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	04/27/2026

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, staff and resident interviews, facility documentation, and policy and procedures, the facility failed to protect the right's of two of four sampled resident's (#1, #2) to be free from physical abuse by another resident. The deficient practice could result in the residents being in an unsafe environment. Findings Include: -Regarding Resident #1Resident #1 was admitted on [DATE], with a diagnosis that included cirrhosis of the liver, Parkinsonism, hydrocephalus, bipolar disorder, and mild cognitive impairment of uncertain.A care plan initiated on October 31, 2025, included a focus for impaired cognitive function with interventions that included communicating with the resident/family/caregivers regarding the resident's capabilities and needs, using the resident's preferred name, providing the resident with necessary cues, and stopping and returning if agitated.A quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview forMental Status (BIMS) score of 05, indicating severe cognitive impairment.A care plan initiated on February 16, 2026, included focus area related to the resident having behavioral disturbances, which included but were not limited to refusal of care, refusal of medication, verbal and physical abuse, related diagnosis of Parkinsonism, and Cirrhosis of the liver. Interventions included documenting behaviors and residents' responses to interventions, praising any indication of progress or improvement in behavior, providing a program of activities that is of interest to the resident, administering medication as ordered, monitor/ and documenting for side effects and effectiveness, allow the resident to make decisions about treatment regime to provide sense of control, provide a clam, quiet environment as needed, intervention as necessary to protect the rights and safety of others, approach/speak in clam manner, divert attention, remove from situation and take to alternate location as needed. An internal facility incident report dated April 10, 2026, at 09:44 AM revealed that physical aggression was observed by the Activities Assistant (Staff #3) who witnessed a resident-to-resident altercation on the patio between Resident #1 and Resident #2. The report included that Resident #2 slapped Resident #1's head after a verbal confrontation. The report further revealed that the residents were immediately separated by the Activities Assistant. The report revealed a skin assessment for Resident #1 with no apparent injuries, and that Resident #1 nodded his head yes that he felt safe in the facility. Furthermore, it was documented that the residents were monitored every 15 minutes for 72 hours, behavior monitoring was initiated, and patio checks continued. A social services note dated April 10, 2026, revealed that a statement was obtained from Social Resident #1 regarding the incident that occurred earlier that morning. The note relayed Resident #1 stated he was doing fine.A physician's orders dated April 10, 2026, related to change of condition monitoring for behaviors for three days.A Behavioral disturbance care plan, revised April 14, 2026, revealed that Resident #1 had an actual physical behavior on April 10, 2026, and no new interventions were implemented.A further review of the physician's orders dated April 14, 2026, revealed an order for behavioral charting for verbal aggression every shift. A review of Medication Administration Review for April 14, 2026, for behavioral charting for verbal aggression every shift revealed no concerns. A psych Evaluation dated April 16, 2026, at 09:15 AM revealed that another resident struck Resident #1 after Resident #1 stated (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

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	04/27/2026

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	something to the other party and angered them. An interview was conducted on April 27, 2026, at 09:16 AM with Resident #1, who made head gestures of nodding his head in the direction of up and down, related to having a resident-to-resident altercation, and then he physically touched his head. The resident verbalized slowly; he did not know who it was, but it happened on the patio, and he stated he was in pain afterwards and was scared. He then started nodding his head up and down, agreeing to feeling safe in the facility at this time. -Regarding Resident #2Resident #2 was initially admitted on [DATE], and re-admitted on [DATE], with a diagnosis that included metabolic encephalopathy, and pain.A care plan focus initiated on January 29, 2026, for an incident occurring related to behavioral disturbances, which included but were not limited to refusal of care, refusal of medication, verbal and physical abuse, related diagnosis of End Stage Renal Disease, and seizure activity. Interventions included documenting behaviors and resident responses to interventions, praising any indication of progress/improvement, administering medication as ordered, monitoring/documenting for side effects, and evaluating effectiveness. If reasonable, discuss behavior, explain/reinforce why the behavior is inappropriate and or unacceptable. Intervene as necessary to protect the rights and safety of others. Approach and speak calmly, divert attention, remove from the situation, and take to an alternate location as needed, x-ray to the right arm, referral to an appropriate psychiatric provide as needed. An incident note dated January 30, 2026, at 11:39 AM revealed that the Interdisciplinary team (IDT) met to review the incident that occurred on January 29, 2026, of physical altercation with another resident, but Resident #2, who was a non-aggressor. Resident #2 was on the patio with another resident, where they got into a disagreement, and the other resident got up from the wheelchair and pursued Resident #2. Residents were separated and placed on 15 minutes check till discharged from the IDT team to change in manifestation and or mood, psych provided notification to eval, and appropriate parties were notified. A physician's order with the start date of April 05, 2026 for behavioral charting for verbal aggression and argumentative behavior every day and night shift.A Medication Administration (MAR) note dated April 09, 2026, at 6:15 PM, for behavior charting evidenced by verbal aggression revealed Resident #2 exhibiting aggressive behavior due to changes in the room and Resident #2 cursing at staff and yelling. An internal incident facility report dated April 10, 2026, at 09:45 AM for Resident #2 indicated that a resident-to-resident altercation on the patio between Resident #1 and Resident #2 was witnessed by Staff member #3. It was also documented that Resident #2 slapped Resident #1 on the back of the head after verbal confirmation and skin assessment was completed no apparent injuries were notated for Resident #2. At the time of the internal incident, the facility report revealed that Resident #2 was oriented to person, place, situation, and time. Further, it was noted that both of these residents were separated, and 15-minute checks were initiated for 72 hours for Resident #2, and behavior monitoring was initiated. Patio checks ongoing.A social services note dated April 10, 2026, at 3:27 PM revealed that Resident #2 reported that he was doing well and had no concerns.A MAR note dated April 10, 2026, at 6:24 PM, for behavior charting evidenced by verbal aggression revealed Resident #2 had an incident with another resident. Resident #2 was verbally aggressive to staff and other residents throughout this shift.A review of the five-day investigative reports submitted on April 10, 2026, revealed that the camera footage on April 10, 2026, verified that the incident occurred between Resident #1 and Resident #2, and the incident was verified by the facility. A physician's orders dated April 10, 2026, had orders for a change of condition for behaviors for three days.A Behavioral disturbance care plan, revised April 13, 2026, revealed that the resident #2 had an actual incident on April 10, 2026, and intervention included medication review via long-term care Pharmacy services.A request to review the Camera Footage for April 10, 2026, at 1:47 PM was made, but the Administrator (staff member #12) stated that camera footage was not available as it was deleted after 72 hrs.An interview was conducted on April 27, 2026, at 09:24 AM with Resident #2, who stated that he did not have any altercation with anyone or hit anyone, then started to curse. After that, he was unable to continue the interview. An interview was conducted on April 27, 2026, at 11:16 AM, with the Activities Assistant (continued on next page)

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	04/27/2026

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	(Staff #3), who stated that her role as activities assistant was to assist residents with activities. She stated that there are different types of abuse, such as physical, verbal, mental, stealing, and being mean. She stated that the facility process for abuse is to notify our boss immediately or the nurse. The Activities Assistant stated that if she witnessed a resident-to-resident altercation, she would separate the residents and then request assistance via a walkie-talkie. The Activity Assistant stated recently that she observed the physical altercation between Resident #1 and Resident #2 on the smoking patio. She stated that she did not see Resident #2 hit Resident #1, but heard a loud sound of slapping because she was talking to another resident at the time. She stated that when she observed Resident #2 standing, she immediately got in the middle of those two residents, but the walkie talkie was not working, so she asked another Resident, #10, to get her help, and Resident #9 distracted Resident #1 with her phone. The Activities Assistant also mentioned that before the incident, both of the residents were listening to the radio, and no argument was noted.An interview was conducted on April 27, 2026, at 11:52 AM with the Social Services Coordinator (Staff #6), who stated that her role as social services coordinator is to speak to residents, help them with room changes, Arizona Long Term Care Services (ALTCS) application, help residents with social security benefits, do care plan meeting, and be a advocate for the residents. The Social Services Coordinator stated that there are different types of abuse, such as financial, verbal, sexual, and physical. She stated that she was made aware of the resident-to-resident altercation between Resident #1 and Resident #2, a staff member intervened, and the incident was reported by a nurse. The Social Services Coordinator stated that she reported the incident to APS and the Ombudsmen, and then started an investigation. She stated that Resident #1 did not say much, only stating that he felt okay, and that Resident #2 stated that they were playing around and he hit him, but they are friends. An interview was conducted on April 27, 2026, at 12:37 PM with witness Resident #9, who stated that she saw Resident #2 hit Resident #1 on his head with a book on the patio. She stated that the Activity Assistant (Staff #3) separated both residents, and that Resident #9 distracted Resident #2 with her phone by watching videos, then the nurses came and took Resident #1. Resident #9 stated that there was no argument before this incident, that Resident #2 was mad because Resident #1 kept saying the book was his.An interview was conducted on April 27, 2026, at 12:48 PM with a Certified Nursing Assistant (CNA/Staff #4), who stated that there are different types of abuse, such as financial, sexual, physical, mental, emotional, and psychological. She stated the facility's process for physical abuse is to separate the individuals who are involved in the abuse, ensure they are safe, then notify the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and on weekends, whoever is in charge. She stated that if she sees a resident hit another resident or slap their head, she would separate the residents, and then report it to the nurse who is in charge of those residents and notify the Administrator. She stated that she has not witnessed any resident-to-resident altercation recently. The CNA stated that she had worked with both Residents #1 and Resident #2, but did not witness an altercation between the residents, but heard that they had had one a while ago. She stated that she heard that Resident #2 put his hands on Resident #1. An interview was conducted on April 27, 2026, at 1:02 PM with LPN (staff #5), who stated that there are different types of abuse, such as physical, neglect, verbal, financial, and emotional. She stated that if she witnessed any resident-to-resident altercation, she would try to stop and separate the resident, then report immediately to higher-ups. LPN stated that she will then chart the incident, inform the physician, family member, and do a skin assessment for the residents. She stated that if she witnesses a resident hitting another resident with a book, she would immediately remove the residents and report the incident immediately. She stated that she has worked with Resident #1 but has not heard him having an altercation with any residents.An attempt was made to call Resident #10 on April 27, 2026, at 1:13 PM, who had been identified as being present during the altercation, but the resident did not answer the call or return the call. An interview was conducted on April 27, 2026, at 1:50 PM with the DON (Staff #11), who stated that there are different types of abuses, such as physical, verbal, mental, sexual, neglect, (continued on next page)

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	04/27/2026

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	misappropriation of funds, and emotional. She stated she expected staff members to report any incidents of abuse to her, or the executive director (ED), if they are not available in the building, is to notify via phone. The DON stated that staff are expected to separate residents who are involved in an altercation immediately, take them to a different area where they can be monitored, perform 15-minute checks, and skin assessments. She stated that the residents will be monitored for the first 24 hours, and may be extended depending on the behaviors. The DON further stated that she received a report regarding a resident-to-resident altercation between Resident #2 and Resident#1. The DON also stated that camera footage was reviewed and the where the two residents were having a conversation about 3 feet away from each other on smoking patio, then Resident #2 wheeled up to Resident #1 hit him on the head. She stated that there was physical abuse that clearly happened from the camera footage. The DON stated that the incident would be abuse, because Resident #2 hit Resident #1.An interview was conducted on April 27, 2026, at 2:09 PM with Administrator (Staff #12), who stated that there are different types of abuse, such as verbal, physical, sexual, misappropriation of funds, and belongings. He stated that he expected staff to separate the residents when resident-to-resident altercations occur to protect the residents. He stated that staff are expected to report the incidents of abuse to the supervisor and abuse coordinator, which is him. The Administrator stated that once the staff member notifies him, will make sure that the residents were separated and are safe. He stated that then nursing will perform a skin assessment, complete a risk management report, notify appropriate parties such as local police, ombudsmen, APS, family, physician, and have a corrective plan in place for the residents. He stated that based on the video footage, there was a resident-to-resident altercation, where Resident #2 tapped on Resident #1's head. A Policy titled Abuse Prevention, Identification, Investigation, and Reporting Policy with a revision date of October 1, 2025, revealed that all employees are responsible for ensuring that all residents are free from all types of abuse.