

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Inspire Behavioral Health		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36044</p> <p>Based on observation, interview and record review, the facility failed to implement effective safety measures in place to prevent elopement (the act of leaving without supervision and authorization) or absence without leave (AWOL, leaving the facility without permission) for one of four sampled residents ( Resident 1) who was at high-risk for elopement due to the fact that:</p> <ol style="list-style-type: none"> <li>1. Staff had prior knowledge and awareness of Resident 1's desire and motivation to elope when Resident 1 had expressed a desire to go home prior to the visitation by a friend on 1/15/25,</li> <li>2. Facility's staff did not follow the instructions of Resident 1's conservator restricting visitation by Resident 1's friends after the reported incident on 12/17/24 when Resident 1 was found to have a contraband (goods that have been imported -[goods or services brought into a country from abroad for sale] or exported illegally [goods and services that are produced in one country and sold to [NAME] in another without proper documents] and cigarette lighter in her drawer.</li> <li>3. Certified Nursing Assistant (CNA) B did not ensure Resident 1 was not near or in close proximity to the visitor's lounge exit door when her visitor was leaving the facility after visitation; hence, Resident 1 was able to exit and ran outside of the facility when CNA B opened the door to let the visitor out.</li> <li>4. The care plan for elopement was not updated to include interventions to help prevent elopement such as restricting visitation from friends and checking of Resident 1's visitors ID (identification) as indicated by the program director (PD) plan when Resident 1's conservator instructed facility not to allow friends to visit Resident 1.</li> <li>5. Staff did not check Resident 1's visitor's ID when they visited Resident 1 on five occasions.</li> </ol> <p>These failures resulted in Resident 1's elopement from the facility where staff could not bring her back safely to the building, and her whereabouts could not be determined after the elopement incident, which collectively could jeopardize her health and safety.</p> <p>Findings:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's admission record indicated she was admitted to the facility on [DATE] with diagnoses including psychosis ( is a condition of the mind or psyche that results in difficulties determining what is real and what is not real), stimulant induced psychotic disorder ( a mental disorder that occurs when a person experiences delusions (is an unshakable belief in something that's untrue)or hallucinations (is a false perception of something not present) soon after ingesting or withdrawing from a substance) and depression ( a common mental health condition that causes a persistent feeling of sadness and changes in how persons think, sleep, eat and act).</p> <p>Review of Resident 1's physician progress notes, dated 9/19/24, indicated, This is a [AGE] year-old . female with a long history of mental illness (a problem on a person's state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well) and stimulant disorder (a type of substance use disorder where the use of stimulants caused clinically significant impairment or distress), was admitted recently on a 5150 (is a legal term that refers to the California law code for an involuntary hold of someone who's a danger to themselves or others) after she was observed on stranger doors and that babies are getting murdered. She eventually stabilized . She denies auditory hallucinations (hearing voices or noises that aren't there and has no gross delusions. She wants to go home.</p> <p>Review of Resident 1's admission Risk for Elopement assessment, dated 9/19/24, indicated a score of greater than 10, (a score of 10 and above indicates at risk for elopement.</p> <p>Review of Resident 1's Risk for Elopement assessment, dated 10/15/24, indicated a score of 13, she was at risk for elopement.</p> <p>Review of Resident 1's care plan, At risk for elopement related to: mental illness and history of drug abuse dated 9/19/24, it included interventions as, the resident is determined to be an AWOL risk, resident will be placed on close supervision and Resident will be redirected away from the exit doors when observed standing by the exit doors. There is no documented evidence that the care plan was updated to include interventions such as: checking the identification (IDs) of Resident 1's visitors and restricting visitation from friends.</p> <p>During an interview on 3/3/25, at 3:00 p.m., with the Director of Nursing (DON), the DON verified that the Client 1's care plan for elopement was not updated.</p> <p>Review of Resident 1's minimum data set (MDS, a federally mandated resident assessment tool), dated 12/26/24, it indicated her brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (a core of 14-15 indicates intact cognitive response).</p> <p>Review of Resident 1's change in condition evaluation, dated 1/15/25, it indicated Resident eloped from facility.</p> <p>Review of Resident 1's Progress notes by her primary care physician (PCP, primary care provider, is a health care professional who practices general medicine) dated 1/15/25, indicated, Patient went AWOL, seemingly assisted by visitors to the facility; incident is still currently investigated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a further review of Resident 1's interdisciplinary team (IDT, is a group of different experts who work together with a common goal for the resident) notes, dated 1/16/25, it indicated, Around 7:15 pm, staff reported resident suddenly ran out of the visitors lounge during a visit. Facility AWOL protocol was utilized. Staff responded immediately, followed resident on foot and in cars at a safe distance. Resident was observed walking and running unsafely on a . street. Staff attempted to redirect resident back to the facility, but resident was not receptive, selectively mute. Resident remained in sight of staff. Suddenly a white van with her visitor and another man drove by resident and resident went inside the van. The van drove quickly away from the facility. Staff attempted to follow the van but lost sight. Law enforcement notified and notified of van's license plate.</p> <p>During a telephone interview on 1/24/25, at 10:30 a.m.,and 2/7/25, at 4:17 p.m., with Registered Nurse (RN) A, RN A stated after the elopement incident on 1/15/25, he notified Resident 1's conservator (person responsible for making decisions for a mentally ill adult) and was told by Resident 1's conservator that only Resident 1's parent was approved to see her. RN A further stated, during visitation on 1/15/25, Resident 1 was heard telling her visitor that she wants to go home. RN A also stated; that the elopement occurred on 1/15/25, at 7:15 p.m., after which he called the police at 7:30 p.m. when staff were unable to redirect Resident 1 back to the facility. RN A confirmed she should have called the police right away as usually done in the past.</p> <p>During a telephone interview on 1/24/25, at 2:48 p.m., Resident 1's conservator, the conservator stated, on 1/3/25 and 1/10/25 she had spoken with the facility's staff (a nurse) and the Assistant Program Director (APD) giving instructions not to allow Resident 1's friends to visit her except her parent (mother). The conservator also stated that, Resident 1's location could not be determined until this time.</p> <p>During a review with the APD on 3/3/25, at 1:37 p.m., the APD provided copies of the email messages from Resident 1's conservator to the Program Director (PD, who no longer works atthe facility) dated 12/18/24, and Cc: (copy furnished) to the DON, Program Director, Social Services and the mental health worker (MHW) that indicated, Effectively immediately, please do NOT allow (Resident 1) to have visitation from friends (words highlighted by the sender). Staff found packet of lighter in her drawer, upon interviewing her, she said it was given by friend who visited her, she did not mention name of friend. IF she wants friends to visit, please let me now (know) name and number of friends, I will then contact her parents to see if that particular friend safe to visit. And please let ALL the staff know, especially the weekend staff. (Resident 1) was introduced to Meth (Methamphetamine- a potent central nervous system stimulant that is mainly used as a recreational or performance-enhancing drug and less commonly as a second-line treatment for attention deficit hyperactivity disorder)/drugs from these supposed friends .</p> <p>Further review with the APD on the email message response by the PD to Resident 1's conservator dated 12/19/24, indicated, Thank you for the information. I will let staff know to closely monitor any visitations from friends with (Resident 1). I will also ask staff to check IDs (identification) of visitors and make copies. We will keep you posted</p> <p>A review of Resident 1's visitation log from 12/19/24 to 1/15/25, it indicated she had a total of five visits from her friends on 12/19/24,12/21/24,12/29/24,12/25/24 and 1/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/24/25, at 3:40 p.m., with the administrator (ADM), the ADM confirmed that staff did not follow Resident 1's conservator's instructions to prevent Resident 1's friends from visiting her. The ADM admitted the facility staff (PD, APD, DON and DSS, director of social services) who received the email message from Resident 1's conservator did not notify the IDT and /or call the attending physician to obtain a visitation restriction order for no visitations from friends for Resident 1 after receipt of the email instruction on 12/18/24.</p> <p>During a telephone interview on 1/27/25, at 4 p.m., the Program Director (PD) stated, Resident 1 acknowledged her substance abuse, she has poor insight with episode of anxiety and had mentioned she wants to leave the facility.</p> <p>During a telephone interview on 1/28/25, at 9:38 a.m., and 2/7/25, at 3:25 p.m., with CNA B), CNA B stated during the shift change on 1/15/25, CNA D endorsed to her and to other staff in the unit that CNA D overheard Resident 1 crying to someone over the phone before 3 p.m. on 1/15/25, asking to let her out of the facility and that she wanted to go home. CNA B also stated she supervised Resident 1 at the visitation lounge room on 1/15/25, from 7:05 p.m. when Resident 1's visitor arrived at the facility. CNA B stated when the visitor was leaving, she opened the door for the visitor but did not check the whereabouts of Resident 1. Suddenly, Resident 1 pushed her from behind and ran out of the door towards the street. CNA B further stated Resident 1 was last seen sitting on a black chair about seven steps from the visitor's lounge door. CNA B claimed Resident 1 had planned this elopement.</p> <p>During an interview with the ADM on 2/6/25, at 10:10 a.m., and 10:50 a.m., the ADM stated CNA B should have provided preventive safety measures to prevent Resident 1's elopement, and staff (CNA B) should have asked for help in supervising Resident 1 during this visitation. The ADM also stated the staff who spoke with Resident 1's conservator should have communicated to the IDT regarding the conservator's instructions to restrict Resident 1's visitation by friends. The ADM stated after the incident of Resident 1's elopement from the facility, she revised their facility's policies and procedures that requires two persons to supervise residents during visitation, and to ensure residents are back to the unit before letting visitors out, and to keep residents away from the door during any visit.</p> <p>During an inspection of the visitation lounge (location where Resident 1 and her visitor was during the visit) and concurrent interview on 3/3/25, at 12:50 p.m., with the DON, the DON checked the distance of the side seats (where Resident 1 was sitting during that time of visit) from the exit door. The DON stated if Resident 1 was sitting on that chair which was about seven steps away from the exit door, then Resident 1's location would be too close to the exit door. The DON also stated CNA B probably did not pay attention cautiously.</p> <p>During a review of the facility's sign in log for December 2024 and January 2025 with the DON on 3/4/25, at 2:30 p.m., the DON confirmed there was no documented evidence indicating the IDs (identification) of Resident 1's two different visitors (friends) were checked by the facility staff when they visited Resident 1 from 12/19/24 to and 1/15/25.</p> <p>During an interview with the Director of Social Services (DSS) on 3/3/25, at 4:30 p.m., and on 3/21/25 at 4:00 p.m., the DSS stated Resident 1's whereabouts were still unknown up to this time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy and procedure (P&amp;P) titled, Policy and Procedure for Elopement And AWOL. dated 10/15/24, indicated, The facility shall take the following steps to identify, prevent, detect and respond to situations of resident elopement/ AWOL. Staff shall not open the exit doors if a resident is in the close proximity of the door.</p> <p>Review of the facility's policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Person- Centered, indicated, Reflects currently recognized standard of practice for problem areas and conditions. Care plan interventions are . , and relevant clinical decision making. Assessment of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change.</p>		