

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 07/11/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>37935</p> <p>Based on interview, record review, and facility policy, the facility failed to notify the Ombudsman when a resident transferred or discharged from the facility for 3 (Residents #75, #78, and #118) of 3 sampled residents reviewed for hospitalization .</p> <p>Findings included:</p> <p>A facility policy titled, Transfer or Discharge, Emergency, revised in 09/2012, indicated, 1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative or other family member; f. Assist in obtaining transportation; and g. Others as appropriate or as necessary.</p> <p>1. An Admission Record revealed the facility admitted Resident #75 on 05/12/2020. According to the Admission Record, the resident had a medical history that included a diagnosis of hypertension.</p> <p>Resident #75's Progress Notes, dated 04/20/2024 at 2:37 PM, revealed Resident #75 discharged to the hospital for further evaluation due to some abnormal laboratory test results.</p> <p>2. An Admission Record revealed the facility admitted Resident #78 on 04/02/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of insomnia.</p> <p>Resident #78's Progress Notes, dated 04/12/2024 at 10:41 PM, revealed 911 was called to transport the resident to the hospital.</p> <p>Resident #78's Progress Notes, dated 04/13/2024 at 2:47 PM, revealed the resident was still in the hospital.</p> <p>3. An Admission Record revealed the facility admitted Resident #118 on 12/27/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of insomnia. The Admission Record revealed the resident discharged from the facility on 05/04/2024.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 07/11/2024 at 11:10 AM, the Administrator stated the previous Social Services Director (SSD) was terminated at the end of 05/2024 and the termination did not go well. He Administrator stated the former SSD did not leave their office in good order and the staff had been unable to locate a lot of information, to include the transfer/discharge binder that contained documentation of the Ombudsman notification of residents' transfers/discharges. The Administrator stated the facility was not able to locate any of the transfer/discharge notifications from 01/2024 to 05/2024.</p> <p>During an interview on 07/11/2024 at 11:19 AM, Director of Nursing (DON) stated he was not involved in the process of notifying the Ombudsman of resident transfers/discharges. The DON stated he would expect the Ombudsman to be notified timely of all resident transfer/discharges.</p> <p>During an interview on 07/11/2024 at 11:41 AM, the Ombudsman stated the ombudsman's office did not have any of the transfer/discharge notifications for Residents #75, #78, and #118.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>37935</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 (Resident #33) of 1 sampled resident reviewed for respiratory care.</p> <p>Findings included:</p> <p>An Admission Record revealed the facility admitted Resident #33 on 07/21/2017. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD).</p> <p>Resident #33's care plan, initiated on 01/07/2022, revealed the resident was on oxygen therapy due to decreased oxygen, diagnoses of COPD, acute respiratory failure and a history of COVID-19 and pneumonia.</p> <p>A quarterly MDS, with an Assessment Reference Date (ARD) of 06/27/2024, revealed Resident #33 has a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident did not receive oxygen therapy.</p> <p>Resident #33's Order Summary Report with active orders as of 07/02/2024, revealed an order dated 11/29/2018, that directed the staff to monitor the resident's oxygen saturation level every four hours and if the resident's oxygen saturation level was below 88%, staff should apply supplemental oxygen to the resident at two liters per minute by way of a nasal cannula every shift for a diagnosis of COPD.</p> <p>On 07/09/2024 at 9:04 AM, the surveyor observed Resident #33 with a nasal cannula on with a supplemental oxygen concentrator set at two liters per minute.</p> <p>During an interview on 07/10/2024 at 10:04 AM, Registered Nurse (RN) #18 stated Resident #33 had been receiving supplemental oxygen therapy since 11/29/2018. RN #18 stated the resident's quarterly MDS with an ARD of 06/27/2024 should have indicated the resident received oxygen therapy.</p> <p>During an interview on 07/10/2024 at 10:34 AM, the Director of Nursing (DON) stated Resident #33 received oxygen therapy and the resident's quarterly MDS with an ARD of 06/27/2024 should have reflected the resident's use of supplemental oxygen. The DON stated he expected the MDS to be accurate.</p> <p>During an interview on 07/10/2024 at 10:40 AM, the Administrator stated she was aware Resident #33 was on oxygen and would expect the MDS to be correct.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>37683</p> <p>Based on interview and record review, the facility failed to provide trauma-informed care to 1 (Resident #67) of 1 sampled resident reviewed for behavior-emotional, with a diagnosis of post-traumatic stress disorder.</p> <p>Findings included:</p> <p>An Admission Record revealed the facility admitted Resident #67 on 06/01/2022. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder, post-traumatic stress disorder (PTSD), mood disorder due to a known physiological condition, and depression.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2024, revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #67's care plan, initiated on 06/02/2022 revealed the resident was at risk for impaired cognitive status related to diagnoses of schizoaffective disorder, depression, mood disorder, and PTSD. Interventions initiated on 06/02/2022, directed staff to assist in activities of daily living (ADLs) as needed; assure resident was monitored during mealtime, if needed; continue on conservatorship; diet as ordered, monitor intake; involve in activities that do not depend on the resident's ability to communicate; listen to the resident when they verbalized concerns over disease symptoms and address issues raised; medication as ordered by the physician; monitor ADLs for assistance; monitor the resident for changes in condition; monitor vital signs as needed and report abnormal vital signs to the physician; and verbal reminders which assist in orientation.</p> <p>Resident #67's Psychosocial Assessment, dated 06/06/2022, revealed the resident did not have a history of trauma and/or PTSD syndrome.</p> <p>Resident #67's Psychosocial Assessment, dated 03/08/2024, revealed the resident did not have a new onset of trauma/PTSD since the last evaluation.</p> <p>During an interview on 07/08/2024 at 1:51 PM, Resident #67 stated the facility did not address their trauma or history of PTSD. Resident #67 stated when they were admitted , there was no trauma interview, no discussion of their diagnosis of PTSD, or what triggered their trauma.</p> <p>During an interview on 07/09/2024 at 2:50 PM, Certified Nursing Assistant (CNA) #8 stated she did not know why Resident #67 had PTSD.</p> <p>During an interview on 07/10/2024 at 8:30 AM, Resident #67 stated people of the opposite sex and crowded spaces triggered their PTSD anxiety. Resident #67 stated they minimized their interactions with people of the opposite sex as the facility did not.</p> <p>During an interview on 07/11/2024 at 8:34 AM, Registered Nurse #9 stated she did not know about Resident #67's diagnosis of PTSD.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/11/2024 at 8:41 AM, Licensed Vocational Nurse #10 stated she did not know about Resident #67's PTSD diagnosis, the source of the resident's trauma, or how to provide care in a way that would not re-traumatize the resident.</p> <p>During an interview on 07/11/2024 at 9:02 AM, the Director of Nursing (DON) stated the resident admitted to the facility with a diagnosis of PTSD, that he was not familiar with, and there were no assessment, that he knew of that pertained the resident's diagnosis of PTSD.</p> <p>During an interview on 07/11/2024 at 9:39 AM, CNA #11 stated she did not know what set off Resident #67's behaviors.</p> <p>During an interview on 07/11/2024 at 9:41 AM, CNA #12 stated she did not know what triggered Resident #67's PTSD.</p> <p>During an interview on 07/11/2024 at 10:45 AM, Mental Health Worker #14 stated he did not know why Resident #67 had PTSD.</p> <p>During an interview on 07/11/2024 at 12:01 PM, the Administrator stated the facility did not have a policy related to trauma-informed care, but understood there was trauma-informed care the facility was supposed to provide. The Administrator stated his understanding was that the facility did not base things on a resident's history, but rather what the resident told the staff. According to the Administrator, the resident had never brought up to him ny trauma or that triggered them. The Administrator stated he expected social services to assess the resident for trauma and provide trauma-informed care.</p> <p>During an interview on 07/11/2024 at 12:57 PM, the DON stated social services normally did trauma assessments and he did not know why Resident #67 had no trauma assessment.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37683</p> <p>Based on observation, interview, and facility policy review, the facility failed to staff washed their hands before they applied gloves during the preparation of food. This deficient practice had the potential to affect all residents who received food from the kitchen.</p> <p>Findings included:</p> <p>A facility policy titled, Glove Use Policy, dated 2023, revealed 3. Wash hands when changing to a fresh pair. Gloves must never be used in place of hand washing.</p> <p>On 07/10/2024 at 10:32 AM, Specialist Dining Services Aide (SDSA) #16 answered the locked kitchen door, while he was in the middle of making peanut butter and jelly sandwiches. After SDSA #16 answered the door, he applied a new pair of gloves without washing his hands first, and then continued to make the peanut butter and jelly sandwiches.</p> <p>During an interview on 07/10/2024 at 1:00 PM, SDSA #16 confirmed that he did not wash his hands before he applied a new pair of gloves. SDSA #16 stated he understood handwashing was important to prevent contamination.</p> <p>During an interview on 07/10/2024 at 1:19 PM, the Dining Services Manager stated staff should change gloves and wash hands after touching high-contact surfaces and before touching food items.</p> <p>During an interview on 07/11/2024 at 9:02 AM, the Director of Nursing stated that staff were expected to wash their hands after they touched high-contact surfaces and before touching food.</p> <p>During an interview on 07/11/2024 at 12:01 PM, the Administrator stated kitchen staff should follow infection control procedures and she expected staff to wash their hands after they touched the door or trashcan and before they made sandwiches.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>28193</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff documented the administration of medications for 1 (Resident #35) of 5 residents observed for medication administration.</p> <p>Findings included:</p> <p>An undated facility policy titled, Specific Facility Medication Administration Procedure for [facility name], indicated Policy To administer medications in safe and effective manner. The policy specified, 3. Licensed Nurse who prepared the medication shall administer medication and document administration accordingly.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/2024, revealed the facility admitted Resident #35 on 10/12/2023. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #35's Order Summary Report, with active orders as of 07/11/2024, revealed an order dated 01/06/2021, for benzotropine mesylate tablet 0.5 milligram by mouth one time a day.</p> <p>During medication administration observation on 07/10/2024 at 9:25 AM, Registered Nurse (RN) #5 administered medications to Resident #35 to include benzotropine mesylate; however, the nurse did not sign the medication administration record (MAR) to indicate the medication had been administered.</p> <p>Resident #35's MAR that contained the order for benzotropine mesylate, with an order date of 01/06/2021, revealed no evidence to indicate the medication was administered on 07/10/2024 at 8:00 AM.</p> <p>On 07/10/2024 at 2:27 PM, the surveyor attempted to interview RN #5; however, was told RN #5 had stepped away from the facility for a few minutes.</p> <p>On 07/10/2024 at 3:55 PM, the surveyor attempted to interview RN #5, but was told RN #5 had not returned to the facility.</p> <p>On 07/11/2024 at 9:15 AM, the surveyor requested to speak with RN #5, but the Director of Nursing (DON) stated RN #5 was not working today. The surveyor requested RN #5's telephone number to attempt a telephone interview, and the DON stated she would provide it.</p> <p>During an interview on 07/11/2024 at 10:40 AM, the surveyor again requested from the DON, RN #5's telephone number to attempt an interview with the nurse. The DON stated the nurse should have documented the administration of the medication as the medication was administered.</p> <p>During an interview on 07/11/2024 at 10:47 AM, the Administrator stated the nurse should have documented the administration of the medication after the resident took the medication.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/11/2024 at 12:50 PM, Licensed Vocational Nurse (LVN) #6 stated a nurse should immediately sign that a medication was administered, so that one did not forget what medication had been administered to a resident.</p> <p>During an interview on 07/11/2024 at 12:55 PM, LVN #7 stated a nurse should sign that a medication was administered right after the medication was given to the resident. Per LVN #7, waiting to sign that a medication had been administered could cause an error.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41493</p> <p>Based on observation, interview, and facility policy review, the facility failed to soak soiled linen in a machine or sink as directed by their policy for 1 of 116 residents who resided in the facility.</p> <p>Findings included:</p> <p>An undated facility policy titled, Sorting, Washing, and Drying, revealed 8. Soak kitchen linen, towels, aprons, etc. [et cetera, and other similar things], in machine or sink using a degreasing presoak or detergent for at least an hour to remove grease and stains prior to washing.</p> <p>During a concurrent observation and interview on 07/10/2024 at 10:11 AM, outside of the laundry exit, there were two buckets filled with a liquid and clothing that was covered with a trash bag. The Laundry Aid stated the clothes in the bucket were from 07/09/2024 and they belonged to a resident who had heavily soiled their pants and the staff allowed the items to soak.</p> <p>During an interview on 07/10/2024 at 10:20 AM, the interim Laundry Manager stated the soiled items should have been washed.</p> <p>During an interview on 07/11/2024 at 11:21 AM, the Administrator stated he expected staff to follow to the policy.</p> <p>During an interview on 07/11/2024 at 11:34 AM, the Director of Nursing stated staff should follow the policy on how to handle soiled linen.</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>37683</p> <p>Based on observation, resident interview, staff interview, and facility policy review, the facility ensure 1 (Station 2 dining room) of 2 dining room provided sufficient space to accommodate all the residents who wished to eat their meals in the dining room.</p> <p>Findings included:</p> <p>An undated facility policy titled, Social Dining, specified, Our recovery-oriented program offers a structured environment designed to assist residents in managing daily living tasks. Social Dining, a key component of this program, is specifically tailored to meet residents' needs in developing and practicing a range of skills. These include, but are not limited to, fairness, patience, courtesy, mood regulation, acceptance of reality, and learning the benefits of orderly conduct like queuing. Residents are given the opportunity to request preferred meals, wait patiently for their meal to be served, appreciate the communal aspect of dining, await their turn for seconds, and manage their emotions when their preferences cannot be met.</p> <p>During an observation of dining on 07/09/2024 at 12:32 PM, it was noted that one of the dining rooms was not large enough to accommodate all the residents. There was a queue of eight residents outside of the dining room, with five more residents coming down the hallway toward the dining room.</p> <p>During an interview on 07/09/2024 at 12:37 PM, Mental Health Worker (MHW) #1 stated the dining room was not large enough to accommodate all the residents. MHW #1 stated the room could only accommodate 24 residents and she was not sure how many residents were on the unit, but there were 116 in the facility.</p> <p>During an interview on 07/10/2024 at 2:49 PM, Resident #90 and Resident #109 both stated that they had to wait about five to 15 minutes to get to lunch because there was not enough space for everyone in the dining room at once. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2024, revealed Resident #90 had a Brief Interview for Mental status (BIMS) score of 15, which the resident had intact cognition. A quarterly MDS, with an ARD of 06/29/2024, revealed Resident #109 had a BIMS score of 14, which indicated the resident had intact cognition.</p> <p>During an interview on 07/10/2024 at 3:14 PM, Resident #111 stated they had to wait 15 minutes, sometimes longer, for food service. Resident #11 stated there was not enough room in the dining room for everyone who wanted to attend. A quarterly MDS, with an ARD of 05/24/2024, revealed Resident #111 had a BIMS score of 14, which indicate the resident had intact cognition.</p> <p>During an interview on 07/10/2024 at 3:16 PM, Certified Nursing Assistant (CNA) #2 stated the dining room was not big enough to accommodate all the residents.</p> <p>During an interview on 07/10/2024 at 3:30 PM, CNA #3 stated residents usually had to wait only 10 minutes for lunch. CNA #3 stated there was not enough room for everyone in the dining room and only 24 residents could fit in the Station 2 dining room.</p> <p>(continued on next page)</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/10/2024 at 3:33 PM, CNA #4 stated there was room for only 24 residents in the dining room and residents usually had to wait for only five minutes while in line.</p> <p>During an interview on 07/11/2024 at 9:02 AM, the Director of Nursing said it was his expectation that all residents should be able to eat at mealtimes when they were hungry or ready to eat.</p> <p>During an interview on 07/11/2024 at 10:41 AM, the Dining Services Manager stated the occupancy of the dining room on Station 2 was 24 residents.</p> <p>During an interview on 07/11/2024 at 12:01 PM, the Administrator stated staff had tried two different setting for meals; however, it did not work so now the dining room on Station 2 had a first-come, first-served system to prepare the residents for transition back into the community.</p> <p>During an interview on 07/11/2024 at 12:51 PM, Resident #87 stated the line wait for the ding room was sometimes 10 to 15 minutes and they did not like having to wait in line because they got tired and wanted to sit down. An admission MDS, with an ARD of 05/29/2024, revealed Resident #87 had a BIMS score of 14, which indicated the resident had intact cognition.</p>		