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	03/13/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the clinical records, staff interviews, and review of facility's policy and procedure, the facility failed to ensure PASARR (pre-admission screening and resident review) were updated appropriately and accurately submitted, when applicable, for six of 8 sampled residents (#17, #24, #26, #30, #40, and #42). The deficient practice could result in residents' medically related social and emotional needs not being met. The census was 50. Findings include: -Regarding Resident #17: Resident #17 was admitted to the facility on [DATE] with diagnoses that included Schizoaffective Disorder Bipolar Type, Congestive Heart Failure, and Type 2 Diabetes Mellitus. The care plan initiated on October 21, 2025, revealed that the Resident uses psychotic medications for Schizoaffective disorder. The intervention included to administer the medications as ordered by the provider and to monitor for side effects. The admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8.0, indicating cognition moderately impaired. The Resident's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15.0, indicating the resident has an intact cognition. A Pre-admission Screening and Resident Review (PASRR) document for Resident #17 was requested on March 12, 2026. The document provided by the facility revealed a completed PASRR level 1 and level 2 dated January 26, 2026, which was completed by the Social Service Director (Staff #22) on January 26, 2026. However, there was no PASRR document found on admission for Resident #17, nor an updated PASRR after the resident stay exceeded 30-days in the facility. An interview was conducted with the Social Service Director (Staff #22) on March 13, 2026, at 11:53 AM. The Social Service Director stated that she completed a level 2 PASRR and she attempted to submit the level 2 PASRR for Resident #17. At 3:05 PM, the Social Service Director stated that she was waiting for the Resident's guardian's signature before she can submit the form. However, Resident #17's PASRR's individual or health care decision maker signature section revealed per the document, a verbal consent was received from the Resident's guardian on January 26, 2026. -Regarding Resident #30 (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30 was admitted to the facility on [DATE] with diagnoses that included Schizoaffective Disorder, Bipolar Disorder, and Major Depressive Disorder. The clinical census revealed that the Resident's status was not active in the facility after September 1, 2025, and she had an active status on December 8, 2025. A review of the provider's progress note dated December 9, 2026, revealed that the resident has a medical history of schizoaffective disorder, and that the resident will be a long-term care resident at the facility. An admission MDS assessment for the resident dated December 14, 2025, revealed a BIMS score of 15.0, indicating that the resident has an intact cognition. Further, the assessment revealed that there were no behavioral symptoms exhibited by the resident. A review of the clinical record dated February 17, 2026, revealed a psychiatric evaluation visit was completed for MDD (major depressive disorder), nicotine dependence, other psychoactive substance abuse, bipolar, and schizoaffective bipolar. A review of the care plan which was revised on February 26, 2026, revealed that the Resident had behavioral disturbances, which included but not limited to refusal of care, refusing medications, and having false allegations with the staff. Another clinical record review revealed that the Resident's Pre-admission Screening and Resident Review (PASRR) Level 1 dated September 15, 2025, was completed by another facility that meets the admission criteria for a 30-day convalescent care, and per the document No Referral Is Necessary. But, according to the form, The NF (Nursing Facility) must update the Level 1 at such time that it appears the individual's stay will exceed 30 days. Further review of the PASRR document dated September 15, 2025, revealed that the document was not updated. The section for mental illnesses was left blank. The section for symptoms was left blank. The section for the History of Psychiatric Treatment was left blank. The section for Psychotropic Medications was left blank. The section for Intellectual Disability (ID) and Developmental Disabilities (DD) was left blank. The section for Referral Determination was left blank. And, the section for signature of individual or health care decision maker for consent to a level II PASRR was also left blank. The PASRR document found in the medical record when Resident #30 was admitted on [DATE] was not updated after the resident stay exceeded 30-days in the facility. -Regarding Resident #42: Resident #42 was admitted to the facility on [DATE], with diagnoses that included Schizoaffective Disorder, Depression, and Anxiety Disorder. A review of the admission MDS assessment dated [DATE], revealed a BIMS score of 11.0, indicating that the resident has a moderate cognitive impairment. A care plan was initiated on February 13, 2026, which revealed a focus plan for depression. A review of Resident #42's PASRR revealed per document that a PASRR was completed on March 5, 2026, by the Social Service Director (Staff #22). However, there was no PASRR document found in the (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medical record when Resident #42 was admitted on [DATE]. An interview was conducted on March 12, 2026, at 12:32 PM with the Social Service Director (Staff #22). The Social Service Director stated that Resident #42's PASRR was completed on March 5, 2026. The Social Service Director said that she was told to stop sending level 1 PASRR until the facility receives their AHCCCS identification number, and the State Agency responsible for the PASRR can process it. At 3:05 PM, the Social Service Director stated that Resident #42's PASRR was not submitted to the State Agency for PASRR as she was told not to send paper PASRR document. -Regarding Resident #26: Resident #26 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, and Schizoaffective Disorder. A review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15.0, indicating cognitively intact. The Resident's care plan initiated on February 15, 2026, revealed that the Resident uses antidepressant medication related to depression. A review of the physician history and physical progress note dated February 16, 2026, revealed that the resident has a past medical history for depression and bipolar disorder. Further, per document, the assessment and plan included depression, bipolar disorder and schizoaffective disorder, and to continue the medication and consult psych. A review of Resident #26's PASRR dated December 22, 2025, revealed that the Resident's PASRR was completed at another facility that meets the admission criteria for a 30-day convalescent care, and per the document No Referral Is Necessary. But, according to the form, The NF (Nursing Facility) must update the Level 1 at such time that it appears the individual's stay will exceed 30 days. Further review of the PASRR document dated December 22, 2025, revealed that the document was not updated. The section for mental illnesses was left blank. The section for symptoms was left blank. The section for the History of Psychiatric Treatment was left blank. The section for Psychotropic Medications was left blank. The section for Intellectual Disability (ID) and Developmental Disabilities (DD) was left blank. The section for Referral Determination was marked for no referral necessary for any level 2. And, the section for signature of individual or health care decision maker for consent to a level II PASRR was also left blank. Despite having a PASRR initiated from the other facility on December 22, 2025, the Resident's PASRR was not updated. Per facility's policy regarding Resident Assessment-Coordination with PASARR Program, all applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. An interview was conducted on March 12, 2026, at 8:37 AM with the Social Service Director (Staff #22). The Social Service Director stated that one of her responsibilities included the completion of PASRR for the resident. She said that she was unable to complete PASRRs because her facility has no Arizona Health Care Cost Containment System (AHCCCS) identification number since the facility was owned by a new company. She said that the AHCCCS application was still pending, and without an AHCCCS identification number, she cannot submit a PASRR. She said she was even sending the PASRRs through email and she end up receiving an email stating that it can only be submitted through (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the online portal. She also said that she can submit the PASRRs without using the online portal until their facility receives its AHCCCS identification number. On March 12, 2026, at 9:03 AM, the Business Office Manager (BOM/Staff #14) was interviewed. The BOM stated that the facility was going through change of ownership since October 1, 2025, and the facility had applied for AHCCCS identification number and the application status was still pending. At 9:11 AM, the Social Service Director and the Regional Financial Coordinator (Staff #77) joined the interview. Regional Financial Coordinator stated that because they are still under acquisition, they have no official AHCCCS identification number and therefore cannot submit anything that requires an AHCCCS identification number. The Social Service Director stated that submitting a PASRR to the State Agency requires an AHCCCS identification number. The Social Service Director stated that regarding providing services to their residents, they have a behavioral team for their residents' behavioral management. The Social Service Director also stated that, if a resident remains in the building for 30 days, she will complete a level 1 PASRR to request a Level 2 PASRR. The Social Service Director stated that PASRR level 1 also is completed upon admission, and if the resident has a serious mental illness (SMI), then she will submit a level 2 PASRR for review. The Social Service Director stated that all residents should have a level 1 PASRR on file, and she has been conducting an audit on who currently do not have a PASRR or a current PASRR. A follow up interview was conducted on March 12, 2026, at 10:45 AM with the Social service Director. Regarding Resident #30's PASRR, the Social Service Director stated that the Resident went out to the hospital on September 1, 2025 and the Resident was readmitted on [DATE]. The Social Service Director stated that the resident has been in the facility for more than 30 days since admission, and the Resident's next PASRR should have been completed on January 8, 2026, and then submitted for a level 2. She said that she will look for the Resident's PASRR in the paper form. She also said that she became an employee of the facility on January 21, 2026, and no one has been able to submit any PASRR since the takeover or transition on October 2025. She said that she has not been able to locate any completed PASRR prior to her employment. Furthermore, the Social Service Director stated that PASRR is important to determine placement is appropriate for the resident. She said that if a Resident's PASRR was not completed, the resident would not be placed appropriately and the level of care they needed would not be appropriately provided. She said that since the PASRRs were not completed and were not sent out for referral, that there was no impact to the residents because they have psych providers at the facility monitoring their residents, their residents were being managed, and they have staff equipped and trained to monitor their residents' behaviors. On March 12, 2026, a facility document was provided to the State Agency surveyor which revealed a letter dated February 6, 2026, that the facility submitted a letter to AHCCCS Division of Member and Provider Services for a provider enrollment application. Another interview was conducted with the Social Service Director (Staff #22) on March 13, 2026, at 11:46 AM. The Social Service Director stated that if a Resident have a PASRR from another state, she would complete a new level 1 PASRR because every state has different policies and she would make sure that she follows the state policy. She said that she does not see a level 1 PASSAR for Resident #36. She said that she completed a 30-day PASRR on February 3, 2026, and the resident did not require a level 2 because resident does not have a serious mental illness (SMI). She said that depression is not SMI. According to the Arizona Health Care Cost Containment System, the Pre-admission Screening and Resident Review (PASRR) Level I is a preliminary assessment completed for all individuals prior to (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission to a Medicaid-certified Nursing Facility in order to determine whether an individual might have a mental illness or intellectual disability. A Level I Screening must be completed before an individual can be admitted into a Medicaid- certified nursing facility and can be completed in a hospital, emergency room, doctor's office or in any community setting. The PASRR Level II is a comprehensive evaluation required as a result of a positive Level I Screening. A Level II is necessary to confirm the indicated diagnosis noted in the Level I Screening and to determine whether placement or continued stay in a Nursing Facility is appropriate. The determination is the outcome of the Level II evaluation which ensures that Nursing Facility placement is, or continues to be, appropriate, and that services provided to individuals with a MI, ID, or related condition meet the individual's needs, including the need for specialized services. Level II evaluations for individuals with ID are performed by the Department of Economic Security (DES) and evaluations for individuals with MI are coordinated by AHCCCS and performed by a designated entity. For individuals requiring admission to a nursing facility for a convalescent period, or respite care (not to exceed 30 consecutive days), do not require a PASRR Level II Evaluation. If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level I Screening must be completed as soon as possible or within 40 calendar days of the admission date to the nursing facility. Review of the facility policy titled Resident Assessment-Coordination with PASARR Program with a revision date of October 1, 2025, revealed that all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. -Regarding Resident #24: Resident #24 was admitted on [DATE], with the diagnoses of auditory hallucinations, anxiety disorder, schizophrenia, restlessness and agitation, bipolar disorder, and major depressive disorder. The clinical record revealed no evidence of a completed Level 1 PASARR. The Order Summary Report revealed the following physician orders dated September 30, 2025:which prescribed -Sertraline hydrochloride 50 MG. The order indicated to give 50 mg by mouth one time a day for major depressive disorder, as evidenced by verbalized sadness. The order directed to monitor every shift for antidepressant behavior. A medication care plan initiated on October 15, 2025, pertaining to antidepressant use, revealed that the resident is on antidepressant medication due to depression, as evidenced by verbalized sadness and sleeplessness. Interventions included administering antidepressant medications as ordered and monitoring/documenting side effects. A psychotic medication care plan initiated on October 15, 2025, revealed that the resident is on psychotic medications related to the diagnosis of schizophrenia, as evidenced by auditory hallucinations. Interventions indicated to administer medications as ordered, monitor for side effects and effectiveness every shift, and monitor/record the occurrence of target behaviors. An anti-anxiety medication care plan initiated on October 15, 2025, documented that the resident used anti-anxiety medications related to anxiety, as evidenced by restlessness. Interventions included administering anti-anxiety medications as ordered, and monitoring/documenting side effects/ effectiveness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated October 20, 2025, prescribed Trazodone hydrochloride 50 MG (milligram), to give one tablet at bedtime for depression, as evidenced by insomnia, and to hold for sedation. A quarterly MDS (minimum data set) assessment dated [DATE], revealed that the resident had a BIMS (brief interview for mental status) score of 12, indicating moderate cognitive impairment. The MDS revealed that at the time of the assessment, the resident had diagnoses of anxiety disorder, depression, bipolar disorder, schizophrenia, and auditory hallucinations. Per the MDS, the resident was administered antipsychotic, antianxiety, antidepressant, and opioid during the assessment period. An order dated February 13, 2026, prescribed fluphenazine decanoate injection solution 25 MG/ML, inject 37.5 mg intramuscularly one time a day every 12 days for schizophrenia. A behavioral care plan initiated on February 27, 2026, revealed that Resident #24 had behavioral disturbances, which included refusal of care, related to the diagnosis of schizophrenia. Interventions included documenting behaviors and resident responses to interventions, administering medications as ordered, and referring to a psychiatric provider as needed. An order dated March 9, 2026, prescribed Risperdal oral tablet 0.5 MG and indicated to administer 0.5 mg at bedtime for schizophrenia. Another order dated March 12, 2026, revealed that Resident #24 is to receive fluphenazine decanoate injection 37.5 intramuscularly one time a day every 12 days for schizophrenia. An interview with the Social Services Director (Staff #22), the Business Office Manager (Staff #14), and the Regional Financial Coordinator (Staff #77) was conducted on March 12, 2026, at 9:03 AM. The Regional Financial Coordinator stated that the facility underwent a change of ownership on October 1, 2025, and had to register the facility with the state's Medicaid agency member and obtain an ID (identification). At the time of the interview, and could not provide an exact date of when the paperwork was submitted to the Medicaid agency. The Regional Financial Coordinator stated that without an ID, the facility is unable to submit items such as PASARR screenings, which require an ID. During the same interview conducted on March 12, 2026 at 9:03 AM, the Social Services Director (Staff #22) stated that current mental health concerns were reviewed under behavioral health solutions for psychological testing, supervision, and medication management. The Social Services Director also stated that they had sent a few PASARR applications and had received a response email, which explained that due to the lack of an ID, the state agency is unable to process the PASARR, and that there is a running list of residents whose PASARR had not been processed. The Social Services Director further stated that all residents are admitted with a level 1 PASARR, and a level 2 PASARR if needed. The Social Services Director also stated that residents who stay in the facility over 30 days and have an SMI (serious mental illness) diagnosis would require an updated PASARR to be completed and kept within their records per facility procedure. The Social Services Director said she conducted an audit and listed residents who required resubmission and an updated PASARR. During a follow-up interview with the Social Services Director (Staff #22), on March 12, 2026, at 11:32 AM, the Social Services Director reviewed Resident #24's PASARR and stated that the resident was admitted on [DATE], however, the only PASARR in the resident's clinical record was dated April 5, 2021, and was initiated for another facility. The Social Services Director admitted that did not meet (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's expectations. Additionally, the Social Services Director stated that the PASARR should have been reviewed for accuracy during admission, and should have been flagged after the resident exceeded 30 days of their stay, as well as during audits. The Social Services Director did not have access to the records prior to January 2026 since it had been prior to her taking over the position, but she acknowledged that Resident #24 should have received an updated PASARR screening. The Social Services Director further stated that the a Level 2 PASARR should have been submitted for determination due to the diagnoses of schizophrenia, bipolar disorder, major depressive disorder, and anxiety disorder. She stated that those conditions warranted a level II screening. The Social Services Director said that the risk of an inaccurate and incomplete PASARR and failure to submit for level II determination could result in inadequate placement in an inappropriate setting, and the resident might not receive appropriate treatment, such as psychiatric care. The Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, regarding the PASARR level I screening tool, revealed that the nursing facility must update the level I at such time that it appears the individual's stay will exceed 30 days. A facility policy titled, Resident Assessment – Coordination with PASARR Program, last reviewed/revised on October 1, 2025, revealed that the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy indicated that all applicants to the facility would be screened for serious mental disorders and intellectual disabilities and related conditions in accordance with the state's rules. A PASARR level I would be completed before admission, with a determination of either negative or positive. If positive, a comprehensive evaluation would be completed by the appropriate state-designated authority that determines whether the individual has MD (mental diagnosis), ID (intellectual disability), or a related condition, and determines the appropriate setting for the individual's needs. Per the policy, the facility will only admit individuals with an MD or ID who the state has determined to be appropriate for admission. The PASARR would be maintained within the resident's medical record. According to the policy, exceptions to the PASARR screening program include those individuals who are readmitted and/or admitted directly from a hospital, require nursing facility services for the condition for which the individual received care in the hospital, and have been certified by an attending physician before admission that the individual is likely to require less than 30 days of services. A resident not meeting those exceptions and remaining in the facility longer than 30 days must be screened using the state's level I screening process and refer any residents who have or may have MD, ID, or a related condition to the appropriate state-designated authority for a level II PASARR evaluation and determination, and completed within 40 calendar days of admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one of 21 sampled residents (Resident #37) was free from accidents and hazards, in regards to safe smoking. The deficient practice can lead to the possibility of burns, fires, smoke inhalation, serious injury, death, and potentially cause facility-wide danger. The sample size is 21. The census was 50. Regarding Resident #37:Resident #37 was admitted to the facility on [DATE], with the diagnosis that included encounter for immunization; multiple sclerosis, unspecified; encounter for therapeutic drug level monitoring; schizoaffective disorder, bipolar type; mood disorder due to known physiological condition, unspecified; generalized anxiety disorder; and other muscle spasm.A safe smoking assessment dated [DATE], revealed that Resident #37 had not been able to smoke a cigarette or utilize a smoking device with safe technique, including lighting matches and/or lighter and disposing of ashes appropriately. The assessment also revealed that Resident #37 had not been able to hold the cigarette or other smoking devices while smoking, not been able to dispose of ashes appropriately while smoking, and not been able to extinguish the cigarette and dispose of it in an appropriate container, before it became dangerously short. A care plan focus initiated on October 21, 2025, revealed that Resident #37 was a smoker and required supervision during smoking, and not suffer injury from unsafe smoking practices through the review date. The care plan focus also revealed that the facility will instruct the resident about smoking risks and about the facility's policy on smoking locations, times, and safety concerns. A smoking policy form signed by Resident #37 and dated on November 14, 2025, revealed that all residents who smoke will have all their smoking materials stored in a secure area, without the ability of anyone to take the materials. If the resident has or holds any cigarettes or combustible material, it will be a direct violation of this policy, and the smoking privilege on the premises will be revoked. It also revealed that this included electronic cigarettes, regardless of the nicotine level, as smoking materials.A quarterly MDS assessment dated [DATE], revealed that Resident #37 had a BIMS score of 13, indicating that Resident #37 had intact cognition, with normal thinking and memory function. A smoking violation document dated March 6, 2026, revealed that Resident #37 received a level 1, verbal education offense for having a lighter/matches. The materials had been confiscated, and a room search had been conducted per the facility policy.On March 11, 2026, at 1:08 PM, an interview was conducted with a CNA (certified nursing assistant/Staff #48), who stated that there was no exact list that stated who was and who was not a resident who smoked in the facility, and that the resident's would tell staff if they were a smoker, and, that the resident's were able to keep their smoking materials on their person. Staff #48 also stated that she was unsure where residents were able to charge their smoking materials and where the smoking materials were to be kept when not in use, stating the risk of a resident who maintained their smoking materials on their person could have the potential risk of burns and fires if not used for the intended purpose. On March 11, 2026, at 1:16 PM, an interview was conducted with an LPN (licensed practical nurse/Staff #51), who had been training another LPN (Staff #2). Staff #51 stated that there are two different expectations regarding smoking in the facility. She further stated that an assessment is conducted with a resident to determine if they can light and hold their own smoking materials. Should it be determined that a resident can do so without complications, then the resident can smoke their materials with no supervision. Staff #51 further stated that should a resident be assessed with any difficulty, then the resident will require supervision during the designated smoking times and area. Staff #51 also stated that it was to her understanding that residents, both supervised and unsupervised, were not allowed to keep their smoking materials on their person, which include cigarettes, lighters, matches, and electronic vapes. Staff #51 further stated that smoking materials were kept within a box and stored in the activities room with the supervision of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities director and assistants. Staff #51 further stated that she had not witnessed resident's with their smoking materials on their person and not in the appropriate smoking areas, and that if she did observe a resident with smoking materials on their person, she would provide education to the resident on the importance and risk of the materials on their person, confiscate the materials, and advise the resident that the materials could be retrieved from the activities director, as the risk for having the materials on their person could be the possibility of resident's burning themselves, lighting a fire, and sharing their materials with their friends, to which Staff #51 stated resident's were not allowed to do in case of disagreements between residents and potential for altercations.On March 11, 2026, at 1:22 PM, an interview was conducted with the activity's director (Staff #59), who stated that the facility had supervised smokers and unsupervised smokers. Regarding supervised smokers, Staff #59 stated that those residents are designated to smoke in the smoking area near the dining room, with staff supervision, due to being assessed as unsafe to smoke by themselves. Regarding unsupervised smokers, those residents can smoke on their own. Staff #59 further stated that smoking materials are kept in her office under her supervision, for supervised smokers, and that residents who are determined to have unsupervised smoking times can keep their smoking materials on their person. Staff #59 further stated that with the change of ownership, the facility went away with the usage of electronic vapes and that residents were only allowed to have cigarettes, lighters, or matches. She further stated that smoking assessments are conducted at the time of admission, as well as if they are caught smoking in their room. Staff #59 stated uncertainty about whether an assessment would be completed following a change in condition that could affect the resident's ability to smoke. She further stated that at the time of admission, residents are educated on the facility's smoking policy and are required to express understanding and to sign the policy once they acknowledge what they can have, and not have, when and where. Staff #59 stated that the risk of not following the facility's smoking policy is that residents are at risk of catching the facility on fire, burning down the facility, and burning themselves.On March 11, 2026, at 1:36 PM, an interview was conducted with a clinical resource (Staff #78) who stated that residents are assessed for smoking capabilities at the time of admission, and if it is determined that they can light and smoke their materials with no difficulty, they can smoke without supervision. Staff #78 also stated that at the time of admission, an inventory of the resident's items is done, and it is expected to confiscate any contrabands, such as electronic vapes, and to store smoking materials in the activities room and provide education for storing the smoking materials and how to obtain the smoking materials. Staff #78 further stated that should a resident not pass the assessment, they are determined to have supervised smoking, or not at all. Staff #78 further stated that smoking materials are kept in the activities, and can be accessed by nurses with a key, and that residents were not allowed to keep their smoking materials on their person. Staff #78 further stated that electronic cigarettes were not allowed in the facility and were against the facility's policy. Staff #78 stated that the risk of residents keeping smoking materials on their person, and if the facility is unaware, it could put residents at risk of potential harm, such as burns. On March 11, 2026, an interview was conducted with the interim DON (director of nursing/Staff #76) at 1:55 PM. Staff #76 stated that residents were assessed on admission by a nursing staff to determine if a resident requires supervision while smoking or if they're able to smoke unsupervised. Staff #76 also stated that supervised residents can smoke during designated smoking times and that the smoking materials for these residents will be maintained, monitored, and stored by nursing staff. Staff #76 stated that the policy did not state where unsupervised residents can keep their smoking materials; however, she stated that changes to the policy would need to be made as both supervised and unsupervised residents were not allowed to keep their smoking materials on their person, and, that staff is expected to provide education to residents as to why smoking materials should not be kept on their person and where the materials could be retrieved from. Staff #76 further stated that there had not been a separate policy for electronic cigarettes but that residents should not have had them in their room as the risk of having the devices in their room could potential start fires and (continued on next page)

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	035205	A. Building B. Wing	03/13/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explode, and that they are expected to be stored properly, meaning away from other residents, and not on their person, with staff until the device is needed. Staff #76 reviewed smoking policies provided to residents that required their signature and stated that the form is proof of an assessment being done, and should be done at the time of admission, annually, and with a change of condition, and signed by the resident for understanding. On March 12, 2026, at 2:05 PM, an interview was conducted with the environmental services director, Staff #30, who stated that she is one of the staff members who provide supervision for the residents who can smoke in the supervised area of the facility. At this point of the interview, an observation was made with Staff #30, in which Resident #37 was observed smoking in the designated area for supervised smoking residents. Staff #30 stated she witnessed Resident #37 with tremors and dropped ash all over her, with no smoking protector present. Staff #30 also stated that Resident #37 didn't have a smoking protector to begin with, and had dropped ashes and her cigarette on her person, and ended up dropping a cigarette on the ground. Staff #30 further stated that the risk of a resident not utilizing a smoking protector while smoking, as it relates to Resident #37, is that she always drops her cigarette and ashes on the ground, and if it had landed on her, she could have burned herself on her skin, and that if an incident were to happen where there is harm to the resident, then the DON is to be notified. Staff #30 further stated that the observation made during this interview would be relayed to the DON for the inclusion of a protector.During a secondary review of Resident #24's electronic health record, a smoking evaluation due to a significant change, dated March 12, 2026, with an effective time of 4:29 PM, revealed that Resident #37 required adaptive equipment that included a smoking apron and staff supervision with lighting and safety reminders.On March 13, 2026, at 12:35 PM, an interview was conducted with the Administrator (Staff #24). Staff #24 stated that residents were not allowed to have smoking materials on their persons; and that the smoking materials would need to be locked in drawers, and all their smoking materials should be kept there until necessary, and if staff are to observe residents with their smoking materials on their person, staff is expected to confiscate the materials and put them in a box, and that the items should not be in their purse or in their wheelchair. Staff #24 stated that a locked cabinet is located in the rooms of the resident and that supervised residents had been previously instructed to keep their smoking materials in these locked cabinets that they have a key for, and that it shouldn't be left unlocked. Staff #24 stated that the facility is in the process of transitioning into a new system, which will be implemented regarding keeping the containers in a certain area and taking what they need, in the reception, for all of the unsupervised smokers, and that the smoking materials of supervised stays will be kept in the activities room and locked. Staff #24 also stated that new admissions are provided with a smoking assessment and a smoking policy to sign and are expected to be put into their files. Staff #24 further stated that electronic cigarettes are not allowed and that those materials would be confiscated during inventory checksStaff #24 stated that implementing the admission process for smoking expectations is important due to the potential risk of fire, smoke, and the possibility of burns, which is a component included in the admission assessment. Regarding Resident #37, Staff #24 stated that Resident #37 had been on restrictions previously due to inappropriate behaviors while smoking or to attain smoking materials from other residents, and that recently, she was determined to be able to smoke under staff supervision.A policy titled ?Resident Smoking', last reviewed and revised October 1, 2025, stated that it is the policy of the facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking, and that safety protections apply. The policy also stated that all residents will be asked about tobacco use during the admission process and during each quarterly or comprehensive MDS assessment process. Residents who smoke will be further assessed, using the ?Resident Safe Smoking Assessment' to determine whether or not supervision is required for smoking, or if a resident is safe to smoke at all. The policy also stated that electronic cigarettes, such as e-cigarettes, vapes, or vapor pens, can catch on fire and/or explode if not handled and stored safely, with additional safety measures that will include but not limited to the use of e-cigarettes in designated smoking (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, review of the clinical record, facility documentation, and policy, the facility failed to implement its smoking policy for three residents (#12, #26, and #41). The deficient practice could result in inadequate smoking interventions due to the lack of an assessment and put residents at increased risk for smoking-related incidents. The sample size is 21. The census was 50. Findings include: -Regarding Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses of type 2 diabetes mellitus, nicotine dependence, chronic obstructive pulmonary disease (COPD), depression, anxiety, and seizures. A safe smoking assessment dated [DATE], indicated that all smoking materials would be kept in a designated area for safety purposes. A smoking evaluation dated October 9, 2025, revealed that the Interdisciplinary team (IDT) would educate residents on proper storage of lighter and smoking materials per facility and CMS (Centers for Medicare and Medicaid Services) guidelines. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. An interview was conducted on March 10, 2026, at 11:46 a.m., with Resident #12, who stated that she smokes in the facility designated smoking area from 7 a.m. to 10 p.m. The resident stated that she stored cigarettes and lighters under the cushion of her wheelchair in her room. The Resident #12 stated that the facility evaluated residents every 6 months for smoking. Resident #12 stated that unsupervised smokers are allowed to keep cigarettes and lighters in their room. An observation was conducted with Resident #12 in her room, on March 11, 2026, at 11:37 a.m., the resident removed an orange colored lighter that was stored under the cushion of her wheelchair in her room. A follow-up interview was conducted on March 11, 2026, at 11:37 a.m., with Resident #12 who stated that she smokes at least 3 cigarettes in a day in the facility designated smoking area. The resident further stated that the Activity Director (staff #59) bought and supplied cigarettes and lighters for the facility's residents. The resident stated that she stores her orange lighter in her room. An interview was conducted on March 11, 2026, at 11:44 a.m., with the activity's director (staff #59). She stated that she provides activities and do weekly shopping for residents. Staff #59 stated that she also purchases cigarettes and lighter for Resident #12 and other residents in the facility. Staff #59 further stated that the facility had supervised smokers and unsupervised smokers. Regarding supervised smokers, Staff #59 stated that those residents are designated to smoke in the smoking area near the dining room, with staff supervision, due to being assessed as unsafe to smoke by themselves. Regarding unsupervised smokers, those residents can smoke on their own. Staff #59 then stated that unsupervised smoker are allowed to keep cigarette and lighter in their room. Staff #59 further stated that Resident #12 keep cigarette and lighter in her room. Staff #59 then stated that (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk if resident keep lighter in their room would be catching fire at facility, and burning down the facility and themselves. During an interview conducted on March 11, 2026, at 2:12 p.m., with a Licensed Practical Nurse (LPN/ staff # 46), the LPN stated that residents were not allowed to store cigarettes and lighters in their room because of safety concerns. The LPN reviewed Resident #12's smoking evaluation dated October 09, 2025, and stated that per the evaluation the resident is an unsupervised smoker, but the facility should store the cigarette and lighter for the resident. An interview was conducted on March 11, 2026, at 2:27 p.m. with an LPN (staff # 3), who stated that residents should not have any lighters stored in their room because the resident could cause harm and injury to himself and to the other residents. Additionally, The LPN stated that the lighter could cause a fire and explosion if it was near a supplemental oxygen source. The LPN reviewed the resident's smoking evaluation dated October 09, 2025, and stated that per the evaluation the IDT educated the resident regarding proper storage of cigarette lighters per facility and CMS guidelines. An interview was conducted on March 11, 2026, at 12:35 p.m., with a Director of Nursing (DON/staff #76), who stated that residents are not allowed to store cigarettes and lighters in their rooms and all smoking material should be stored in a locked unit for the residents. She then stated that residents should not store lighters in their rooms because the residents could burn themselves and fire could spread to another room. Regarding Resident #26: Resident #26 was admitted to the facility on [DATE], with a diagnosis that included paraplegia, complete; major depressive disorder, single episode, unspecified; anxiety disorder, unspecified; bipolar disorder, unspecified; and schizoaffective disorder, unspecified. A progress note dated February 13, 2026, revealed that Resident #26 arrived at the facility and had been identified as a smoker and had been orientated to the facility's smoking areas. There was no evidence of a smoking assessment or a signed smoking policy indicated in this note. A care plan focus initiated February 15, 2026, revealed that Resident #64 had been a smoker, and that Resident #26 would not suffer injury from unsafe smoking practices through the review date. It also revealed that the facility will instruct the resident about smoking risks and hazards and about the smoking policy that includes locations, times, and safety concerns. An admission MDS (minimum data set) assessment dated [DATE], revealed that Resident #26 had a BIMS (brief interview of mental status) score of 15, indicating that Resident #26 had intact cognition, with normal thinking and memory function. An initial review of Resident #26's electronic health record revealed no evidence of a smoking assessment or a signed smoking policy per the facility policy. During a secondary review of Resident #26's electronic health record, a smoking evaluation dated March 11, 2026, with an effective time of 3:11 PM, revealed that the IDT (interdisciplinary team) needed to educate on proper storage of lighters and smoking materials as per facility and CMS guidelines, and, that she did not need 1:1 smoking help, she would be able to light and hold without difficulty, and able to demonstrate a safe smoking routine, and that she had been able to extinguish (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without difficulty in a proper ashtray. Resident #26 required the facility to store her lighter and cigarettes. Regarding Resident #41: Resident #41 was admitted to the facility on [DATE], with the diagnosis that included a personal history of transient ischemic attack and cerebral infarction without residual deficits; major depressive disorder, single episode, unspecified; and polyneuropathy, unspecified. A smoking assessment dated [DATE], revealed that the IDT team needed to educate Resident #41 on proper storage of lighters and smoking materials as per facility and CMS guidelines, and, that she did not need 1:1 smoking help, she would be able to light and hold without difficulty, and able to demonstrate a safe smoking routine, and that she had been able to extinguish without difficulty in a proper ashtray. A care plan focus initiated on October 13, 2025, revealed that Resident #41 had been a smoker and that Resident #41 would not suffer injury from unsafe smoking practices through the review date. It also revealed that the facility will instruct the resident about smoking risks and hazards and about the smoking policy that included locations, times, and safety concerns. A quarterly MDS assessment dated [DATE], revealed that Resident #41 had a BIMS score of 15, indicating that Resident #37 had intact cognition, with normal thinking and memory function. A smoking policy form signed by Resident #41 and dated on November 14, 2025, revealed that all residents who smoke will have all their smoking materials stored in a secure area, without the ability of anyone to take the materials. If the resident has or holds any cigarettes or combustible material, it will be a direct violation of this policy, and the smoking privilege on the premises will be revoked. It also revealed that this included electronic cigarettes, regardless of the nicotine level, as smoking materials. On March 10, 2026, at 9:50 AM, an initial screening interview was conducted with the Resident #26, who also stated that she kept all of her smoking materials, including cigarettes, lighters, matches, and electronic vapes, located on their person and located in the room. On March 11, 2026, at 1:00 PM, an additional interview and observation were done with Resident #26, who stated she had six electronic vapes on her person, and provided a visual of all six electronic vapes. She also stated that she had a box of cigarettes and a lighter on her person, which she had also provided a visual of. Resident #26 also stated that the facility did not provide the resident with a smoking policy to sign at the time of admission. Resident #26 stated that she had been taken outside to the assigned unsupervised smoking area, and the facility determined that she could hold and light her own cigarettes with no difficulties. At this point in the interview, the interim DON (director of nursing/Staff #76) had been called to enter the room and observed the six electronic vapes in her possession and confiscated the devices, as well as cigarettes and a lighter, and then further provided education as to why the items were confiscated, and where she would be able to retrieve her cigarettes and lighter when necessary. On March 11, 2026, at 1:08 PM, an interview was conducted with a CNA (certified nursing assistant/Staff #48), who stated that there was no exact list that stated who was and who was not a resident who smoked in the facility, and that the resident's would tell staff if they were a smoker, (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and, that the resident's were able to keep their smoking materials on their person, and identified Resident #41 as a resident who not only keeps their smoking material on them, but had been seen with an electronic vape in their room. Staff #48 also stated that she was unsure where residents were able to charge their smoking materials and where the smoking materials were to be kept when not in use, stating the risk of a resident who maintained their smoking materials on their person could have the potential risk of burns and fires if not used for the intended purpose. On March 11, 2026, at 1:16 PM, an interview was conducted with an LPN (licensed practical nurse/Staff #51), who had been training another LPN (Staff #2). Staff #51 stated that there are two different expectations regarding smoking in the facility. She further stated that an assessment is conducted with a resident to determine if they can light and hold their own smoking materials. Should it be determined that a resident can do so without complications, then the resident can smoke their materials with no supervision. Staff #51 further stated that should a resident be assessed with any difficulty, then the resident will require supervision during the designated smoking times and area. Staff #51 also stated that it was to her understanding that residents, both supervised and unsupervised, were not allowed to keep their smoking materials on their person, which include cigarettes, lighters, matches, and electronic vapes. Staff #51 further stated that smoking materials were kept within a box and stored in the activities room with the supervision of the activity director and assistants. Staff #51 further stated that she had not witnessed residents with their smoking materials on their persons. Staff #51 further stated that if she did observe a resident with smoking materials on their person, she would provide education to the resident on the importance and risk of the materials on their person, confiscate the materials, and advise the resident that the materials could be retrieved from the activity director. Staff #51 further stated the risk of having the materials on their person could be the possibility of residents' burning themselves, lighting a fire, and sharing their materials with their friends, to which Staff #51 stated residents were not allowed to do in case of disagreements between residents and potential for altercations. On March 11, 2026, at 1:22 PM, an interview was conducted with the activity's director (Staff #59), who stated that the facility had supervised smokers and unsupervised smokers. Regarding supervised smokers, Staff #59 stated that those residents are designated to smoke in the smoking area near the dining room, with staff supervision, due to being assessed as unsafe to smoke by themselves. Regarding unsupervised smokers, those residents can smoke on their own. Staff #59 further stated that smoking materials are kept in her office under her supervision, for supervised smokers, and that residents who are determined to have unsupervised smoking times can keep their smoking materials on their person. Staff #59 further stated that with the change of ownership, the facility went away with the usage of electronic vapes and that residents were only allowed to have cigarettes, lighters, or matches. She further stated that smoking assessments are conducted at the time of admission, as well as if they are caught smoking in their room. Staff #59 stated uncertainty about whether an assessment would be completed following a change in condition that could affect the resident's ability to smoke. She further stated that at the time of admission, residents are educated on the facility's smoking policy and are required to express understanding and to sign the policy once they acknowledge what they can have, and not have, when and where. Staff #59 stated that the risk of not following the facility's smoking policy is that residents are at risk of catching the facility on fire, burning down the facility, and burning themselves. On March 11, 2026, at 1:36 PM, an interview was conducted with a clinical resource (Staff #78) who stated that residents are assessed for smoking capabilities at the time of admission, and if it is determined that they can light and smoke their materials with no difficulty, they can smoke without supervision. Staff #78 also stated that at the time of admission, an inventory of the resident's items (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is done, and it is expected to confiscate any contrabands, such as electronic vapes, and to store smoking materials in the activities room and provide education for storing the smoking materials and how to obtain the smoking materials. Staff #78 further stated that should a resident not pass the assessment, they are determined to have supervised smoking, or not at all. Staff #78 further stated that smoking materials are kept in the activities, and can be accessed by nurses with a key, and that residents were not allowed to keep their smoking materials on their person. Staff #78 further stated that electronic cigarettes were not allowed in the facility and were against the facility's policy. Staff #78 stated that the risk of residents keeping smoking materials on their person, and if the facility is unaware, it could put residents at risk of potential harm, such as burns. On March 11, 2026, at 1:46 PM, an interview with Resident #41 was conducted. Resident #41 stated that she had bought her smoking materials during an outing and that she can keep the smoking materials on her person. It was then observed that Resident #41 had what she identified as two boxes of cigarettes, one in her dresser and one in her bag, as well as a lighter in her bag. On March 11, 2026, an interview was conducted with the interim DON (Staff #76) at 1:55 PM. Staff #76 stated that residents were assessed on admission by a nursing staff to determine if a resident requires supervision while smoking or if they're able to smoke unsupervised. Staff #76 also stated that supervised residents can smoke during designated smoking times and that the smoking materials for these residents will be maintained, monitored, and stored by nursing staff. Staff #76 stated that the policy did not state where unsupervised residents can keep their smoking materials; however, she stated that changes to the policy would need to be made as both supervised and unsupervised residents were not allowed to keep their smoking materials on their person, and, that staff is expected to provide education to residents as to why smoking materials should not be kept on their person and where the materials could be retrieved from. Staff #76 further stated that there had not been a separate policy for electronic cigarettes but that residents should not have had them in their room as the risk of having the devices in their room could potentially start fires and explode, and that they are expected to be stored properly, meaning away from other residents, and not on their person, with staff until the device is needed. Staff #76 reviewed smoking policies provided to residents that required their signature and stated that the form is proof of an assessment being done, and should be done at the time of admission, annually, and with a change of condition, and signed by the resident for understanding. Regarding Resident #26, Staff #76 stated that there was no evidence of a signed smoking policy or smoking assessment in her records, and that it would have been expected to have been completed at the time of the resident's admission by nursing or social services, and that her smoking materials were supposed to have been confiscated at time of admission and provided education regarding where to retrieve her materials and why it needed to be stored properly. Regarding Residents #12 and #41, Staff #76 stated that she was not allowed to have their smoking materials on their person for the risk of safety issues should the resident attempt to smoke in the building, or to share the smoking materials. At this point of the interview, it was advised that smoking materials were observed in possession of Residents #12, #26, and #41, and on their persons, and had been identified by the resident as smoking materials. On March 13, 2026, at 12:35 PM, an interview was conducted with the Administrator (Staff #24). Staff #24 stated that residents were not allowed to have smoking materials on their persons; and that the smoking materials would need to be locked in drawers, and all their smoking materials should be kept there until necessary, and if staff are to observe residents with their smoking materials on their person, staff is expected to confiscate the materials and put them in a box, and that the items should not be in their purse or in their wheelchair. Staff #24 stated that a locked cabinet is located in the rooms of the resident and that supervised residents had been previously instructed to keep their (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking materials in these locked cabinets that they have a key for, and that it shouldn't be left unlocked. Staff #24 stated that the facility is in the process of transitioning into a new system, which will be implemented regarding keeping the containers in a certain area and taking what they need, in the reception, for all of the unsupervised smokers, and that the smoking materials of supervised stays will be kept in the activities room and locked. Staff #24 also stated that new admissions are provided with a smoking assessment and a smoking policy to sign and are expected to be put into their files. Staff #24 further stated that electronic cigarettes are not allowed and that those materials would be confiscated during inventory checks. Staff #24 stated that implementing the admission process for smoking expectations is important due to the potential risk of fire, smoke, and the possibility of burns, which is a component included in the admission assessment. A policy titled 'Resident Smoking', last reviewed and revised October 1, 2025, stated that it is the policy of the facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking, and that safety protections apply. The policy also stated that all residents will be asked about tobacco use during the admission process and during each quarterly or comprehensive MDS assessment process. Residents who smoke will be further assessed, using the 'Resident Safe Smoking Assessment' to determine whether or not supervision is required for smoking, or if a resident is safe to smoke at all. The policy also stated that electronic cigarettes, such as e-cigarettes, vapes, or vapor pens, can catch on fire and/or explode if not handled and stored safely, with additional safety measures that will include but not limited to the use of e-cigarettes in designated smoking areas only; a safe smoking assessment completed on all residents who use e-cigarettes; staff supervision of resident use if indicated; education on the manufacturer's recommendations for use and care of the device; only use of batteries recommended for the device; the encouragement to residents to utilize the devices with safety features; to not use the device around flammable gasses or liquids, such as oxygen, propane, or gasoline; to store loose batteries and extra cartridges away from coins, keys, or other metal objects; adequate replacements should the battery become damaged or wet; to charge the device with the intended charger it came with, and not by a cell phone or tablet; that the device to not be left to charge overnight or unattended, and will be charged on a clean, flat surface; and to not be charged in extreme temperatures. The policy also stated that any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan, and should a resident experience a decline in condition or cognition that he/she will be reassessed for the ability to smoke independently and/or to evaluate whether any additional safety measures are indicated. The policy also revealed that the smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The facility policy titled, Smoking, signed by the Resident #12, on November 12, 2025, revealed that smokers will have all their smoking materials stored in a secure area and without the ability of anyone taking the material. Per the policy residents who store cigarettes or combustible material, will be in direct violation of the policy and the smoking privilege on the premises will be revoked.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility policy, and the Resident Assessment Instrument (RAI) manual, the facility failed to transmit Minimum Data Set (MDS) data for one resident (# 16) within the regulatory timeframe of 14 days after admission. This deficient practice could result in delayed identification of potential risks and care needs. The sample size was one. The universe was 50. Findings Include:Resident # 16 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, atrial fibrillation, and bipolar disorder. The admission MDS, dated [DATE], revealed the Assessment Reference Date (ARD/Observation end date) as October 26, 2025. The signature of the Registered Nurse Assessment Coordinator verified assessment completion on November 3, 2025. The assessment revealed the resident had a Brief Interview Mental Status (BIMS) score of 14, indicating he was cognitively intact.Review of the CMS QIES Third-Party Service Bureau User Request form, dated August 4, 2025, revealed the facility authorized an outside entity to submit Payroll-Based Journal (PBJ) and/or assessment data on the facility's behalf. However, further review of the form indicated that the Minimum Data Set (MDS) submission option was not selected. The user request form also indicated that after submission of the request, if no response was received within two business days, the facility was instructed to contact the helpdesk immediately.Review of the resident's Minimum Data Set Summary, obtained March 11, 2026, revealed the assessment was accepted on December 23, 2025. An interview conducted on March 12, 2026, at 1:00 p.m., with the MDS Coordinator (LPN/Staff #28) confirmed the admission date of October 20, 2025, and stated the observation end date was October 26, 2025. The MDS Coordinator stated that October 26, 2025 was selected as the observation end date, because it was within the allowable 7-day window to allow time for information gathering. The MDS Coordinator stated the MDS assessment process began on October 20, 2025, and was completed on November 3, 2025. The MDS Coordinator further stated all disciplines completed their portions of the assessment within the 14-day completion timeframe and reported no known staffing or documentation delays. The MDS Coordinator acknowledged that, per regulatory expectations, the completed MDS assessment should have been transmitted within 14 days of completion, which she calculated to be by November 17, 2025; however, the assessment was not transmitted until December 23, 2025, which she stated did not meet facility expectation. The MDS Coordinator stated the delay in transmission occurred due to issues within the facility affecting the MDS process. For example, The MDS coordinator stated that the previous MDS coordinator quit unexpectedly, and that the facility decided to use a third-party transmission service. The MDS Coordinator further indicated the assessment was initially delayed due to an incorrect CMS Certification Number (CCN), which required correction before successful transmission. The MDS Coordinator stated once the issue was resolved and approval was obtained, the assessment was transmitted on December 23, 2025, and accepted. The MDS Coordinator stated failure to transmit assessments timely can result in noncompliance with CMS requirements and may impact reimbursement and facility certification status.An interview was conducted on March 13, 2026, at 11:30 a.m. with the Assistant Director of Nursing (ADON/Staff #67). The ADON stated that although it had been several years since she last performed MDS coordination duties, it remains the facility's responsibility to ensure that MDS assessments are completed and transmitted timely in accordance with CMS requirements. The ADON reported that timely completion and transmission of assessments are necessary to meet regulatory expectations and may impact reimbursement and quality indicators. The ADON further stated that assessments are expected to be completed and transmitted on time unless there is a significant issue that prevents CMS from accepting the assessment.On March 13, 2026, at approximately 2:30 p.m., the Executive Director (ED/Staff #24) provided email communications demonstrating that the facility was attempting in good faith to correct the MDS (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transmission issue. These communications included efforts to address request errors and coordinate with the third-party service bureau and CMS to ensure successful submission of MDS assessments. The ED reported that the facility had been actively working to resolve the transmission issues and referenced the email correspondence as evidence of these efforts.According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1, October 2025), MDS assessments must be completed and transmitted within required timeframes. Comprehensive assessments are required to be electronically transmitted within 14 days of the Care Plan Completion Date. The manual further stated that the failure to meet the required timeframes may result in inaccurate or outdated resident assessment data being used for care planning and regulatory compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure that one resident (#2) received physician-ordered testosterone therapy per physician's order. This deficient practice could result in the worsening of a resident's underlying condition. The sample size was five. The universe was 50. Findings include:Resident # 2 was re-admitted to the facility on [DATE] with diagnoses that included testicular dysfunction.The quarterly Minimum Data Set (MDS) assessment, dated January 6, 2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. On March 7, 2026, a complaint was received through the Arizona Online Complaint Portal alleging that the resident, who had been prescribed testosterone injections every two weeks by a urologist for low testosterone levels, did not receive the medication as scheduled, against accordance with the provider's orders. An order for Testosterone Cypionate Intramuscular (IM) solution 200 mg, dated January 15, 2026, revealed the resident was to receive the injection in the afternoon every 14 days for supplementation. The January 2026 Medication Administration Record (MAR) revealed the resident received the injection on January 15, 2026. The MAR failed to reflect the resident receiving the medication on January 29, 2026. A nursing note, dated February 8, 2026, revealed the resident received the Testosterone IM injection on that date, which was well tolerated by the resident. The clinical record failed to reflect supporting documentation allowing the facility to administer the IM injection exceeding the ordered 14 days. An interview was conducted on March 12, 2026, at 7:08 a.m. with a Registered Nurse (RN/Staff #33). The RN stated that testosterone therapy is important for maintaining the resident's mood and overall well-being. The RN indicated that if the medication is not available, the provider should be contacted, and staff should document notification of the pharmacy. The RN further explained that some medications may be obtained from the automatic medication dispensing cabinet; however, if the medication is not available, the Director of Nursing (DON) can contact the pharmacy to expedite delivery. The RN stated it is important to inform the resident when a medication is not available and to educate them on potential signs and symptoms that may occur if a dose is missed. The RN identified possible effects of missed testosterone injections as including mood swings and fatigue.An interview was conducted on March 13, 2026, at 11:30 a.m. with the Assistant Director of Nursing (ADON/Staff #67). The ADON reviewed the resident's clinical record and stated that an order was written on January 13, 2026, for testosterone 200 mg injection to be administered every two weeks. The ADON reported that the resident previously received the injections at a urology office; however, the resident expressed a preference to receive the injections at the facility. The ADON explained that testosterone therapy is intended to maintain appropriate hormone levels and treat the resident's testicular hypofunction. The ADON further stated that failure to administer the hormone injections as ordered could result in worsening of the resident's condition, including exacerbation of testicular hypofunction, mood swings, and irregularities in vital signs. The ADON stated that the facility expectation was for the provider to have been notified of the missed or delayed doses, in order to allow the provider to evaluate the resident's hormone levels and determine whether any dosage adjustments were necessary. The ADON stated that the expectation is for staff to follow physician orders as written, and if the medication is unavailable or cannot be administered as ordered, the provider should be notified promptly for further direction.An interview was conducted with the resident on March 13, 2026, at 12:20 p.m. The resident stated that he had recently informed his urology clinic of his decision to resume receiving his testosterone injections at the clinic, citing concerns that the facility had not been reliable in administering the injections as scheduled. The resident further stated that the medication is important to his health and expressed concern that his condition could worsen due to inconsistent administration by facility staff.An interview was conducted on March 13, 2026, at 1:11 p.m. with the Interim Director of Nursing (IDON) (Staff #76). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, the IDON reviewed the clinical record and confirmed that a prescribed testosterone injection, ordered on January 13, 2026, was not administered on January 29, 2026, and that there was no supporting documentation indicating that the provider was notified of the missed dose. The IDON also stated that the resident did not receive his next dose of Testosterone until February 8, 2026, which exceeded the 14-day order. The IDON stated that the facility's expectation is that when a medication is unavailable, nursing staff are to notify the provider to receive further instructions. The IDON acknowledged that facility protocol was not followed regarding the missed testosterone dose in January 2026, and confirmed that the expectation for medication administration and provider notification was not met.The facility's Pharmacy Services policy, revised October 1, 2025, revealed the pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that supports resident's healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation, and policy review, the facility failed to ensure one resident (Resident #5), with a history of Substance Use Disorder (SUD), was not administered pain medications outside provider-ordered parameters. This deficient practice places residents at risk for adverse drug reactions and dependence. The sample size was 5. The universe was 50. Findings include:Resident # 5 was re-admitted to the facility on [DATE] with diagnoses that included aftercare following surgical amputation, paraplegia, cirrhosis of the liver, and alcohol dependence. The opioid consent form, dated December 2, 2025, revealed dependence, and addiction as opioid therapy risks. A behavioral disturbance care plan, related to anxiety and alcohol abuse, revised on December 17, 2025, revealed the resident was to be administered medications as ordered. A paraplegic care plan, revised on January 8, 2026, revealed medications were to be given as ordered, and to provide pain management as needed. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. The assessment indicated the resident received as-needed (PRN) pain medication and reported a worst pain intensity of 7 during the assessment's 5-day look-back period. The assessment also identified that the resident was receiving opioid therapy, which is classified as a high-risk medication.Regarding Oxycodone HCL:An order for Oxycodone HCL (an opioid for pain) 10 mg tablets, instructed staff to give every four hours as needed for a pain level between 5-10. A review of the January 2026 Medication Administration Record (MAR) revealed Oxycodone HCL 10 mg was given outside of parameters on January 18, 2026 at a pain level of 1, and on January 22, 2026 at a pain level of 1. A review of the February 2026 MAR, revealed Oxycodone HCL 10 mg, was given outside of parameter on February 13, 2026 at a pain level of 2. A review of the March 2026 MAR, revealed Oxycodone HCL 10 mg, was given outside of parameter on March 1, 2026 at a pain level of 1. An interview was conducted on March 13, 2026, at 11:30 a.m. with the Assistant Director of Nursing (ADON/Staff #67). During the interview, the ADON reviewed the resident's clinical record and confirmed that the resident was prescribed Oxycodone 10 mg to be administered every four hours as needed for pain levels between 5 and 10. The ADON also reviewed the resident's medical history and noted a history of substance abuse, specifically alcohol abuse. The ADON stated that if a nurse needs to administer medication outside of the prescribed parameters, the provider must be notified. The ADON stated that the expectation is that nursing staff follow the physician's order, and if the medication is not available or administration falls outside of the ordered parameters, the provider should be contacted for further direction. The ADON stated that administration of opioids outside prescribed parameters may increase the risk of dependency, cause adverse reactions, affect vital signs, and alter pain tolerance. In addition, the ADON stated that the provider must be informed to assess the resident's condition and determine whether a dosage adjustment is necessary. An interview was conducted on March 13, 2026 at 12:29 p.m. with the resident. The resident revealed having no issues with his current pain management or opioid therapy. An interview was conducted on March 13, 2026, at 1:11 p.m. with the Interim Director of Nursing (IDON/Staff #76). During the interview, the IDON reviewed the resident's clinical record and identified several instances between January and March 2026 in which Oxycodone HCl was administered outside of the prescribed parameters. The IDON stated that the nurses responsible for administering the opioid outside of the ordered parameters on those dates are no longer employed at the facility. The IDON further stated that provider orders are expected to be followed as written and within the established parameters at all times. The IDON reported that the facility was unable to locate any supporting documentation or provider authorization for administering Oxycodone HCl outside of the prescribed parameters on the identified dates. As a result, the DON stated that the facility failed to meet its expectations for the proper administration and management of the resident's opioid therapy. Additionally, the IDON (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that the resident has a history of alcohol abuse and emphasized that caution should be exercised when administering opioids to residents with a history of substance use disorder (SUD), as this may increase the risk of relapse and other adverse outcomes. A review of the facility policy entitled Medication Administration Policy, reviewed/revised on October 1, 2025, revealed that medications are administered as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on an observation, staff interviews, and the facility policy and procedures, the facility failed to ensure one medication cart was secured when left unattended. The deficient practice could result in residents, visitors and/or staff members having unrestricted access to medications.Findings include:An observation was conducted on March 10, 2026 at 09:32 a.m. for call light responses and revealed on the South Wing, a staff member was preparing medications at the medication cart, collected the medication cup with the medications prepared and walked around the cart and into a resident room that was next to the cart. The medication cart was left facing out into the hallway, was left unattended and unlocked. Evidenced by Licensed Practical Nurse (LPN) Staff #35 leaving the medication cart unsecured and going into a resident room.An interview was conducted on March 10, 2026, at 09:33 a.m. with LPN (Staff #35) who verified that the medication cart was unlocked when she returned from passing medications to a resident. The LPN stated that the risk for leaving a medication cart unlocked and unattended could result in unauthorized staff or residents/visitors accessing the medications.An interview was conducted on March 11, 2026 at 12:24 p.m. with Chief Nursing Officer (CNO) Interim Director of Nursing (CNO/DON/Staff #76), who stated that medication carts should be locked at all times when not in use or when a nurse is not in front of the medication cart. The CNO state that the risk for leaving a medication cart unlocked and unattended could result in unauthorized persons or residents gaining access to medications.The facility policy titled, Medication Storage, reviewed/revised October 1, 2025, revealed that all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms).