #2 started to aggressively hit resident #4 in the back of the head. Staff #22 stated resident #2 struck resident #4 about three times and as she tried to grab resident #2 hand she pulled and was very strong and hit resident #4 in the back of the head two more times. Staff #22 stated additional staff came to assist- two certified nursing assistants and a nurse- they helped get resident #2 away from resident #4 by placing resident #4 in the hallway. Staff #22 stated a skin check was done immediately on resident #4 revealing there were no noted injuries. Staff #22 stated the appropriate staff were notified of the altercation.</p> <p>An attempt to interview was conducted on April 1, 2025 at 3:24 pm with resident #4. Resident #4 was asleep and not easily roused.</p> <p>An attempt to interview was conducted on April 1, 2025 at 3:26 pm with resident #2. Resident #2 was not cooperative and not interviewable. Resident stated it's a sin to talk to you.</p> <p>An interview was conducted April 1, 2025 at 3:37pm with Certified Nursing Assistant (CNA/Staff #36). Staff #36 stated she was made aware of the altercation between residents #2 and #4. Staff #36 stated she was informed resident #2 had hit resident #4 on the head because she was taking too long in the bathroom. Staff #36 stated the residents were separated and resident #2 was placed on 1:1 and moved to a different room, with no further altercations.</p> <p>Regarding Resident #6 and #8:</p> <p>-Resident #6 was admitted to the facility January 7, 2025 with diagnosis including epilepsy, unspecified, not intractable, with status epilepticus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, restless legs syndrome, unspecified mood [affective] disorder, other specified depressive episodes, other personality and behavioral disorders due to known physiological condition.</p> <p>The care plan date-initiated January 14, 2025 with a revision on January 29, 2025 revealed the resident was at risk for behaviors related to mood disorder, cognition. Interventions included administer medications as ordered and intervening as necessary to protect the rights and safety of others.</p> <p>The admission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating the resident cognition was intact; and that, the resident had no indicators for mood or behaviors.</p> <p>A progress note dated March 20, 2025 for psych follow-up revealed that the staff reported that the patient is doing well, taking her medications as prescribed without any reported verbal or physical aggression. Resident #6 is eating and sleeping well. Behavioral documentation was reviewed and is found to be at baseline. Further review revealed documentation that there was an incident involving another resident; however, the patient was not the antagonist, and the issue has been resolved and does not continue to be a concern.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	
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 - Some</p>	<p>Further review of the progress notes revealed an alert note dated March 20, 2025. The note text reported resident is on alert charting for changing shifts. Resident has adjusted well, no complaint of being in her new room.</p> <p>-Resident #8 was admitted to the facility June 30, 2022 with diagnosis including polyneuropathy, unspecified, bipolar disorder, unspecified, major depressive disorder, single episode, severe with psychotic features, mild cognitive impairment of uncertain or unknown etiology, nicotine dependence, cigarettes, uncomplicated.</p> <p>A behavioral treatment care plan dated March 25, 2025 revealed current behaviors for verbal were disruptive behaviors. aggression, cursing and threats. Known triggers were identified as experiencing symptoms of depression. Past behaviors were identified a disruptive sound. Interventions included when exhibiting signs of anxiety, agitation, or restlessness, approach with a calm and soothing demeanor. If resident should become aggressive, provide space and do not confront directly- allow time for de-escalation.</p> <p>The care plan date-initiated September 7, 2022 with a revision on April 3, 2024 revealed the resident has a behavior problem as exhibited by yelling out, using profanities, opens urine bag and drains onto the floor, impaired cognitive function and impaired thought processes related to Bipolar disorder. Interventions include administer medications as ordered.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 06 indicating severe cognitive impairment; and that the resident had no indicators for mood or behaviors.</p> <p>A progress note dated March 21, 2025 revealed a physician encounter reporting resident having some change in behavior- mainly increased irritability and mild increased confusion.</p> <p>Review of the facility investigation with discover date of March 20, 2025 included that both resident #6and #8 were interviewed. Per the documentation, resident #6 reported that resident #8 was jealous of another resident, identified as resident # 12, Resident #6 reported all three residents were outside waiting for smoke break talking, when resident #8 became upset and slapped resident #6 across the left side of her face and then balled up his fists. Resident #8 reported not being able to remember hitting anyone during smoke break.</p> <p>Continued review of the facility investigation included that the facility identified this incident was a verbal argument between residents #6 and #8, but there was no indication of physical contact being made and that the facility was unable to substantiate abuse.</p> <p>An attempt to interview was conducted on April 1, 2025 at 3:03 pm with Registered Nurse (RN/Staff#46). A message was left for a return phone call.</p> <p>An interview was conducted on April 1, 2025 at 3:40 pm with resident #6. Resident #6 stated resident #8 slapped her on the left side of her face and doubled up his fists like he was going to hit me again when resident #12 stood up and stopped him. Resident #6 stated that her face was red for a while where her hit her. The resident stated he called her some names that she chooses not to repeat, but feels that he was jealous of resident #12.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	
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 - Some</p>	<p>An interview was conducted on April 1, 2025 at 3:51 pm with resident #12. Resident #12 stated he was sitting on the patio next to resident #8 who was seated next to resident #6. Resident #12 stated resident #8 called resident #6 some names and four-letter words. Resident #12 stated resident #8 said f*** y** and that resident #6 replied with not in your wildest dreams when resident #8 reached over and slugged her in the face-with a partially closed hand, he hit her twice on her face. Resident #12 stated there was one staff one staff there present. Resident #12 stated resident #6 was very upset and shocked from him smacking her like that.</p> <p>An interview was conducted on April 1, 2025 at 4:03 pm with resident #8. Resident #8 stated I don't remember anything with resident #6.</p> <p>An interview was conducted on April 1, 2025 at 4:24 pm with (CNA/Staff #60) CAN stated she has worked for the facility for [AGE] years and is familiar with residents #6 and #8. Staff #60 stated resident #8 started having behaviors and was being very aggressive with staff and other residents. Staff #60 stated resident #8 was moved to another unit due to the behaviors. Staff #60 stated she did not observe the incident, but was given report that that resident #8 had on the smoking patio. Staff #60 stated this behavior was out of character for resident #8.</p> <p>Regarding Residents # 8 and #10:</p> <p>-Resident #8 was admitted to the facility June 30, 2022 with diagnosis including polyneuropathy, unspecified, bipolar disorder, unspecified, major depressive disorder, single episode, severe with psychotic features, mild cognitive impairment of uncertain or unknown etiology, nicotine dependence, cigarettes, uncomplicated.</p> <p>A behavioral treatment care plan dated March 25, 2025 revealed current behaviors for verbal were disruptive behaviors. aggression, cursing and threats. Known triggers were identified as experiencing symptoms of depression. Past behaviors were identified a disruptive sound. Interventions included when exhibiting signs of anxiety, agitation, or restlessness, approach with a calm and soothing demeanor. If resident should become aggressive, provide space and do not confront directly- allow time for de-escalation.</p> <p>The care plan date-initiated September 7, 2022 with a revision on April 3, 2024 revealed the resident has a behavior problem as exhibited by yelling out, using profanities, opens urine bag and drains onto the floor, impaired cognitive function and impaired thought processes related to Bipolar disorder. Interventions include administer medications as ordered.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 06 indicating severe cognitive impairment; and that the resident had no indicators for mood or behaviors.</p> <p>A progress note dated March 25, 2025 revealed a psych follow-up. The note states the patient is being seen for follow up after being moved to Sunset after becoming physically aggressive. Patient previously underwent a GDR of antipsychotic which has seemingly failed. Will restart the patient on Seroquel 25mg. Remeron previously increased due to mood/irritability issues. Medication not effective in managing behaviors at current dose, will reduce to 15mg. Will also plan to stop Namenda during future encounters.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	

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 - Some</p>	<p>Review of the room change notification indicates room change date on March 25, 2025. The interdisciplinary team determined the need for the room change was due to physical aggression.</p> <p>-Resident #10 was admitted to the facility February 11, 2025 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, moderate, anxiety disorder, unspecified.</p> <p>A behavioral treatment care plan dated December 3, 2025 revealed current behaviors for verbal aggression (cursing, expressing anger at others), self-isolation, repetitive motions. Past behaviors for suicidal thoughts, throwing items, verbal aggression and poor boundaries. Known triggers are when staff assist with completing care needs. Interventions include; Assess for agitation/anxiety, check in with resident regularly throughout the day and historically, she has engaged with peers in conversation during smoke breaks.</p> <p>Review of the care plan-initiated February 20, 2025 revealed a focus for behavior problems, a smoker and has impaired cognitive function/dementia or impaired thought processes. Interventions include Administer medications as ordered.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating the resident cognition was intact; and that, the resident had no indicators for mood or behaviors.</p> <p>Review of the nurse assessment behavior charting dated March 26, 2025 reported no adverse behaviors noted at this time.</p> <p>Review of the progress notes revealed no documentation regarding the alleged altercation between residents #8 and #10.</p> <p>Review of the facility investigation with discover date of March 25, 2025 included that resident #10 was on the patio and when resident #8 came out on the patio and kicked resident #10 on her leg and hit her on her left arm. The conclusion states resident #8 kicked resident #10.</p> <p>An interview was conducted on April 1, 2025 at 4:00 pm with resident #10. Resident #10 stated she and resident were arguing over the placement of the ashtray. Resident #10 stated she had placed it in the middle where they could both reach it. Resident #10 stated resident #8 wanted it near him and when she tried to move it he folded the smoking apron and hit her over the head with it and kicked her on her right leg.</p> <p>An interview was conducted on April 1, 2025 at 4:03 pm with resident #8. Resident #8 stated I don't remember anything.</p> <p>An interview was conducted on April 1, 2025 at 4:10 p.m. with the LPN (staff #64) who stated she was walking by when she saw residents #8 and #10 on the smoking patio. Staff #64 stated the standing ashtray was in in the middle where resident #10 had moved it. Resident #8 went to move it back and when resident #10 tried to move it again, resident #8 kicked resident #10 in the leg and hit her with the smoking apron. Staff #64 stated resident #10 reported the same to her. Staff #64 stated they were separated and assessment of resident #10 was made with no noticeable injuries on the leg. Staff #64 stated the Director of Nursing (Staff #27) was called and the resident was moved from the unit.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 South 7th Street Phoenix, AZ 85042	
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 - Some</p>	<p>An interview was conducted on April 1, 2025 at 4:35 p.m. with Director of Nursing (DON/Staff #27). The DON stated it is the expectation that all residents are kept safe at all times. The DON stated staff are provided with education regarding abuse through monthly meetings and in-services so that they understand the process with reporting incidents. The DON stated she was informed by staff who witnessed the altercation between residents #2 and #4 that resident #2 had gone out to the hallway to get the nurse and when resident #4 came out of the bathroom resident #2 charged at resident #4 and hit her. The DON stated the residents were either moved to different units or different rooms for their safety. The DON stated it is her expectation that staff keep residents safe at all times and report anything concerning.</p> <p>An interview was conducted on April 1, 2025 at 4:47 p.m. with Administrator Abuse Coordinator (Staff #50). Staff #50 stated he became aware of the resident to resident altercations through his DON (Staff #27) Staff #50 stated all staff are aware from in-service and abuse trainings the process for reporting any concerns for abuse. Staff #50 stated the facility substantiated the report regarding residents #2 and #4 based on the interviews with staff and residents. Staff #50 stated the interventions made for the residents are they were separated and placed in different rooms, with increased monitoring and supervision. Staff #50 stated the facility substantiated the report regarding residents #4 and #6 based on their investigation and camera footage it could be seen that resident #8 did hit resident #6 on the head. Staff #50 stated the facility also substantiated the report regarding residents #8 and #10 as they were able to see from the camera footage that resident #8 did hit resident #10 on the head with a smoking apron and raise his leg and kick her.</p> <p>Review of the facility policy titled Abuse Policy (Revised December 2016) state Our residents have a right to be free from abuse, neglect, misappropriation of resident property and exploitation, this includes, but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, neglect, deprivation of goods or services, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p>		