STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035205	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resolve Harmony Center, LLC	2211 East Southern Avenue Phoenix, AZ 85040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to protect the rights of one resident (#4) to be free from abuse by another resident (#6). The deficient practice could result in further resident abuse.Findings: -Regarding Resident #4Resident #4 was admitted to the facility on [DATE], with a diagnosis that included schizophrenia, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, unspecified.A review of the Annual MDS (minimum data set) assessment dated [DATE], revealed a BIMS (brief interview of mental status) score of 07, which indicated the resident had severe cognitive impairment. Further review of the MDS revealed no indicators for mood, no indicators for behaviors, but concerns with wandering daily.Review of Care Plan initiated on October 9, 2025, with reviewed/revised date of August 16, 2025, revealed a problem start date on August 12, 2022, for behaviors associated with wandering into other residents' rooms. Further review of the care plan revealed a problem start date on September 23, 2025, with resident #4 involved in an altercation with another resident. Approaches for the assessed problems included providing supervision as indicated, assessing the area with visible bruising, swelling, or open injury present, and separating the resident to a safe area, back to his room.Review of the electronic health record for skin assessments revealed that no skin assessment was documented for the date of the alleged altercation.Review of the progress notes dated September 21, 2025, 20:28, revealed SN (staff nurse) was administering medications on the South hall to Residents, when SN heard a loud verbal outburst and turned to observe Resident #4 in a physical altercation with another Resident, Resident #4 was at the entrance of the other Residents room while the other Resident was facing towards him with his arm raised, drawn back and his fist clenched, SN immediately intervened and separated both parties as Resident #4 verbalized He punched me! Right here. pointing at the left side of his face, SN assessed the area with no visible bruising, swelling or open injury present, SN redirecting Resident #4 to his room with the assistance of the CNA, for safety and further assessment, Resident vitals b/p 110/73 p 85 t 97.2 O299%ra rr 18, Resident denies any pain or discomfort at this time, No acute distress noted, ADON was notified as the first line of contact and facility protocol followed as directed, AZDHS, APS, Phoenix PD, Physician, DON, and case manager notified between the times of 1413-1430, no contact noted on face sheet to notify, Phoenix PD arrived on site around 1700, Police report #2025-01383343, Resident continuously monitored throughout shift with no changes in condition.Review of the Facility Incident Report Form dated September 21, 2025, and reported by the Director of Nursing (DON/Staff#11) documented on the form a description of any type of injury noted on resident #4. The description stated slight redness to skin on L (left) cheek. No bruising or pain. The Facility Incident Report further states that residents #4 and #6 were separated, and resident #6 was moved to another room. However, review of the facility census revealed that resident #6 was not moved from room [ROOM NUMBER]-A to 135-A until September 22, 2025.-Regarding Resident #6Resident was admitted to the facility on [DATE], with a diagnosis that included hemiplegia and hemiparesis following unspecified (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cerebrovascular disease affecting unspecified side, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, and pain, unspecified. Review of the quarterly MDS dated [DATE], revealed a BIMS assessment score of 15, indicating the resident's cognition was intact. However, review of the mood assessment revealed the resident was not assessed due to the resident rarely or never understood. Further review of the MDS revealed no indicators for behaviors, diagnosed with hypertension, aphasia, cerebrovascular accident (CVA, TIA or stroke, non-Alzheimer's dementia, and hemiplegia or hemiparesis.A review of the Care Plan, initiated September 29, 2025, revealed a problem start date of March 26, 2025, for behaviors related to hitting another resident in the past. On September 21, 2025 resident was involved in a physical altercation with another resident. Further review of the care plan revealed problems related to cognitive loss and dementia, and communication-related diagnoses for cerebrovascular accident (CVA) with expressive aphasia. Approaches included anticipating and meeting needs promptly. He was informed that physical altercations are strictly prohibited on this campus. SSD issued a verbal warning concerning the incident, emphasizing that it constitutes a violation of the policies at Suncrest. Moving forward, the resident must refrain from any unwanted or physical altercations; failure to do so may result in a 30-day notice to vacate the campus. Review of the progress notes dated September 21, 2025, 20:26 revealed SN was administering medications on the South hall to Residents, when SN heard a loud verbal outburst and turned to observe Resident [NAME] engaged in a physical altercation with another Resident, Resident [NAME] was seated in his wheelchair at the entrance of his room with his left arm drawn back, and fist clenched, aiming towards the other Resident, SN immediately intervened, providing verbal redirection and separated both residents, Resident [NAME] was redirected to his room and educated on safety measures and expectations for behavior, Resident smiled and laughed in response to SN, for resident safety and the safety of others Resident [NAME] was returned to his bed with staff monitoring, ADON was notified as the first line of contact and facility protocol followed as directed, AZDHS, APS, Phoenix PD, Physician, DON, and case manager notified between the times of 1413-1430, no contact noted on face sheet to notify, Physician ordered labs (CBC, BMP, UA), and facility drug screen, orders and labs submitted, drug screening positive for Buprenorphine and negative for all other substances, Phoenix PD arrived on site around 1700, Police report #2025-01383343.An attempt to interview resident #6 was conducted on October 21, 2025, at 8:56 a.m. The resident was lying in bed resting. Surveyor unable to complete the interview. Resident #6 is diagnosed with aphasia and is only able to respond to yes and no questions with cueing. An interview was conducted on October 21, 2025, at 9:00 a.m. with resident #4 in his room. The resident stated he was punched in the face by a black man about a few weeks ago when I was by my room. The resident reported, [NAME] punched me in my face and pointed with his finger to the left side of his face. Resident #4 stated he was unsure of any discoloration from being punched, but did state that it did hurt and that he had a conversation with the administrator regarding the incident. Resident #4 reported feeling safe now that they moved him to another room the next day. An interview was conducted on October 21, 2025, at 9:08 a.m. with a Registered Nurse (RN/Staff #15). Staff #15 stated that it was reported to her that approximately one month ago, on a weekend, resident #4 was trying to pass down the hallway to his room when resident #6 went over to resident #4 and hit him in the face. Staff #15 stated that resident #6 was moved the following day due to attempting to hit resident #4 the next day. Staff #15 stated that the weekend, Licensed Practical Nurse (LPN/Staff #18) witnessed the altercation, and completed an incident report when it happened. Staff #15 stated the facility provides abuse training to all staff and is responsible for filing reports to the state, after notifying the abuse coordinator, DON, police, and completing a resident assessment for any injuries within two hours of any alleged abuse allegations. An interview was conducted on October 21, 2025, at 9:21 a.m. with Administrator/Abuse Coordinator (Staff #18). A request was made for the facility five five-day report involving residents #4 and #6. Staff #18 stated she had reviewed the videotape of the altercation, and it did not appear that resident #6 struck resident #4 as reported. A request was made to view the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	videotape in person. Staff #18 stated she would see if the video was still available to view. An interview was conducted on October 21, 2025, at 11:57 a.m. with resident #8. Resident #8 stated she was lying in her bed and was able to see both residents #4 and #6, outside her door in the hallway. She stated she saw resident #6 strike resident #4 on his face with a closed fist, causing resident #4 to yell out. She stated this is when LPN/Staff #13 yelled at resident #6 to stop, as he had his hand raised to hit resident #4 again. She stated that resident #6 is known for hitting other people. She stated the following day, resident #6 attempted to hit resident #4 again while in the same hallway, and this is when they moved resident #6 to another hall.An interview was conducted on October 21, 2025, at 12:05 p.m. with resident #10. Resident #10 stated she was in the hallway when the incident occurred. She stated she was in her wheelchair in front of residents #4 and #6, as resident #4 had moved to allow her pass. She stated she heard LPN/Staff #13 yell out, Resident #6, don't hit him again! She stated she turned in their direction to see resident #6 with his hands raised like he was going to hit resident #4, and that resident #4 was holding his hand to his face, yelling, he hit me on my face. Resident #10 stated LPN/Staff #13 caught resident #6 trying to hit resident #4 again on the next day, and this is why resident #6 was moved to a different hall. Resident #10 stated that resident #6 used to go around bumping other residents with his wheelchair on purpose. An attempt to telephonically interview was conducted on October 21, 2025, at 1:28 p.m. with (LPN/Staff #13). No response, message left for a return phone call.An interview was conducted on October 21, 2025, at 1:01 p.m. with Certified Nursing Assistant (CNA #23). Staff #23 stated that staff are expected to report if they suspect or if they see any form of abuse. Staff #23 stated they are expected to separate the residents, report to their charge nurse, and if nothing is done once they have reported to the nurse, then it is their responsibility to report the incident themselves within a two-hour timeframe. Staff #23 stated there are many different forms of abuse, including sexual, physical, mental, and financial, and resident-to-resident altercations would be considered a form of physical abuse, almost like assault. Staff #23 stated the facility provides abuse training frequently and feels that there is sufficient staffing to provide supervision and monitoring for all the residents in the facility, by working together and recognizing that it is everyone's responsibility to watch all of the residents. An interview was conducted on October 21, 2025, at 1:12 p.m. with the Director of Nursing (DON/Staff#21). The DON stated her expectations for resident-to-resident altercations are to separate the two residents involved, make sure they are okay, by assessing the resident both physically and mentally. The process would also involve notifying the administrator herself and the charge nurse. The DON stated a skin assessment should have been documented in the resident's medical record as a change of condition, so staff could continue to monitor the injury. She further stated the facility would have conducted an immediate room change if the residents were roommates. The DON stated resident #6 was moved the next day, due to the proximity of their rooms. An interview was conducted on October 21, 2025, at 1:28 p.m. with Administrator/Abuse Coordinator (Staff #18). Staff 18 reported that the facility is going through a transitional period and the new owners have implemented new policies and processes to ensure the safety and well-being of the residents. This has involved having conversations with the residents at a resident-council meeting, establishing boundaries and expectations. Staff #18 stated this will also involve re-assessing the residents' needs and behaviors to ensure they are in the right facility and can meet those needs. Staff #18 did not provide the opportunity to view the videotape at exit. Review of the facility policy titled ABUSE PREVENTION, IDENTIFICATION, INVESTIGATION, AND REPORTING POLICY date reviewed/revised October 1, 2025 states It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Identification of Abuse, Neglect, and Exploitation included that the facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff-to-resident abuse and certain resident-to-resident altercations.