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	01/03/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068 Based on interview and record review, the facility failed to accurately code the elopement risk assessment (an assessment tool to evaluate whether an individual that need additional safety measures is at risk of leaving the facility unsupervised) for one of two residents (Resident 1). This failure had the potential to place the resident's health and safety at risk for not receiving appropriate care. Findings: Review of Resident 1's medical record on 1/3/25 indicated that on 12/26/24 at 11:55 a.m., Resident 1 had an incident of elopement /AWOL(absence without leave- the act of leaving a facility unsupervised and without prior authorization) from the facility. He was returned safely to facility with no injuries around 12:14 p.m. on same day. Review of Resident 1's medical record indicated he was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included schizoaffective disorder (a mental disorder that affect your thoughts, mood, and behavior), bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression of elevated periods of emotional highs). Review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/31/24 indicated his cognition (mental process including thinking, attention, language, learning, memory, and perception) was intact, but with periods of difficulty focusing attention and disorganized thinking. He also had episodes of hallucinations (false perception of objects or events) and delusions (false beliefs that conflict with reality). He did not have impairment of both upper and lower extremities and was able to walk independently. Review of Resident 1's Psychiatry Discharge Summary from the Hospital dated 4/24/24 indicated he had a history of often AWOLs from unlocked residential facilities to use drugs. Review of Resident 1's readmission initial elopement risk assessment dated [DATE] indicated, Registered Nurse A (RN A) coded that Resident 1 had no history of elopement attempts. (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
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Registered Nurse A (RN A) on 1/6/25 at 11:29 a.m., she confirmed she coded incorrectly the readmission initial elopement risk assessment dated [DATE] that Resident 1 had no history of elopement attempts. RN A further stated she did not read the Psychiatry's Discharge Summary from the Hospital dated 4/24/24 that Resident 1's had a history of often AWOLs from the unlocked residential facilities to use drugs. RN A acknowledged she should have read the Psychiatry Discharge Summary and should have coded that Resident 1 had made one or more attempts of elopements. During an interview with the Director of Nursing (DON) on 1/3/25 at 3:45 p.m., he acknowledged RN A should have read Resident 1's Psychiatry Discharge Summary from the Hospital dated 4/24/24 that Resident 1 had history of AWOLs and should have coded that Resident 1 had one or more elopement attempts on readmission initial elopement risk assessment dated [DATE] for Resident 1's appropriate care. Review of the undated facility's policy and procedure titled, Admission Assessment and Accuracy: Role of the Nurse: Steps in the Procedure indicated, 7. Conduct an admission assessment (history and physical), including: a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall health prior to admission. B. Relevant medical, social, and family history. Review of the facility's policy and procedure dated 8/17/15 titled Job Description: Charge Nurse (RN) indicated, Assure that effective quality nursing care is delivered which is outcome focused through utilization of the nursing process (a systematic step by step method that nurse use to provide patient-centered care that involves: assessment, diagnosis, planning, implementation, and evaluation).