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	11/05/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the needed care and services that are resident centered for one of four residents (Resident 124) when:1.The facility did not accurately assess Resident 124's risk for falls prior to the two fall events Resident 124 had within one month on 2/16/25 and 3/7/25.2. The facility failed to implement an intervention that was included in Resident 124's care plan after her previous fall incident on 2/16/25.3.The facility did not follow their policy and procedure (P&P) when they failed to complete Resident 124's orthostatic blood pressure measurements (blood pressure measurements that are taken in three different positions: Lying down, sitting up, and standing up) as indicated in the SBAR (Situation, Background, Appearance, Recommendation Review and Notification, a way to communicate an event to the provider) completed on 3/7/25, and there was no documented evidence that orthostatic blood pressure measurements were completed in the Fall Risk assessment in Resident 124's chart.These failures contributed to Resident 124's fall with fracture to the left femur (bone in upper leg) after the facility failed to accurately assess the fall risk for Resident 124, resulting in the inability to provide appropriate fall risk interventions that are resident centered. These failures put Resident 124 at risk for further medical complications.Findings:1.Review of Resident 124's MDS Section GG (for measuring resident's assistance levels for activities of daily living such as going to the bathroom, hygiene, walking, with our without assistance) indicated Resident 124 was marked for use of wheelchair, with level of assistance marked as Independent-Resident completes the activity by themself with no assistance from a helper.Review of Resident 124's physician orders indicated Resident 124 had orders for aripiprazole (an antipsychotic medication), divalproex (an anti-seizure medication also used to treat mood disorders), lorazepam (an anti-anxiety medication) and olanzapine (an antipsychotic medication). Review of Resident 124's clinical record document titled Clinical Health Status (Quarterly/Annual), completed on 2/2/25, indicated Resident 124 had a fall risk score of 3. A fall risk score that is below 10 is classified as low fall risk, and a score above 10 is classified as high fall risk. Under Section 1a titled Fall Risk Assessment, question 5, titled GAIT [a person's manner of walking] BALANCE [being able to stay steady on one's feet]: To assess the resident's Gait/Balance, have him/her stand on both feet without holding on to anything; walk straight forward through a doorway, and make a turn is marked for response Balance Problems while walking, when in the MDS assessment, the resident was marked to be using a wheelchair. Question 7, titled MEDICATIONS: Response based on the following types of medications: Anesthetics [a drug or other substance that causes a loss of feeling or awareness], Antihistamines [used to treat allergic reaction symptoms such as hives, sneezing, watery eyes], Antihypertensives [a type of drug used to treat high blood pressure], Antiseizures [used to control or prevent seizures, which is abnormal electrical activity in the brain], Cathartics [used to accelerate having a bowel movement], Diuretics [used to remove excess fluid by causing increased urination], Hypoglycemics [used to lower blood sugar levels], Narcotics [used to relieve pain], Psychotropics [a drug that affects how the brain works], Sedatives [used to induce a calming affect]/Hypnotics [used for trouble sleeping] is marked for response NONE of these medications taken currently or within last 7 days.Review of Resident 124's clinical record document titled SBAR Post Fall, completed on 2/16/25, indicated Resident 124 had a fall risk score of 7. In section S. Situation, for question 5 titled Adaptive equipment [includes walkers, wheelchairs and canes] at time of fall:, the response None was marked. In section B. Background, for question 2 titled Medications received in the last 8 hours, no response was recorded.During a concurrent interview and record review with the DON on 11/4/25 at 11:45 AM, the DON confirmed that the fall risk score documented in the assessment Clinical Health Status (Quarterly/Annual), completed on 2/2/25 and the SBAR Post Fall, completed on 2/16/25, were both not accurate. The DON also stated the assessments were not accurate because the resident was on psychotropic medications, and she used a walker or wheelchair. The score should be higher. The DON also said All residents here in the facility have a high fall risk because they all take psychotropic medications, and for safety.During an interview and demonstration with the infection preventionist (IP) of how the Fall Risk Score is calculated in any assessment that has the Fall Risk Score on 11/5/25 at 9:18 AM, the IP demonstrated how choosing a different response to different questions, such as the medication question and the gait and balance question, would change the fall risk score. The IP further said The medication question is weighted more than other questions, and the score can change a lot depending on the response.Review of facility P&P titled Fall Risk Assessment, revised December 2007