STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A277	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspire Behavioral Health	401 Ridge Vista Avenue San Jose, CA 95127

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36044 Based on observation, interview, and record review, the facility failed to implement their policies and procedures to report a sexual allegation within the required two hours timeframe to the local law enforcement, the California Department of Public Health (CDPH) and Ombudsman as required for one of three sampled residents (Resident 1); and prevent the recurrence of sexual allegation for of three sampled residents (Resident 2) when: 1. Resident 1 claimed Resident 2 held her breast on 6/18/24. 2. Resident 2 had two sexual assault incidents involving two female residents in a period of one week. The failure to report the sexual allegation within two hours to reporting entities could compromise the welfare, health and safety of Resident 1 and other vulnerable residents; and the failure to prevent recurrence of sexual assaults could potentially put all vulnerable residents at risk. Findings: 1. Review of Resident 1's Situation Background Assessment Recommendation (SBAR, a verbal or written communication tool used by healthcare professional), dated 6/18/24 at 12:16 p.m., indicated, Resident (Resident 1) claimed that Resident 2 held her breast last night (6/17/24). Further review of Resident 1's minimum data set (MDS, an assessment tool) assessment, dated 6/4/24, it indicated her brief interview for mental status (BIMS) summary scored 13 (BIMS score from 13 to 15 means cognitively intact). According to her progress notes on 6/18/24 at 10:39 a.m. that assistant of program director E (APD E) received resident 1's self-reporting at 7 a.m. of 6/18/24 and law enforcement notified at around 7:26 a.m. of 6/18/24. During an observation and interview on 6/18/24, at 1:40 p.m., with Resident 1 in her room, she stated, while she played poker and talked to Resident 3 in the hallway where was nearby the nursing station one, Resident 2 passed by her and suddenly touched and grabbed her right breast. She immediately swung back to Resident 2, so he walked away. She further stated that couple of certified nursing assistants (CNAs) were in the nursing station one at the time of incident, but they did not do anything to help her, so she had approached to staff in nursing station one to allege Resident 2 inappropriately touched her breast before going back to her room. Resident looked upset while described what happens to her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/18/24, at 1:49 p.m., with Resident 3 in a private room near the activity room, Resident 3 confirmed Resident 1's statements about the sexual assault that happened on 6/17/24. Resident 2 stated Resident 1 reported the incident to couple of staff about the sexual assault just after the incident, then she walked back to her room. Review of Resident 3's MDS dated [DATE] indicated her BIMS score was 14 (cognitively intact). During a telephone interview on 6/19/24, at 11:19 a.m., with the licensed vocational nurse A (LVN A), she stated she was the med (medication) nurse working at the nursing station 2 (NS 2) on the night of 6/17/24. While she was walking by NS 1 looking for NS1's med nurse, Resident 1 approached her and reported that Resident 2 inappropriately touched her breast. During a telephone interview on 6/19/24, at 11:38 a.m., with licensed vocational nurse B (LVN B), LVN B stated, she was the med nurse for NS 1 on the night of 6/17/24 when the incident of sexual assault happened, but she did not receive any reports from the staff when Resident 1's breast was inappropriately touched by Resident 2. During a telephone interview on 6/19/24, at 12:52 p.m., with CNA D, she confirmed Resident 1 approached her in the nursing station 1 (NS 1) while she was with other CNAs on 6/17/24 at around 9:00 p.m., Resident 1 reported that Resident 2 touched her breast while she in the hallway near nursing station playing poker card with Resident 3 on 6/17/24. During a telephone interview on 6/19/24, at 1:11 p.m., with the registered nurse C (RN C) who was the supervisor on the night of 6/17/24, she confirmed the sexual allegation incident was reported late. RN C further stated, she received reports from CNA D that Resident 1 was touched by Resident 2, but CNA D did not elaborate the specific detail information, so she just endorsed to the incoming night shift nurse for that night (6/17/24) to keep an eye on both Residents 1 and 2. During a telephone interview on 6/21/24, at 2:30 p.m., with ADM to verify the date and time of the incident because of the discrepancy between documented date of incident and the interviews conducted, the ADM stated the documentation of incident occurred time was based on Resident 2's statements for the time of incident was between 7 p.m. to 8 p.m. of 6/17/24. However, after the ADM interviewed staff, the interview indicated the incident happened 8:45 to 9 p.m. on 6/17/24 when at that time Resident 1 yelled and screamed for help. The ADM further stated after investigation, she suspended RN C for not following their abuse policy and procedure of reporting sexual abuse allegation right away. 2. Review of Resident 2's progress notes dated 6/11/24, indicated at 8:30 p.m. he inappropriately touched another female resident's buttocks (Resident 4) in front of the nursing station. Further review of his progress notes dated 6/12/24, indicated at around 2 p.m. Resident 2 hit a female resident's buttocks (Resident 4) in front of the nursing station. Resident 2's MDS dated [DATE] indicated his BIMS score was 13 (cognitively intact). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's plan of care for alleged sexual abuse, dated 6/11/24 , indicated . notification to physician, public guardian (PG, conservator serves as conservator of a person and/or estate of individuals needing protective intervention), Ombudsman, Department of Health (DOH), Sheriff's Department, abuse coordinator and all regulatory agencies. Separated residents and assessed for any injuries or PRN (as needed). Placed on 24 hours monitoring for72 hours alert charting and would continue to monitor for safety. The record review of Resident 2's care plan indicated, there was no added intervention/s in place to prevent future incident/s of sexual assault/abuse as confirmed by the program director (PD). During an interview on 6/18/24, at 1 p.m., with the program director (PD), she stated, Resident 2 was sent to emergency psychiatric service (EPS, is the only 24-hour locked psychiatric emergency room , which provides emergency psychiatric care) because Resident 2 had pattern of recurrent of sexual allegation in one week. The PD admitted that Resident 2's current plan of care was ineffective in preventing any further incidents of sexual abuse. Review of the facility's policy and procedure (P&P) titled , Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation, dated 2/14/18, the P&P indicated, it is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source, misappropriation of resident property and exploitation. All alleged violations will be reported immediately, but not later than: within 2 hours if the alleged violation involves ABUSE OR results in serious bodily injury.