STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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 - Few	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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 - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure they reported an allegation of abuse to the Department of Public Health (DPH) within two hours, as required. On 06/15/25, Resident #1 was observed with an injury of unknown origin and were also made aware of an allegation of physical abuse related to the injury, the Facility did not report the incident to DPH, until 06/17/25, 48 hours after the injury had been identified.Findings include:Review of the Facility Policy titled Abuse, Neglect, and Exploitation, dated as last revised 03/2025, indicated that the Facility is to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The Policy indicated that possible indicators of abuse, include, but are not limited to:-Resident, staff or family report of abuse;-Physical marks such as bruises or patterned appearances;-Physical injury of a resident of unknown source; and-Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. The Policy further indicated that reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies (e.g. law enforcement when applicable) within specific time frames: -Immediate, but no later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or-Not later than 24 hours if the events that cause the allegation do not involve abuse and do not involve serious bodily injury.Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 06/17/25, indicated that on 06/17/25, a Police Officer arrived at the Facility to speak to the Director of Nurses (DON) and Administrator regarding a recent incident involving Resident #1, a suspected fall with injury The Report indicated that the police officer informed the Facility that the Health Care Agent (HCA) of Resident #1 was alleging that the injury (laceration) had been intentionally inflicted.During a telephone interview on 07/22/25 at 2:22 P.M., Resident #1's HCA said that she had received a phone call from a nurse at the Facility on the morning of 06/15/25, informing her that Resident #1 had a fall and sustained a wound to his/her forehead.The HCA said she asked the Nurse how he/she could have possibly fallen because Resident #1 was immobile and unable to move by him/herself. The HCA said after she asked the Nurse that question, the Nurse changed the story and said that they found him/her with a wound on his/her forehead.The HCA said that once she arrived at the Hospital Emergency Department (ED) and saw the wound, thought it could not have been from a fall and said she thought the wound was inflicted intentionally.Resident #1 was admitted to the Facility in 10/2022, diagnoses include, but not limited to, dementia, adult failure to thrive, anxiety, and depression.Review of Resident #1's Document of Resident Incapacity Form dated 10/26/22, indicated his/her Health Care Proxy (HCP) had been activated.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 03/27/25, indicated he/she required extensive to total assistance of one to two staff members with all Activities of Daily Living (ADL's).Review of Resident #1's Facility Incident Report, dated 06/15/25, indicated at 7:15 A.M., Nurse #1 was called into Resident #1's room by Certified Nurse Aide (CNA #3), and that Resident #1 was sitting in his/her wheelchair, dressed and ready for the day. The Report indicated that Resident #1 had an open area to his/her forehead that was bleeding, he/she complained of pain in his/her index and middle finger of his/her right hand, and Nurse #1 saw a small spot of blood on the floor next to the bed.The Report further indicated Resident #1 was transferred back to his/her bed, a dressing was applied to his/her forehead, and Resident #1 was transferred to the ED for treatment and evaluation. During a telephone interview on 07/24/25 at 10:18 A.M., CNA #2 said that when she got to work on the morning of 06/15/25, she went into Resident #1's room to get him/her up for breakfast, dressed him/her in bed and then transferred him/her into his/her wheelchair.CNA #2 said that she noticed some (what looked like) dry blood underneath his/her fingernails, said she did not see where it was coming from and thought Resident #1 must have scratched him/herself. CNA #2 said that she then called for CNA #3 to come into his/her room.CNA #2 said that when CNA #3 came into his/her room she had noticed the cut on Resident #1's forehead and called for Nurse #1.During a telephone interview on 07/28/25 at 9:50 A.M., Nurse #1 said that on 06/15/25 at approximately 7:18 A.M., CNA #3 called out to her to go to Resident #1's room. Nurse #1 said that she went into his/her room, and she saw a wound on Resident #1's forehead and asked why CNA #2 had gotten him/her out of bed instead of calling for her first.Nurse #1 said she asked Resident #1 what happened and that Resident #1 said that they tussled me and beat me, I think they broke my finger. Nurse #1 said that after she assessed Resident #1, he/she was put back to bed and was then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who was found on the floor on 07/19/25 after an unwitnessed fall, the Facility failed to ensure he/she was provided care and treatment that met professional standards of nursing practice related to initial and ongoing assessments, and physician notification. Findings include:Review of the Facility Policy titled Accidents and Incidents, dated as last revised 09/2024, indicated that an Accident refers to any unexpected or unintentional incident, which may result in injury and an Incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. The Policy further indicated; -Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so;-The Supervisor will be notified of the accident/incident;-The Nurse will contact the resident's practitioner to inform them if the accident/incident, report any injuries or other findings, and obtain orders, if indicated; and-The Resident's Family or representative will be notified of the accident/incident and any orders obtained. Review of the Facility Form titled Incident and Accident Checklist, undated, indicated that the Checklist is to be completed for each incident and accident and signed off as complete by the DON and Administrator supporting that through a thorough and complete investigation has been completed. The Checklist further indicated that the bold items on the checklist are to be performed by the staff nurses and initiated at the time of the incident/accident, the bold items included; -Notify the Physician;-Obtain statements/interviews from staff, collected for each staff member regardless if directly involved;-Skin Check;-Pain Assessment;-Fall Assessment; and-Neurological signs for all unwitnessed falls. Resident #2 was admitted to the Facility in 10/2022 diagnoses include vascular dementia, adult failure to thrive, diabetes mellitus, and anemia. Review of Resident #2's Document of Resident Incapacity Form dated 08/03/22, indicated his/her Health Care Proxy (HCP) had been activated.Review of Resident #2's Facility Incident Report, dated 07/19/25, indicated that he/she was found on the floor and he/she was unable to state what had happened. Review of Resident #2's Nurse Progress Note, dated 07/19/25, written by Nurse #2, indicated that she heard a resident crying out for help, she went into Resident #2's room and found him/her on the floor. During an interview on 07/24/25 at 8:53 A.M., Nurse #2 said the day she received her orientation for the Facility, her preceptor told her that if she were to find Resident #2 on the floor, not to worry about it and that he/she does it all the time. Nurse #2 said that on 07/19/25 at approximately 9:30 P.M., she heard a resident calling out for help, went into Resident #2's room and found him/her on the floor mat beside his/her bed. Nurse #2 said she called two Certified Nurse Aides (CNA's)'s for assistance and attempted to transfer him/her back into bed, but they were unable to do so manually. Nurse #2 said she left the room to get a mechanical lift.Nurse #2 said that when she returned to Resident #2 room, the CNA's had cleaned and changed Resident #2 because he/she had been incontinent. Nurse #2 said that she did not assess Resident #2 until after he/she was transferred up off the floor and put back into bed.Review of Resident #2's medical record, there was no documentation to support that Nurse #2;-Notified his/her physician that he/she was found on the floor;-Completed a physical assessment prior to having him/her moved off the floor; -Completed a new Fall Risk Assessment; and-Initiated neurological signs, per facility policy.During a telephone interview on 07/28/25 at 11:08 A.M., the Nurse Supervisor said that she was not aware that on 07/19/25, Resident #2 had been found on the floor. The Supervisor said that when a resident is found on the floor or has an unwitnessed event the nurse must assess the resident before moving them, notify the physician, HCA, complete a fall, skin, and pain assessment and initiate neurological checks.During an interview on 07/23/25 at 4:00 P.M., the Director of Nurses (DON) said that he was not aware Nurse #2 had not followed the facility Fall Protocol until after the event occurred. The DON said that it is the Facility's expectation that if a resident has an unwitnessed fall the nurse must first assess the resident for injury, obtain vital signs, ensure the resident's safety and once the resident is assessed and may be safely moved, the nurse may then move the resident.The DON said that the nurse must initiate the Fall Protocol, including notification to the Physician, HCA, initiate neurological signs, and complete the appropriate follow-up assessments.