

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Resolve Harmony Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 review, staff interviews, review of facility documentation and policies, the facility failed to protect the rights of one resident (#2) to be free from physical abuse by another resident (#3). The deficient practice could result in further physical abuse of residents when appropriate actions are not taken. Findings include:-Regarding Resident #2 (alleged victim):Resident #2 was admitted to the facility on [DATE], with diagnoses that included encephalopathy, bipolar disorder, cerebral infarction, fall, and epilepsy. The facility document titled Unsupervised List for residents who smoke revealed that Resident #2 was on the list. A review of the nursing progress notes dated May 14, 2026, at 8:30 PM revealed there was a witnessed Resident to Resident altercation that happened on the smoking patio. Per document, the Residents were separated immediately. The Residents were assessed. The physician, nursing management, administrator, the State Agency, police, families, and the ombudsman were notified of the incident. Resident #2's care plan was updated. A revised care plan dated May 15, 2026, revealed that the resident had a behavioral disturbance which include but was not limited to refusal of care, refusing medications, refusing meals, refusing skin checks, Transphobic; irritable, agitated, verbal aggression, physical aggression related to his diagnosis of Bipolar disorder. The care plan further noted that the Resident had a Resident to Resident altercation. The goal was for the Resident to have fewer episodes of current behaviors. The interventions included for staff to document behaviors, and the Resident's response to the interventions; administer medications as ordered; monitor and document for side effects and effectiveness; provide a calm, quiet environment as needed; and use distracting conversation during cares to divert attention. A social service progress notes dated May 15, 2026, was reviewed. Per the document, the social service staff visited Resident #2 in his room regarding the altercation that occurred on evening of May 14, 2026. A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the Resident's cognition was intact. Per resident's behavioral symptoms assessment, there were no behavioral symptoms exhibited.-Regarding Resident #3 (alleged perpetrator):Resident #3 was readmitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD) dependent on dialysis, and heart failure. A review of the nursing progress notes dated May 14, 2026, at 8:30 PM revealed there was a witnessed Resident to Resident altercation that happened in the smoking patio. Per document, the Residents were separated immediately. The Residents were assessed. The physician, nursing management, administrator, the State Agency, police, families, and the ombudsman were notified of the incident. Resident #3's care plan was updated. A social service progress notes dated May 15, 2026, was reviewed. Per the document, the social service staff visited Resident #2 in his room regarding the altercation that occurred on evening of May 14, 2026. A review of the facility document dated May 20, 2026, revealed that Resident #3 was transferred out to the hospital for behavioral symptoms. Further, the document revealed that the visit to the hospital was related to Resident #3's three resident to resident altercations in 2 months, harm to others, and it was a voluntary admission to the hospital. A review of (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	the 5-day investigation report dated May 20, 2026, revealed that on May 14, 2026, in the evening, a Licensed Practical Nurse (LPN/Staff #7) witnessed a resident to resident altercation on the smoking patio between Resident #2 and Resident #3. Also, the camera footage verified the incident. The investigation report revealed that Staff #7 overheard resident #2 and Resident #3 arguing. Staff #7 asked Resident #2 and Resident #3 to stop arguing. Per the investigation report, Resident #3 grabbed a chair and threw the chair. Resident #2 raised his right arm to stop the chair. Resident #2 and Resident #3 were immediately separated. Resident #2 and Resident #3 were assessed. Resident #2 denied any pain and refused any other treatment and assessment. The investigation report also revealed that Resident #2 stated that Resident #3 was talking to him in Spanish but he could not understand so he moved to the other side of the patio to get away from Resident #3. Resident #3 said F*** you and Resident #2 said F*** your a**. Resident #3 grabbed the chair, walked towards Resident #2 and swung the chair at Resident #2. The investigation report revealed that Resident #2 was assessed and found to have a 1.3 cm (centimeter) by 0.5 cm abrasion to his right arm. The investigation report revealed that on May 20, 2026, Resident #3 volunteered to be transferred out to a hospital for behavioral evaluation and psychiatric follow up. An interview was conducted on June 5, 2026, at 8:49 AM with the Assistant Director of Nursing (ADON/Staff #27). The ADON stated that regarding their smoking process, she stated that the residents are assessed for safety. She stated that if a resident was deemed a safe smoker, then the resident can smoke independently, and if not deemed safe, the resident would be supervised and would have an apron. The ADON also stated that abuse could be physical, emotional, financial, verbal, and neglect. She stated that a physical abuse could be touching, hitting, and striking someone. She also said that if she was made aware of or witness an abuse, she would report the abuse to the administrator. She would report it because she is a mandated reporter and the allegation of abuse needs to be investigated. She also said that if the alleged abuse was not reported, the abuse would. On June 5, 2026, at 11:54 AM, attempted to conduct an interview with a Resident in the unsupervised smoking patio. The Resident stated that he did not have time for an interview. On June 5, 2026, at 11:59 AM, attempted to interview Resident #2 in his room. The resident was observed lying in his bed side ways facing the wall and the white linen sheets covering him all the way to his face. The Resident mumbled words that were difficult to understand. A phone interview was conducted on June 5, 2026, at 12:31 PM with LPN (Staff #7). Staff #7 stated she was working on the day of the alleged incident, during a shift change, in the month of May, when she witnessed a resident to resident physical altercation between Resident #2 and Resident #3. She stated that in the smoking patio, Resident #2 expressed that he was harassed by Resident #3. Resident #3 was speaking in Spanish to Resident #2. She stated that she asked Resident #3 to return to his wheelchair. She stated that Resident #3 proceeded to go to his wheelchair, while she administering a medication to her resident. She stated that she observed Resident #3 headed toward Resident #2. She stated that she informed Resident #3 to go back to his chair, but Resident #3 went toward Resident #2, because Resident #2 was underneath the gazebo. She stated that there was also another resident with his visitor in the smoking area, and Resident #3 still proceeded towards Resident #2. She said that she observed Resident #3 picked up a chair and swung at Resident #2. She stated that Resident #3 attempted to swing the chair again but Resident #3 almost fell over, and Resident #3 walked back to his wheelchair. She stated that it was not Resident #3's first time to threaten other residents and staff members. She stated that Resident #3 gets angry when asking for cigarettes or money from any of his roommates in the past. She further stated that Resident #3 was always threatening the residents because he thought that the other residents were saying things about him. Further, she stated that during the resident to resident altercation with resident #2 and Resident #3, Resident #2 was able to block Resident #3 when Resident #3 was trying to swing the chair. She also said that Resident #2 only got a bruise or cut on his arm. She also stated that the resident that she was administering medications to ran inside to get help from the other nurses. Staff #7 stated that she was unable to get in between Resident #2 and Resident #3 during the altercation. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further, she stated that an abuse could be physical, emotional, and if she witnessed or made aware of an allegation of abuse, she would notify the administrator and Director of Nursing (DON) right away, but, first thing she would do was to separate whoever was involved. She stated that with the incident between Resident #2 and Resident #3, she considered it as physical abuse, and she said that she wrote a statement about the incident between Resident #2 and Resident #3. An interview was conducted on June 5, 2026, at 1:06 PM with the DON (Staff #80). The DON stated that abuse is whatever the resident claims to be abuse, she considered it abuse. She stated that abuse could be physical, verbal, sexual, neglect, misappropriation of funds, and emotional. She said that physical abuse could be a resident to resident altercation, hitting, punching, and swinging at a resident. She stated that regarding the incident between Resident #2 and Resident #3, Resident #2 and Resident #3 were having a verbal discussion in the smoking patio, the verbal discussion got heated, Resident #3 grabbed a chair and directed to throw at Resident #2. The DON stated that the incident was a witnessed event. She also stated that the incident was substantiated because it happened. She stated that Resident #3 was transferred to another facility. She further stated that Resident #3 had previous altercations which has been previously investigated and that Resident #3 was transferred to a more appropriate facility due to causing harm to others or to himself. A review of facility policy titled Abuse Prevention, Identification, Investigation, and Reporting Policy with a review date of October 1, 2025, revealed that it is the policy of the facility to provide care to all residents in an environment which is free from abuse of the resident.		