

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 07/30/2026
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 a review of clinical records, staff and resident interviews, and a review of facility policies and procedures, the facility failed to ensure that one (#1) out of 3 sampled residents was not abused by another resident (#2). The Universe was 62. The deficient practice could lead to physical and psychosocial harm to residents. Findings include:-Regarding Resident #1:Resident #1 was initially admitted to the facility on [DATE] with diagnosis that included unspecified dementia, bipolar, and difficulty in walking.A care plan initiated on October 14, 2025 revealed a focus related to behavioral disturbances related to dementia. Interventions included to distract the resident from wandering.A behavior progress note dated January 7, 2026, at 12:35 p.m., revealed that the resident propelled down the hallway and told one of the staff move out of his fucking way and shut up your fat Bitch. The note included that the resident was educated on the importance of not being rude and the resident raised his arm threatening to hit the staff, if the staff did not move.A behavior progress note dated March 38, 2026, at 5:41 p.m., revealed that the resident was ambulating in the hall with shirt and briefs on and no pants. The note further revealed that the Aide asked the resident to return to the room to don (put on) pants then the resident began to yell and stated Shut up talking to me you black bitch.A behavior progress note dated April 19, 2026, at 4:42 p.m., revealed that the resident exhibited verbally aggressive behaviors towards the female Certified Nursing Assistant (CNA) attempting to get the resident dressed and out of bed. The resident began telling the female CNA to leave him alone and get out of his room in a very loud and aggressive voice. The note then revealed that a male CNA then entered the resident's room after hearing the resident yelling at which time the resident began yelling obscenities at male CNA then called male CNA a nigger. The note then revealed that the Staff gave the resident space and the resident was eventually able to calm himself down before allowing female CNA to assist him in getting out of bed, dressed for the day then into a wheelchair.A care plan initiated on April 22, 2026 revealed a focus related to potential for verbal aggressive behavior related to dementia, ineffective coping skills, and poor impulse control. Interventions included to monitor behaviors.A behavior progress note dated April 26, 2026, at 3:48 p.m., revealed that the resident was yelling at another resident from the hallway I will beat your ass, you fat son of bitch.A minimum data set (MDS) dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 0, which indicated severe cognitive impact. The assessment revealed no behaviors present during the assessment period.A facility incident progress report dated July 13, 2026, at 7:16 a.m. revealed that Resident #1 was observed by Licensed Practical Nurse (LPN, staff # 17) with visible bleeding from the eye area, forehead, and bilateral lower extremities. The report further revealed that the resident was assessed from head to toe and was transferred to the hospital for further evaluation.A physician progress note dated July 13, 2026, at 8 p.m., revealed that the physician received a report from a floor (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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