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	08/21/2025

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** The facility failed to ensure that an allegation of resident abuse was reported to all applicable agencies for 3 out of 4 residents. 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 4 residents (#57, #58, and #59). The deficient practice could result in further allegations of abuse not being reported and investigated by the appropriate state agencies. Findings include:-Regarding Resident # 57Resident # 57 was admitted to the facility on [DATE], with diagnoses of surgery aftercare for genitourinary system, urinary tract infection, sepsis, Parkinson's, and dementia. A comprehensive care plan dated February 27, 2024, revealed that Resident # 57 required assistance with activities of daily livings (ADL) due to weakness. The care plan also revealed that Resident # 57 had a potential for alteration in comfort related to decrease ability to move and recent surgery. The Minimum Data Set (MDS) dated [DATE], revealed that Resident # 57's Brief Interview for Mental Status (BIMS) score was 10 which indicated Resident # 57 had moderate cognitive impairment. A clinical note dated March 31, 2024 at 5:23 p.m., revealed that Resident # 57's caregiver was notified that Resident # 57 was transported to the hospital to evaluate the right shoulder. The writer informed Resident # 57's caregiver that Resident # 57 had indicated a Certified Nursing Assistant had hurt her.Review of the initial State Agency Report received April 5, 2024, revealed that this report was the initial and 5-day investigation report regarding Resident # 57's claim that a CNA hurt her. The report revealed that the facility was aware of Resident # 57's shoulder pain and allegation on March 31, 2024 but did not initially report to the State Agency until April 5, 2024. The 5-day investigation report also did not indicated notifications to law enforcement, adult protective services (APS), nor the Ombudsman. -Regarding Resident # 58Resident # 58 was admitted to the facility on [DATE], with diagnoses that include fracture to right lower leg, fracture to ribs, and fracture to lumbar area.The Minimum Data Set (MDS) dated [DATE], revealed that Resident # 58's BIMS score was 12, which indicated moderate cognitive impairment A comprehensive care plan dated July 27, 2024, revealed that Resident # 58 was resistive to care due to anxiety and staff should provide cares in pairs. Review of the Facility investigation dated July 25, 2024, revealed that Resident # 58 alleged sexual assault by a Certified Nursing Assistant (CNA/Staff # 56) during a transfer from the toilet to a standing position. The Investigation revealed that the Facility contacted police and the state agency within required time limits, but there is no report of contact made to APS. -Regarding Resident # 59Resident # 59 was admitted on [DATE], with diagnoses of right femur fracture, atrial fibrillation, anemia, hypotension, and cognitive communication deficit. A comprehensive care plan dated November 19, 2024, revealed that Resident # 59 had potential for falls related to right femur fracture. Interventions to fall risk included call light within reach when in room. The Minimum Data Set (MDS) dated [DATE], revealed that Resident # 59's BIMS score was 8, which indicated moderate cognitive impairment Review of the Facility Investigation report received December 3, 2024, revealed that Resident # 59 alleged to her son that a server (Staff # 7) had transferred her from the wheelchair to the bed by the waist. It also revealed that Resident # 59's son claimed abuse. The Facility investigation did not indicate that police, APS, or ombudsman had been contacted. An interview with Staff # 7 on August 20, 2025 at 3:02 p.m., revealed that if a resident indicated that they have been abused or neglected Staff # 7 would immediately make sure resident is safe and notify the charge nurse. From there the charge nurse would make notifications to Director of Nursing (DON/Staff # 29) and Administrator (ED/Staff # 14).An interview with CNA Staff # 56 on August 20, 2025 at 2:26 p.m., revealed that if a resident indicated they were abused or neglected, Staff # 56 would report allegation to her nurse and assist in keeping resident safe. An interview with Director of Social Services Staff # 17 on August 20, 2025 at 2:37 p.m., revealed that if a resident makes an allegation of abuse or neglect Staff # 17 would notify ED (Staff # 14) and DON (Staff # 29). Staff # 17 revealed that she has called APS for residents but not in allegations of abuse in facility, that is done by ED Staff # 14 or DON Staff # 29. An interview of ED (Staff # 14) on August 21, 2025 at 9:09 a.m. revealed that if a resident claimed to be abused or neglected, he would make sure resident is safe and start the investigation within 2 hours. ED (Staff # 14) revealed that the initial notification of abuse for Resident # 57 would be late if it came in along with the 5-day investigation. ED (Staff # 14) also revealed that APS and Ombudsman were not contacted for Residents # 57, 58, and 59, and police were not contacted for Resident # 57 and 59, during their investigations. A Policy and Procedure titled, Abuse, Neglect, and Exploitation reviewed on January 11, 2025, revealed that anyone with knowledge or