STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Transitional Care	1521 North Pine Cliff Drive Flagstaff, AZ 86001

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of resident abuse was reported to all applicable state agencies for 3 out of 3 residents (#3, #7, and #5). The deficient practice could result in further allegations of abuse not being reported and investigated by the appropriate state agencies. Findings include:-Regarding Resident # 3Resident # 3 was admitted to the facility on [DATE], with diagnoses of cellulitis, streptococcal infection, and depression. A comprehensive care plan dated June 27, 2023, revealed that Resident # 3 had alteration in skin integrity related to cellulitis. A progress note dated June 27, 2023 at 4:30 p.m., revealed that Resident # 3 was upset with the wound nurse because the nurse seemed inexperienced and lacked wound care experience. Resident # 3 stated to staff that wound nurse intentionally shoved trauma scissors right into the wound causing an indentation. Review of the initial State Agency Report dated June 28, 2023, revealed that the Director of Nursing (DON/ Staff # 25) and Executive Director (ED/ Staff # 9) went to speak with Resident # 3 because she was upset about how the wound care was done the night before. Resident # 3 explained the nurse hurt her when cutting off the bandage. ED (Staff # 9) asked her if she thought it was her intent to hurt her during this and she said yes, and indicated it was abuse. The Minimum Data Set (MDS) dated [DATE], revealed that Resident # 3's Brief Interview for Mental Status (BIMS) score was 15 which indicated Resident # 3 was cognitively intact. Review of the Facility investigation report dated July 2, 2023, revealed that Facility conducted resident and staff interviews, however there was no indication that notifications were made to Law Enforcement, Adult Protective Services (APS), or the Ombudsman. -Regarding Resident #7Resident # 7 was admitted to the facility on [DATE], with diagnoses right femur fracture, orthopedic aftercare, and type two diabetes.A comprehensive care plan dated January 22, 2024, revealed that Resident # 7 had potential for falls related to the hip fracture. Interventions included check resident for any pain, positioning when needed, personal items are within reach, and personal needs are being met. The Minimum Data Set (MDS) dated [DATE], revealed that Resident # 7's BIMS score was 13 which indicated the resident is cognitively intact. Review of the initial State Agency Report dated February 5, 2024, revealed that Resident # 7 returned from a follow-up orthopedic appointment. Family members attended the appointment and returned to facility with her. At that time, Resident # 7 proceeded to tell the family that when they are not around that staff abuse her and push her around in bed. Review of the Facility Investigation with no date, revealed that the facility notified the State Agency, family, and physician, however law enforcement, APS, and Ombudsman were not notified. -Regarding Resident # 5Resident # 5 was admitted on [DATE], with diagnoses infection of surgical site, orthopedic aftercare, asthma, and prediabetes. A comprehensive care plan dated July 24, 2025, revealed that Resident # 5 required assistance with activities of daily living (ADL) due to weakness. Interventions include providing guided maneuvering of extremities, verbal cueing and sufficient time for resident to perform and or assist during dressing and other ADLs as needed. Review of the initial State Agency Report dated July 30, 2025, revealed that Resident # 5 was upset on how the overnight nurse helped her transfer on July 26. 2025. She was a stand by assist. ED Staff # 9 indicated at the time of their conversation Resident # 5 said he was rough with the transfer. No signs of injury. Resident # 5 was safe and staff member will not work until 5-day investigation was completed. The report also indicated no other agencies were contacted.Review of the Facility Investigation dated July 31, 2025, revealed that full investigation was completed however no indication Law Enforcement, APS, or Ombudsman were notified. An interview with Registered Nurse (RN / Staff # 59) on August 7, 2025 at 8:55 a.m., revealed that if a resident indicated that they have been abused or neglected Staff # 59 would immediately make sure resident is safe and notify DON (Staff #25). DON (Staff # 25) and ED (Staff # 9) would handle the allegation from there by conducting their investigation.An interview of Certified Nursing Assistant (CNA/ Staff # 56) on August 7, 2025 at 9:08 a.m., revealed that if a resident indicated they have been abused or neglected Staff # 56 would report it to her nurse and assist in keeping resident safe. CNA # 56 also revealed that the nurse would report the abuse to DON (Staff # 25) and ED (Staff # 9).An interview of DON (Staff # 25) on August 7, 2025 at 9:18 a.m. revealed that if a resident claimed to be abused or neglected her and ED (Staff # 9) would work together to investigate the allegations. DON (Staff # 25) revealed that ED (Staff # 9) would make all notifications to law enforcement, APS, and Ombudsman unless ED (Staff #9) is out of the facility then DON (Staff #25) would make the notifications. An interview of ED (Staff # 9) on August 7, 2025 at 9:58 a.m.