

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the safety for three of 12 residents (Resident 36, Resident 48, & Resident 98) who were at risk for elopement (the unauthorized, unsupervised departure of a patient/resident from a healthcare facility when their condition puts them at risk of injury or death) and eloped from the facility when: 1. The facility failed to provide appropriate and sufficient supervision to Resident 48, when Resident 48 who is deemed gravely disabled (legal term to describe a condition where a person, due to a mental health or substance use disorder, is unable to provide for their basic needs like food, clothing, or shelter) eloped from the locked facility on 10/27/25, when Houskeeper A (HA) failed to follow protocol of ensuring the location of her keys at all times. It was later identified Resident 48 had used HA's keys to exit the locked facility. Resident 48 remained missing until the afternoon of 10/30/25. 2. The facility failed to accurately assess Resident 98's elopement risk on admission on [DATE] and provide the appropriate and sufficient supervision to Resident 98 when she eloped from the facility on 5/24/24. 3. The facility failed to accurately assess Resident 36's elopement risk on 2/20/25 and provide the appropriate and sufficient supervision to Resident 36 when Resident 36 eloped on 10/25/25 after being inaccurately assessed as low risk for elopement and allowed to go on a community walk outside the facility. These failures resulted in Resident 48 to be unaccounted for, causing the facility to fail in providing basic needs of food, medications, and shelter to Resident 48 for approximately three days. These failures had the potential for Resident 48 to be fatally injured, dehydrated (having lost a large amount of water from the body.), or withdraw from medications prescribed by his Physician causing medical and/or psychological deterioration (such as muscle stiffness, headache, dizziness, depression, anxiety, agitation or nausea) These failures had the potential to contribute to Resident 98's elopement on 5/24/24 due to an inaccurate elopement risk assessment. These failures contributed to Resident 36's elopement due to an inaccurate risk assessment reflecting a low risk for elopement. Facility staff allowed Resident 36 to go on a community walk based on the inaccurate assessment. These failures required immediate correction to prevent similar occurrence of elopement due to inaccurate elopement risk assessments at the facility, and staff not accounting for their keys to the locked facility exit doors. On 10/28/25, at 5:40 p.m. an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator and Director of Nursing related to the failure to provide adequate supervision, accurately assess Residents risk for elopement, and ensure facility staff kept their keys secured and accounted for at all times. On 10/31/25, at 4:17 p.m., the IJ was removed after the Administrator submitted an acceptable IJ Removal Plan (IJRP, a plan with interventions to immediately correct the deficient practices), and after the survey team verified and confirmed the corrective actions while onsite. 1. During an observation on 10/27/25 at 8:30 a.m., in Resident 48's room, Resident 48 was not present in his room. (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: 05A277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 10/27/25 at 8:33 a.m., in Station 1 hallway, Resident 48 was not found in the hallway. Resident 62 who was in the hallway spoke loudly to no one in particular, watch out everyone people are stealing keys around here. During an observation on 10/27/25 at 8:35 a.m., in Station 1 activity room, Resident 48 was not found in activity room. During a review of facility self-reported incident 2653540, dated 10/27/25, incident indicated, At around 0710am, staff reported that [Resident 48] was not found in the facility during shift report. Per staff from noc [night] shift, [Resident 48] had his PRN [as needed] medication at around 5:30am and he was reassessed for the effectiveness of PRN medication at around 6:30am. During shift change report, staff were unable to find [Resident 48] Staff Initiated the search for resident in the facility and in the neighborhood . [Resident 48] is not found at this time. During a review of Resident 48's Facesheet (A facesheet is a summary document containing a Resident's personal and demographic information, including contact details and medical history) dated 10/27/25 indicated, Resident 48 had a diagnosis of Schizoaffective Disorder, Bipolar Type (a mental health condition that combines symptoms of schizophrenia and bipolar disorder, this condition is characterized by both psychotic symptoms (seeing things, hearing voices, disorganized thinking or speech) and mood swings (bipolar disorder) simultaneously.) since admission on [DATE]. The Facesheet indicated, Resident 48 had a conservator (a person appointed by a court to manage the health care and financial affairs of an adult who is unable to do so themselves due to mental illness, dementia, or other incapacitating conditions) appointed to him. During a review of Resident 48's Inpatient Psychiatry admission Note dated 4/5/24 indicated, Pt [patient] is well known to [inpatient psychiatric facility] .given his history of non-compliance with medications in the community. However, when patient restabilizes on his medications and is attempted to be placed in a lower-level care, he often AWOLs [Absence without official leave: leaving without approval from the facility] and relapses on methamphetamines [a powerful, highly addictive synthetic stimulant drug that affects the central nervous system] and stops taking his medications. [Resident 48] again presents for hospitalization due to his aggressive and threatening behavior at his residence and is no longer welcomed back and is unable to care for himself. During a review of Resident 48's Reappointment Letters for Conservatorship dated 8/12/25 indicated, Powers of the conservator for a gravely disabled person under chapter 3 (commencing with section 5350), part 1 division 5, of the welfare and institutions code .it is hereby ordered that the conservatee [Resident 48] is still gravely disabled person within the meaning of the law, and the petition for reappointment is granted. Signed by County Superior Court on 7/22/25. During an interview on 10/27/25, at 2:09 p.m., with Certified Nursing Assistant (CNA) I, CNA I stated, she was clocked in for work this morning around 7:07 a.m. and was assigned to be the high risk CNA (she is tasked with monitoring the residents designated as high risk, whether it be a fall risk, or behaviors, she monitors them during her shift). CNA I stated, she did her head count after clocking in and noticed Resident 48 was missing. CNA I stated, she normally sees Resident 48 walking in the hallways in the morning, she then checked the bathroom, phone booth and showers and did not see Resident 48. CNA I stated she then notified the nurse who called the sheriff. CNA I stated, she heard one of the housekeepers lost her keys this morning. During a review of the Facility's head count sheet dated 10/27/25, sheet indicated staff wrote HW (continued on next page)		

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 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[hallway] for end of shift at 7:00 am, indicating Resident 48 was seen in the hallway around 7:00am from the NOC shift CNA. Facility head count sheet indicated, next shift CNA, CNA I charted at 7:00 am AWOL for Resident 48, indicating he was missing, signed by CNA I. During an interview on 10/27/25, at 2:17p.m., with the Director of Nursing (DON), the DON stated, During our initial investigation it was reported to the housekeeping supervisor this morning that the AM housekeeper lost her keys. The DON stated housekeeper (Housekeeper A, HA) was suspended pending the investigation. During an interview on 10/27/25, at 3:35 p.m., the facility Administrator (ADM) stated, around 7:30 a.m., this morning she got a call that Resident 48 was missing. The ADM stated, she instructed staff to search for the nearby area around 8:30 a.m., and was informed staff came back and could not find Resident 48. The ADM also stated, she was also notified at the same time by the housekeeping supervisor (HS) that HA lost her keys. The ADM stated, her protocol for lost keys depends on where the staff loses the key, if they lost the key in the locked area, they are supposed to start a room-to-room search. ADM stated another resident (Resident 62) reported they saw Resident 48 with a set of keys. The ADM stated the missing keys were found outside the Station 1 exit door near the dining room shortly after. The ADM also stated that the housekeepers have lanyards on their keys, and it may have been possible the lanyard was hanging outside her apron and Resident 48 was able to grab it and take the keys. During an interview on 10/27/25, at 4:00 p.m., with the Program Director (PD), the PD stated, she spoke to HA at around 6:15 a.m., this morning. The PD stated, HA last remembered using her keys to open the middle classroom and she was cleaning the phone booth around 7:00 a.m. she was keeping her keys in her apron that morning and realized they were missing. The PD further stated, HA told her she reported to her supervisor (HS) around 6:50-7:00 a.m. that the keys were missing. The PD stated, HA was approached by Resident 48 earlier that morning around 5:40 a.m., when Resident 48 asked HA if her supervisor was going to be here today. The PD stated HA and Resident 48 had no other interactions according to HA. During an interview on 10/27/25, at 4:15 p.m., with the Housekeeping Supervisor (HS) HS stated, she was called around 7:05 a.m this morning by HA who stated she had lost her keys. The HS stated, HA told her she was cleaning, and she had put her keys in her front apron pocket, and she reached in to grab it, and could not find it. The HS stated, HA reported to her that Resident 48 came up to her early in the morning and asked her if HS was working today, and that is the only interaction they had. HS stated, it is her expectation that the housekeepers would keep the keys around their necks and know where the keys are at all times. The HS stated she had to write up the HA for her behavior two times in the past, when she had left open a door to the laundry room leading outside the facility. The HS further stated she gave the HA a warning the first time, then the second time she was found to leave the door open she was suspended for a period of time. During an interview on 10/27/25, at 4:40 p.m., with CNA J, CNA J stated she last saw Resident 48 this morning around 6:30 a.m., walking in the hallway. During an interview on 10/27/25, at 5:05 p.m. with Resident 62, in Residents room. Resident 62 stated he saw Resident 48 with a set of keys that were not his. Resident 62 stated the keys had a black string on them, and he saw Resident 48 put them in his pocket and walk toward the dining room. Resident 62 stated he did not see where Resident 48 got the keys, but he was standing next to the phone room leaning against the wall. (continued on next page)		

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 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 62's Brief Interview for Mental Status (BIMS- a standardized cognitive screening tool used primarily in long-term care facilities to assess a resident's cognitive function) dated 7/31/25, indicated a score of 14. A score of 13-15 indicates being cognitively intact. During an interview on 10/27/25, at 7:00p.m., with CNA K, CNA K stated he was the CNA for the NOC shift prior to when Resident 48 went missing. CNA K stated he last saw Resident 48 around 6:30 in the hallway. During a review of Resident 48's care plan dated 8/9/25, care plan indicated, Resident is an elopement risk AEB [as evidenced by] resident may leave the facility without permission. Noted with a long history of AWOL from previous placements and substance abuse. The care plan had a goal, Resident will have 0 (zero) episode of attempting AWOL q (every) day. It included interventions such as: Resident will be redirected away from the exit doors when observed standing by the exit doors, Nursing or Program staff will observe for exit seeking behaviors, if observed res (resident) to placed on high risk monitoring and counselling. During a review of Resident 48's Psychiatrist Progress Note dated 8/23/25 indicated, Staff reports 8/21/25 patient attempted to elope from the facility by following staff an [sic] pushing past them through station exit door to main lobby. Patient was seen by me for evaluation. Continue treatment plan. Signed by Medical Doctor (MD) L. During an interview on 10/29/25 at 3:56 p.m., with the Medical Director (MD), the MD stated, it is his expectation that the facility staff supervise all residents in order to prevent elopements. The MD stated staff are taught to be cautious. During an interview on 10/30/25, at 3:19 p.m., with the Conservator (CON), he stated he was the appointed conservator for Resident 48 who makes decisions on his behalf. The CON stated, he was concerned that Resident 48 was missing for so long, because he is considered gravely disabled and he cannot provide food or safety for himself. During an interview on 10/30/25 at 9:44 a.m., with MD L, MD L stated, he is Resident 48's psychiatrist and manages his psychiatric medications. MD L stated it is his expectation that staff supervise the residents in order to prevent elopements from the facility. During a review of Resident 48's Physician Orders dated active on 10/27/25, orders indicated Resident 48 was ordered Divalproex Sodium (a medication used to treat manic phases of bipolar disorder) DR (delayed release) 250 mg. give three tablets by mouth two times per day, Lorazepam (a drug of the benzodiazepine group, used especially to treat anxiety) two mg. 1 tablet by mouth two times a day for agitation, and Zyprexa (atypical antipsychotic medication primarily used to treat schizophrenia and bipolar disorder) 20 mg. q HS (every bedtime), Propranolol HCL (hydrochloride, medication to lower blood pressure) 10 mg 1 tablet by mouth two times a day, hold if BP (blood pressure) < (below) 100/60, PR (pulse rate) < 60. During a review of Medication Guide for Divalproex Sodium by the National Institute for Health (NIH), dated 2022, guide indicated, Do not stop taking Depakote [divalproex sodium] without first talking to your healthcare provider. Stopping Depakote suddenly can cause serious problems [such as anxiety, nausea, vomiting, irritability, depression and insomnia]. During a review of Medication Guide for Zyprexa by the National Institute for Health (NIH), dated 2009, (continued on next page)		

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 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	guide indicated, To prevent serious side effects [such as headaches, nausea, brain zaps [electrical like pain sensation] anxiety, mood swings], do not stop taking ZYPREXA suddenly. If you need to stop taking ZYPREXA, your doctor can tell you how to safely stop taking it. During a review of Medication Guide for Lorazepam by the National Institute for Health (NIH), dated 2024, guide indicated, Withdrawal symptoms [such as cramping, anxiety, dizziness, depression, panic attacks, vomiting, weight loss, ringing of the ears] if abruptly discontinued after long-term use. During a review of 5 day Follow up dated 10/31/25 indicated, Resident 48 was found on 10/30/25 at a family members home. Document indicated, Upon investigation, it is determined that [Resident 48] took away the keys from the housekeeping staff and used the keys to exit the facility through the door near the dining room. 2. During a review of Resident 98's Facesheet, document indicated Resident 98 had a diagnosis of Schizoaffective Disorder, Bipolar Type. Record review of Resident 98's Baseline Care Plan dated 5/23/24 indicated, the facility assessed Resident 98's elopement risk. Elopement Risk Assessment portion indicated, Medications: .psychotropics [medications used to treat mental health disorders] 0. NONE of these medications was selected. Diseases (dementia, any type of mental illness) 0. NONE Present was selected. Calculated assessment indicate, Elopement Risk Score less than 10 indicating a low risk for elopement. During an interview on 10/30/25, at 12:41 p.m., with the DON, she stated Resident 98 is taking at least one psychotropic medication. The DON stated the elopement risk assessment was not correct. The DON stated, Resident 98 is taking at least one psychotropic medication. The DON stated, Resident 98 also has a mental illness of schizoaffective disorder. The DON stated the score was incorrect. The DON stated should have selected that the Resident 48 takes two psychotropic medications, and that Resident 48 has a mental illness. DON stated, Resident 98 was taking Seroquel (atypical antipsychotic medication used to treat mental health conditions such as schizophrenia) and Abilify (a prescription atypical antipsychotic medication used to treat several mental health conditions). During a review of Resident 98's Change in Condition dated 5/24/24, document indicated, Resident went AWOL out of the facility. 3. During a review of Resident 36's clinical record, record indicated, Resident 36 was admitted on [DATE] and had a diagnoses of Schizoaffective Disorder, Bipolar Type, Anxiety Disorder (a mental illness that causes constant fear), Epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), and Post Traumatic Stress Disorder (it is a mental health condition that can develop after experiencing or witnessing a traumatic event). Review of Resident 36's quarterly BIMS (brief interview for mental status) score dated 8/29/25 (A score of 0-7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact) score was 15. Review of Resident 36's Baseline Care Plan dated 2/20/25 indicated, the facility assessed Resident 36's elopement risk. Elopement Risk Assessment portion indicated, Diseases (dementia, any type of mental illness) 0. NONE Present was selected. Calculated assessment indicate, Elopement Risk (continued on next page)		

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 11/05/2025
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Score less than 10 indicating a low risk for elopement. During a review of facility self-reported incident 2652972, dated 10/25/25, incident indicated, At around 8:30am on 10/25/25 during neighborhood walk, resident was observed to suddenly run away from walking group. Staff followed resident and attempted numerous times to convince her to return to facility. Resident was not receptive and continued to run. Another staff member called facility to report incident and AWOL protocol was initiated. Multiple staff followed resident on foot and in cars . During an interview on 10/27/25 at 2:07 p.m., with Registered Nurse (RN) O, RN O stated, Resident 36 has no record of elopement or wandering. During an interview on 10/27/25 at 3:39 p.m., with the PD, the PD stated, Residents who are at high risk for elopement are not allowed to go on community walks outside the facility. During an interview on 10/30/25, at 12:41 p.m., with the DON, the DON stated Resident 36's elopement risk assessment was not correct. The DON stated, Resident 36 also has a mental illness of schizoaffective disorder. The DON stated the elopement risk assessment score was incorrect. All residents are at elopement risk in the facility. During a review of Resident 36's Risk for Elopement dated 10/28/25, Risk for elopement indicated the elopement risk assessment was updated by the DON to accurately reflect Resident 36 having a mental illness. Elopement risk score indicated 27 (high risk for elopement). During an interview on 10/29/25, at 4:24 p.m., with Licensed Vocational Nurse (LVN) P, LVN P stated, Resident 36 is no longer going on community walks, because she is at high risk for elopement. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure For Elopement and AWOL dated 2024, the P&P indicated, It if the policy of this facility to take appropriate steps to identify the risk of, prevent, detect and respond promptly to resident elopement/AWOL.All residents are assessed for Risk of Elopement upon admission.		

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 11/05/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision for safe and effective medication administration when: 1. The facility allowed the preparation of medications 1 to 2 hours ahead of administration (or pre-pouring) for all residents at the same time without establishing safeguards and policy and procedures for staff to consistently carry out and to avoid mix-ups or medication errors during the preparation and administration. Consequently, four out of six nursing staff observed during medication administration did not label the medication cup for each resident during the preparation; and did not verify the pre-poured medications against the Medication Administration Record (MAR) for correctness, as a final check, at the time of administration. Also, during the medication administration observation, a nursing staff prepared and administered medications for two administration times (5 PM and 9 PM) for two of 12 sampled residents (Residents 75 and 87). 2. There has been no feedback or oversight from the consultant pharmacist (CP) to identify and evaluate the medication administration process for safe and effective medication use. These failures had the potential for mix-ups of residents' medications during the preparation and administration, which would result in residents receiving the wrong medications. Medication errors could lead to serious consequences for the residents. A review of the Medication Safety Go beyond the basics, dated 5/9/2016, by Lippincott NursingCenter (a nationally recognized organization with evidence-based nursing resources, principles, and practices) indicated: For any nurse working in a direct care setting, preparing medications and administering them to patients is part of the daily routine. Mistakes can happen at any point in the process. Administration errors are one of the most serious and most common mistakes made by nurses. Under Start with the basics, it indicated: Prepare medications for one patient at a time. A review of the facility's P&P titled Medication Administration - General Guidelines, reviewed on 6/1/25, indicated: Prior to administration, the medication and dosage schedule on the resident's medication record (MAR) is compared with the medication label and Medications are administered at the time they are prepared. Medications are not pre-poured. 1. On 10/27/25 at 7:49 AM, at Nursing Station 1 with Registered Nurse (RN) C, the medication cart for Station 1 was observed inside the medication room. RN C stated medications for each resident were pre-poured at around 7 AM this morning, to prepare for the 9 AM medication pass. RN C opened the medication cart for the surveyor to observe. The cart had 4 drawers, and each drawer had multiple compartments (bins) adjacent to one another; each bin was for one resident. Each bin was about the size of half a regular-sized sheet of paper (lengthwise). It had a hand-written or printed name of a resident on the bottom and a small 30-milliliter cup containing the medications for that resident. The medication cups were not labeled with the resident's name or any identifiers. RN C stated most residents will come to the nursing station to take their medications; a few will stay in bed, but staff would get them up to come or bring the medications to them. RN C stated this preparation is necessary because certain residents may get agitated and refuse to take their medications if they wait too long in line. On 10/27/25 at 8:15 AM, many residents were observed lining up in front of Nursing Station 1, waiting to receive their medications. Most were quiet and observing the staff, but a few residents looked impatient and verbalized their frustrations. On 10/27/25 at 8:23 AM, RN C pulled the medication cart from the medication room out to the nursing station. The IP nurse and another staff were observed asking the residents for their names and preparing cups of juice or water for them while RN C pulled the pre-poured medication cups from the medication cart, one by one. To explain another way, after a resident identified him/herself, RN C removed a cup of pre-poured medications from the medication cart and handed it to the resident. She and the other staff observed as the resident took the medications. Then they repeated the same process for the next resident in line. During this process, RN C was observed opening the electronic MAR (eMAR) for that resident, (continued on next page)		

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 11/05/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	but she did not check the medication cup's contents against the MAR before handing it to the resident. On 10/27/25 at 9:00 AM, the same communal medication administration process was observed at Station 2, where RN D handed the pre-poured cups of medications to the residents, one by one. Certified Nursing Assistant (CNA) E was observed assisting with the resident identification and providing juice/water to the residents. During the observation, after a resident was identified, RN D opened the resident's eMAR and then immediately opened the medication cart drawer and removed an unlabeled cup of medications to hand to the resident without checking the medication contents against the MAR. The medication cups did not have any identifiers on them. During an interview with RN D on 10/27/25 at 9:40 AM, in Station 2 Medication Room, she said she started preparing the medications for all residents in Station 2 around 6:30 AM. Her medication cart set-up was the same as that in Station 1: the medication cart had 4 medication drawers, each drawer had multiple bins being placed side by side; each bin had a resident's name on the bottom and each resident's medication cup would go in each bin. RN D was asked to explain the medication preparation. She stated she would pull all the medications from the shelf for a resident, check them against the eMAR; and whichever is due at that time, she would punch the pill(s) into the medication cup. When all medications were in the cup, she would place the cup into the bin with the resident's name in the medication cart. When asked how she would ensure the pre-prepared cups were placed in the right bins in the medication cart, RN D stated she would check the name of the resident before putting the cup in. During an interview with RN C on 10/27/2025 at 1:41 PM in Station 1 Medication Room, when asked her how to ensure prepared medication cup for a resident is not accidentally placed into the wrong bin for another resident with similar name or same last name, RN C stated she pays very close attention to where the cup should go. She stated some residents know their medications by color and would say something if they are not the right colors. On 10/27/25 at 3:15 PM, in the Station 2 Medication Room, Licensed Vocational Nurse (LVN) A was observed preparing afternoon medications for the residents in Station 2. She stated she is preparing medications for residents who have medications scheduled at 5 PM and will prepare medications that are scheduled at 7PM at a later time. During this observation, the surveyor observed the preparation for 5 residents (Residents 8, 13, 15, 17, and 23). LVN A started by pulling a resident's medications from the shelf, checked the eMAR, punched the pills into the medication cup, and placed the cup inside the medication cart that had that resident's name. LVN A did not label the medication cups with any identifiers. When asked how she would identify if there was a mix-up or a resident's cup was accidentally put in the wrong bin, LVN A stated, Some residents know what meds they are taking and how many, and if there's something different, they would know. She acknowledged some residents would not review the medication contents before taking them, and it should not be dependent on the residents to identify the medication errors. On 10/27/25, from 4:37 PM to 5:18 PM, LVN A was observed administering medications for Station 2 residents who were waiting in line in front of the nursing station. After a resident was identified by name, LVN A removed an unlabeled medication cup from the medication cart and immediately handed it to the resident. She and another staff ensured the resident swallowed the medications, then she repeated the same process with the next resident in line. LVN A did not verify the cup's contents against the MAR before handing it to each resident. Most of the residents did not review or question what medications they were taking. During the administration observation with LVN A above, on 10/27/25 at 4:39 PM, LVN A was observed administering 7 medications to Resident 87. Two of the medications, 1 tablet of atorvastatin (medication for high cholesterol) 20 milligrams (mg) and 1 tablet of olanzapine (an antipsychotic medication) 20 mg, were scheduled to be administered at 9PM. On 10/27/25 at 5:25 PM, LVN A confirmed they were due at 9PM but she administered them during the 5 PM medication pass because the resident wanted them all at the same time. LVN A acknowledged the physician's orders indicated to give them at 9 PM, not at 5 PM. Similarly, on 10/27/25 at 4:40 PM, LVN A was observed administering 5 medications to Resident 75. Four of the medications: 2 capsules of lithium (medication to treat mental illness) 300 mg, 1 tablet of haloperidol (an antipsychotic) 10 mg, 1 tablet (continued on next page)		

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 11/05/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of Risperdal (an antipsychotic) 3 mg, and 1 tablet of benztropine (medication to prevent abnormal movement disorder) 1 mg, were due at 9 PM. During a record review and interview on 10/27/25 at 5:20 PM, LVN A stated, When he [Resident 75] goes to bed, he will go to sleep so he doesn't take any more. LVN A acknowledged these 4 medications were ordered to be administered at 9 PM. On 10/28/25 at 9:47 AM, RN D was observed documenting the medication administration after she had just finished with the morning medication pass. She stated documenting the medication administration in the middle of medication pass could cause a delay as some residents get impatient or agitated if they wait too long. During an interview with the Director of Nursing (DON) on 10/28/25 at 10:48 AM, she stated this is not a typical facility where the nurses prepare medications for one resident at a time then administer them right after preparation. She explained that due to the nature of the facility and staff safety, the facility allows for pre-pouring of medications 1-2 hours before administration, and the residents receive their medications at the nursing station. She stated the nursing staff are to prepare medications for one medication pass at a time, such as preparing at 7 AM for 9 AM administration. She stated the facility currently had 62 residents in Station 1, and 54 residents in Station 2. When asked how the staff avoid mix-ups or a medication cup being accidentally placed in someone else's bin, the DON stated the nurses are expected to verify at least the number of pre-poured medications in the resident's cup against the MAR before giving them; and it should not be dependent on the residents to identify the medication errors. She additionally stated that the facility used to require the nursing staff to label the medication cup with the resident's identifier (such as name or initials) but she did not know why it is not done anymore. When asked if the facility policy required the labeling of the cups, she stated, Not in policy. She was requested to provide the policies allowing these practices. On 10/28/25 at 1:15 PM, the DON provided the facility's policy and procedures (P&P) related to pre-pouring of medications. She stated, besides the pre-pouring part, the facility staff followed the provider pharmacy's P&P on general guidelines for medication administration. A review of the provided P&P titled SPECIFIC FACILITY MEDICATION ADMINISTRATION PROCEDURE FOR INSPIRE BEHAVIORAL HEALTH SAN [NAME], undated, indicated: Given facility population with psychiatric and behavioral needs and risks, facility performs pre pouring and administration by licensed nurses only. Purpose: To safely administer medications while maintaining safe environment by preventing escalation in resident's behavior which may result in resident to resident altercation or other accidents. Procedures: 1. Licensed Nurse prepare medications via pre pouring following accurate order (Physician order) and infection control. 2. Licensed Nurse will only prepare medications for the next administration (i.e. start pre pour for 9 am medication at 7 am and pre pour medication for 5 pm at 3 pm). The above P&P did not address the how process of pre-pouring, such as labeling of medication cup with resident's identifier(s), or any other safeguards to ensure the residents receive correct medications during administration. During a concurrent interview and record review with the DON on 10/29/2025 at 12:11 PM, she verified the facility's policy allowed for pre-pouring but it did not address how the staff should pre-pour and processes to safeguard against mix-ups such as medication cups being placed in the wrong bin during preparation, or the wrong cup being taken out of the medication cart (such as for residents with look-alike or sound-alike names) during a high-stress and busy environment during medication administration. The DON stated the nurses should know to check the medications against the MAR at the point of administration. She continued, Since they prepared the meds ahead of time, they won't be able to check the labels against the MAR prior to administration but at least verify the count. When asked if there were additional policies, she stated she will look into any other policies regarding pre-pouring and medication administration. A review of the facility's resident roster indicated there were 4 residents with the same last name; two of these 4 residents (Residents 75 and 78) had look-alike and sound-alike first name, they only differ by the last letter in the name. During another interview with the DON on 10/30/25 at 3:40 PM, the DON stated she found the STP (special treatment program) policy, but it's very generic. There's nothing different from what I already provided to you. On (continued on next page)		

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 11/05/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/31/25 at 12:09 PM, the DON provided the 7/2025 Medication administration Nursing Guideline STP Program/Facility policy. She stated, It did not say anything about labeling [of prepared medications] but this is what we have. A review of this policy indicated, Medications will be pre-poured prior to administration for each scheduled medication pass. The nurse shall verify the Five Rights of Medication Administration before pre-pouring: 1. Right Resident, 2. Right Medication, 3. Right Dose 4. Right Route 5. Right Time. This policy did not have any specific procedures to prevent or minimize medication errors. On 10/31/25 starting at 8:36 AM, the surveyor observed medication administration for 6 residents (Residents 15, 17, 40, 50, 67, and 74) at Nursing Station 2, administered by LVN F who was assisted by two other staff. The medication cups for these residents were not labeled, and LVN F did not verify the medication cup contents against the MAR before handling them out to the residents. During an interview with LVN F on 10/31/25 at 10:36 AM, she stated during the medication administration, she would check the resident's identification against the photo in the eMAR, take the pre-prepared medication cup from the cart and give it to the resident, watch them take the medications, and click on the MAR after they took the medications. LVN F verified she did not label the medication cups during the preparation but was supposed to, and did not check the medication contents against the MAR prior to giving it to the residents. On 11/03/25 at 8:28 AM, the surveyor observed the medication administration for multiple residents in Station 2, administered by RN D. At this observation, the medication cups were observed labeled with the resident's initials. On 11/3/25 at 8:41 AM, the DON joined the observation. RN D was observed removing Resident 17's medication cup from the medication cart and immediately handed it to the resident after the resident identified herself. RN D did not verify the medication cup contents against the MAR. The DON stated the nurses have been in-serviced on labeling the medication cups and checking the medications against the MAR before administration. She stated they did a lot of practice on the weekend and I don't know what happened. A review of a publication titled Implement Strategies to Prevent Persistent Medication Errors and Hazards, dated 3/23/23, by the Institute for Safe Medication Practices (ISMP, a nonprofit patient safety organization with recognized national expertise in medication error prevention), indicated, A medication-use system that is inadequate or poorly designed to support practitioners will lead to errors. It further indicated, The responsibility for accurate medication administration does not lie with a single individual. Rather, it lies with multiple individuals, including organizational leaders, who are responsible for the design, implementation, and maintenance of reliable systems to support safe medication use for all practitioners. 2. On 10/31/25, the DON provided a binder containing the Consultant Pharmacist's medication regimen reviews (MRRs) and quarterly reports to the facility from January 2025 to October 2025. A review of the reports and MRRs indicated they were conducted by 4 different CPs since January 2025. On 10/31/25 at 2:40 PM, a review of the MRR binder with the DON reflected no documented evidence that the CPs observed the medication pass nor any feedback or recommendations regarding medication preparation or administration. The DON stated the pharmacy's nurse consultant and CP have not raised any concerns about the medication pass that she was aware of. During a telephone interview with the Consultant Pharmacist Manager (CPM) on 11/03/25 at 8:50 AM, he stated the pharmacy has been short-staffed so they had to use CPs from a contracting company. He stated there had been different CPs visiting the facility, but he himself had not been there. He was asked if there had been any documented evidence the CPs identified, evaluated, and addressed medication administration-related issues specifically that the nursing staff had been pre-pouring medications without labeling the medication cups and not verifying the prepared medications against the MAR before administration. He stated he will need to research and get back to the surveyor. During a follow-up telephone interview with the CPM on 11/03/2025 5:08 PM, he stated his conversations with the CPs reflected they did not see it as a risky procedure. A review of the facility's P&P titled CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS, reviewed June 1, 2025, indicated The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff and pharmacy (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/05/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	personnel, consultant pharmacist helps identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but not limited to. Assisting the facility in the identification and evaluation of medication-related issues, including the prevention and reporting of medication errors.		

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 11/05/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards, and facility policy for food service safety in the kitchen and dining room, potentially affecting all the 116 residents when:1. The facility failed to label opened eggs in the walk in fridge with open and use by date. Failed to label 9 trays of prepared desserts with the date, or type of dessert in the walk in fridge.2. The facility failed to ensure kitchen staff performed hand hygiene after touching trash on the floor and after operating dirty equipment prior to returning to food preparation.3. The facility failed to ensure staff performed hand hygiene when assisting during meal times for seven residents (Resident 17, Resident 25, Resident 27, Resident 61, Resident 72, Resident 82, and Resident 92)These failures had the potential for residents to receive expired foods, wrong dessert items, and for cross contamination during meal time dining and kitchen food preparation from staff members not sanitizing their hands. 1. During an observation on 10/27/25, at 7:47 a.m., in the kitchen walk in fridge, an opened tray of eggs was observed on the shelf. The eggs were sitting on a carboard sleeve, no open date or use by date was observed on the eggs. During an interview on 10/27/25, at 7:49 a.m., with the Certified Dietary Manager (CDM), the CDM stated, the eggs were not labeled and they should be. During an observation on 10/27/25, at 7:51 a.m., in the kitchen walk in fridge, a cart was observed to contain 9 trays of prepared various gelatin desserts of yellow and green color. The trays were observed with no labels with the type of dessert or the date prepared. The cart was observed with no labels or dates. During an interview on 10/27/25, at 7:52 a.m., with the CDM, the CDM stated, there is no label on the desserts, those are for lunch today. CDM stated, the yellow dessert is CCHO (diabetic diet) and the green is for regular diet. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.All prepared foods need to be covered, labeled, and dated. During a review of the facility's P&P titled, Procedure for Refrigerated Storage dated 2023, the P&P indicated, Eggs need to be dated to assure proper rotation. 2. During an observation on 10/27/25 in the kitchen, at 8:01 a.m., [NAME] N was observed picking up trash on the floor and touching the lid of the trash can to throw the trash away. [NAME] N then returned to operating the dishwasher without performing hand hygiene and removed a clean tray from the dishwasher with a clean sheet pan. During an interview on 10/27/25, at 8:02 a.m., with the CDM, the CDM stated she saw [NAME] N pick up trash and did not wash her hands after. The CDM asked [NAME] N to stop and wash her hands. During an observation on 10/29/25, at 11:15 a.m., in the kitchen, [NAME] M was observed wearing gloves while operating the dishwasher. [NAME] M opened and closed the lid of the dishwasher while wearing the gloves, to wash a dirty whisk, he then removed the clean whisk from the dishwasher, and (continued on next page)		

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 11/05/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	returned to preparing the salad dressing while wearing the same gloves and did not perform hand hygiene prior to starting food preparation. During an interview on 10/29/25, at 11:16 a.m., with [NAME] M, [NAME] M stated he did not was his hands prior to starting food prep after washing dishes. During a review of the facility P&P titled, Hand Washing Procedure dated 2023, the P&P indicated, Hand washing is important to prevent the spread of infection. When Hands Need To Be Washed: 1. Before starting work in the kitchen 2. After handling soiled utensils. 8. Touching a trash can or lid. 3. During an observation on 10/27/25 at 12:30 p.m. in the dining room, certified nursing assistant (CNA) H was observed distributing meal trays to residents; CNA H removed food items from the trays, held plates and utensils, and placed the food in front of each resident, and subsequently stacked the trays on the cart. Multiple observations indicated that CNA H did not perform hand hygiene between tasks involving different residents, including Resident 17, Resident 25, Resident 27, Resident 61, Resident 72, Resident 82, and Resident 92. During an interview with CNA H on 10/29/25 at 1:16 p.m., CNA H confirmed that she did not perform hand hygiene between serving food to each resident during lunch on 10/27/25, in the dining room. CNA H indicated that she should sanitized her hands between tasks for each resident to ensure proper sanitation. During an interview with the infection control preventionist (IP) on 10/31/25 at 2 p.m., the IP stated that staff are required to perform hand sanitization prior to handling food plates and utensils between tasks for each resident in order to prevent the transmission of any diseases from one resident to another. A review of the facility's policy and procedure (P&P) titled, Hand Washing Procedure, dated 2023, the P&P indicated when hands need to wash, Before and after handling foods with hands . FDA Food Code 2022 Chapter 2. Management and Personnel, 2-301.14 indicated, When to Wash. (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing task.		

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 11/05/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was below 5%. The facility had the medication error rate of 13.11% when 8 medication errors occurred out of 61 opportunities observed during the medication administration observation for 4 out of 12 sampled residents (Residents 39, 65, 75, and 87). Residents 75 and 87 received their medications 4 hours before scheduled time, which had the potential for adverse effects such as medications being given too close together from the previous dose or medications not given as intended (such as before bedtime to help sleep). Resident 39 received the incorrect priming (a required safety check to ensure the pen and needle work properly) of the insulin pen (a pre-filled pen containing insulin - medication to lower blood sugar). For Resident 65, the nursing staff did not prime her insulin pen before administering an insulin dose. The failure had the potential for adverse effects such as too low or high blood sugar.1. On 10/27/25 at 3:15 PM, in the Station 2 Medication Room, Licensed Vocational Nurse (LVN) A was observed preparing medications for the residents in Station 2. She stated she is preparing medications for all residents who have medications scheduled at 5 PM at this time, and will prepare medications that are scheduled at 7PM at a later time. On 10/27/25 at 4:39 PM, Resident 87 was observed in front of the Station 2 Nursing Station waiting to take his medications. There were 7 pills of medications inside a small plastic cup which LVN A handed to the resident to take. During the reconciliation of Resident 87's medications against the physician's orders, on 10/27/25 at 5:25 PM with LVN A, it indicated only 5 medications were due (scheduled) at 5 PM. LVN A stated two additional medications, 1 tablet of atorvastatin (medication to treat hyperlipidemia - high lipids in the blood) 20 milligrams (mg, unit of measurement) and 1 tablet of olanzapine (antipsychotic medication to treat mental health conditions) 20 mg, were due at 9PM but she administered them during the 5 PM medication pass because the resident wanted them all at the same time. LVN A acknowledged the physician's orders indicated to give them at 2100 (9 PM), not at 5 PM. A review of Resident 87's physician's orders included the following:a. Atorvastatin 20 mg, give 1 tablet by mouth at bedtime for hyperlipidemia, dated 9/3/23. It was scheduled to be administered daily at 2100 (9 PM). b. Zyprexa (olanzapine) 20 mg, give 1 tablet by mouth at bedtime for episodes of non-factual statements related to schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior), dated 4/6/23. It was scheduled to be administered daily at 9 PM. 2. On 10/27/25 at 4:40 PM, Resident 75 was observed standing in front of Nursing Station 2 waiting to take his medications. LVN A was observed removing a medication cup containing 5 different medications from the medication cart and handed it to Resident 75. During the reconciliation of the observed medications against the physician's orders with LVN A on 10/27/25 at 5:20 PM, Resident 75's clinical record indicated only 1 medication was due at 5 PM; the other 4 medications were due at 9 PM. They included 2 capsules of lithium (medication to treat mental illness) 300 mg, 1 tablet of haloperidol (an antipsychotic) 10 mg, 1 tablet of Risperdal (an antipsychotic) 3 mg, and 1 tablet of benztropine (medication to prevent abnormal movement disorder) 1 mg. LVN A stated, When he [Resident 75] goes to bed, he will go to sleep so he doesn't take any more. LVN A acknowledged these 4 medications were ordered to be administered at 9 PM. A review of Resident 75's physician orders included the following:a. Lithium 600 mg, give 1 capsule by mouth at bedtime for episodes of abrupt changes in behaviors, dated 4/30/24; it was scheduled daily at 9 PM.b. Benztropine 1 mg, give 1 tablet two times daily for extrapyramidal symptoms (involuntary abnormal movements), dated 11/21/22; it was scheduled daily at 9 AM and 9 PM.c. Haloperidol 10 mg, give 1 tablet two times a day for paranoid schizophrenia, dated 6/12/25; it is scheduled daily at 9 AM and 9 PM.d. Risperdal 3 mg, give 1 tablet two times a day for paranoid schizophrenia, dated 4/30/24; it was scheduled daily at 9 AM and 9 PM. During an interview with the Director of Nursing (DON) on 10/28/25 at 10:48 AM, she stated routine medications are to be administered 1 hour before and 1 hour after scheduled time, and nurses are to prepare medications for (continued on next page)		

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 11/05/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one administration at a time, such as nurses can prepare medications at 7 AM for 9 AM administration only. A review of the facility's policy and procedures (P&P) titled, Preparation and General Guidelines, reviewed on 6/1/2025, indicated: Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before and after meal orders, which are administered based on mealtimes. Medications are administered in accordance with written orders of the attending physician. A review of the facility's undated P&P titled SPECIFIC FACILITY MEDICATION ADMINISTRATION PROCEDURE FOR INSPIRE BEHAVIORAL HEALTH SAN [NAME], indicated: 1. Licensed Nurse prepare medications via pre pouring following accurate order (Physician order) and infection control. 2. Licensed Nurse will only prepare medications for the next administration (i.e. start pre pour for 9 am medication at 7 am and pre pour medication for 5 pm at 3 pm) 3. During a medication administration observation on 10/28/25 at 11:53 AM, in the Treatment Room with Registered Nurse (RN) B and Resident 39, RN B was observed pricking Resident 39's left middle finger to obtain a blood sample for blood sugar (BS) measurement. The BS reading was 120. RN B stated the resident had an order to receive 6 units of Novolog (a rapid-acting insulin). On 10/28/25 at 11:59 AM, RN B was observed removing Resident 39's Novolog Flexpen from the medication tray, removed the pen cap, wiped the rubber stopper with an alcohol swab, attached a new needle on the pen, and dialed the dose selector to 2 units. Then she pressed on the push-button at the end of the pen to release the insulin into a cup. Then she removed the needle that she had just primed and replaced it with a new needle. Then she dialed the dose selector to 6 units and proceeded to inject the insulin into the resident's abdomen. RN B was observed removing the needle as soon as she clicked the push-button to give the injection. In other words, she did not hold the pen in the skin for any amount of time. During an interview post medication administration, on 10/28/25 at 12:15 PM, when asked to explain how she primed the Novolog pen, she stated she primed the pen with 2 units of insulin and replaced the needle after it was primed. As for how long to hold the needle in place during the injection, she stated Less than 15 seconds? On 10/28/2025 12:20 PM, a review of the manufacturer's instruction video on how to administer Novolog Flexpen (https://www.novomedlink.com/diabetes/products/treatments/novolog/dosing-and-administration.html) with RN B indicated to prime the pen and needle with 2 units, press the push-button till it turns to zero, then dial the dose selector to the units you need to inject. As for giving the injection, the instruction video indicated to inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. Keep the needle in the skin for a least 6 seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. After the video viewing, RN B stated, Oh so you don't change the needle after priming. She also acknowledged she did not hold the pen in place for at least 6 seconds as required. A review of Resident 39's clinical record indicated an order, dated 8/27/25, for NovoLOG FlexPen. 100 UNIT/ML [unit of insulin per milliliter]. inject 6 unit subcutaneously before meals for diabetes mellitus. 4. During another medication administration observation with RN B in the Treatment Room with Resident 65, on 10/28/25 at 12:05 PM, RN B was observed pricking Resident 65's left ring finger to obtain a blood sample for BS measurement. The BS reading was 157 (high). RN B stated the resident will need 1 unit of insulin based on the physician's order. On 10/28/25 at 12:09 PM, RN B was observed removing Resident 65's Admelog SoloStar pen (a pre-filled pen containing a rapid-acting insulin) from the medication tray, removed its cap, wiped the rubber stopper, attached a new needle, dialed the dose-selector to 1 unit, and injected into Resident 65's right upper arm. RN B did not prime the needle before administering the dose. She held the pen in the skin for about 1-2 seconds before removing it. During an interview post medication administration, on 10/28/25 at 10/28/2025 12:18 PM, RN B acknowledged she did not prime the Admelog Solostar before administering the dose to Resident 65, and did not hold the pen in long enough during the injection. A review of Resident 65's clinical record indicated a physician's order, dated 3/21/25, for Admelog Injection Solution 100 UNIT/ML, inject subcutaneously before meals and at bedtime for insulin sliding scale (set of (continued on next page)		

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 11/05/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructions for administering insulin dosages based on specific BS readings) related to diabetes mellitus.During an interview with the DON on 10/28/25 at 2:19 PM, she stated insulin pens need to be primed before each injection. A review of the Admelog Solostar's Instructions for Use, revised 2019, indicated: Step 3: Do a safety testAlways do a safety test before each injection to:Check your pen and the needle to make sure they are working properlyMake sure that you get the correct insulin dose. 3A. Select 2 units by turning the dose selector until the dose pointer is at the 2 mark.3B. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly.If no insulin appears:You may need to repeat this step up to 3 times before seeing insulin. Step 4: Select the dose. 5D. Keep the injection button held in and when you see '0' in the dose window, slowly count to 10 This will make sure you get the full dose.A review of the facility's 9/2014 P&P on Insulin Administration, provided by the DON on 11/3/25, indicated it did not address the process for insulin pen administration.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/05/2025
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)		
F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observation and interview, the facility failed equip the corridors with firmly secured handrails when the handrail in the hallway across from a resident room (Hallway B). This failure had the potential to adversely affect the health and safety of the residents in the area that use the handrail. During an observation on 10/27/25 at 12:19 PM, the handrail in Hallway B was observed to be loose. An indent in the dry wall was seen where the handrail is supposed to be attached to the wall. During a second observation on 10/29/25 at 12:19 PM, the handrail in Hallway B was observed still to be loose. During an interview with the maintenance person (MAIN) on 10/29/25 at 1:13 PM, the MAIN confirmed the handrail in Hallway B was not supposed to be loose. The MAIN also said he would repair the handrail right away.		

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 11/05/2025
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)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely notify a representative of the Office of the State Long-Term Care Ombudsman (an entity that serves as an impartial advocate for individuals or groups who have concerns or complaints about a particular organization) regarding discharges for one of one sampled resident (Resident 121). The facility faxed discharge notices on the day of discharge. This failure resulted in missed opportunities for an ombudsman to advocate if residents had concerns about their discharge. Findings: A Review of Resident 121's facesheet (A facesheet is a summary document containing a Resident's personal and demographic information, including contact details and medical history) indicated the resident was admitted on [DATE] with diagnoses including Schizoaffective disorders (a mental health condition that's is marked by a mix of schizophrenia [a serious mental health condition that affects how people think , feel and behave] symptoms such as hallucination [an experience involving the apparent perception of something not present] and delusions [a fixed, false beliefs that's persist despite evidence to the contrary and are disconnected from cultural or religious norm] , and mood disorder symptoms), other Stimulant Dependence (continued use of stimulant that leads to significant impairment or distress), Depression (a mood disorder that cause a persistent feeling of sadness and loss of interest), Anxiety disorder (involve more than occasional worry or fear.). Further review of Resident 121's progress notes indicated he was discharged to board and care /assisted living/group home on 8/6/25. A review of resident 121's NOTICE OF PROPOSED TRANSFER /DISCHARGE the resident was provided the discharge notice on 7/30/25, with the discharge effective date on 8/6/25. A review of the fax transmission document sent to the office of the State LTC Ombudsman dated 8/7/25 indicated ,THE FOLLOWING Data Could not be sent. PLEASE GIVE THIS TRANSACTION REPORT TO SENDER. During a concurrent interview and record review with Social Services Director (SSD) on 11/3/25 at 10:39 a.m., the SSD verified that the discharge notice for Resident 121 was dated 8/6/25, and a copy of the notice to the Ombudsman faxed on 8/7/25 did not go through. The SSD further stated she forgot to verify the notification showing it was not sent. The facility faxed the Notice of Proposed Transfer and Discharge to the Ombudsman's office during the facility's annual recertification survey on 11/3/25. During an interview with the Director of Nursing (DON) on 11/4/25 at 11:28 a.m., the DON stated they need to follow the Federal /State regulation of notifying the Ombudsman's office regarding discharge. During an interview with the Administrator (ADM) on 11/4/25 at 9:44 a.m., the ADM stated for planned discharge the social services will notify everybody, including MD (doctor), RP (responsible party) and Ombudsman. The ADM also stated, she usually follow up the next the morning if the notice was sent.		

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 11/05/2025
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)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed assess for the need of a transfer pole for two out of two residents (Residents 9 & 81). These failures had the potential to put the residents at risk for entrapment and serious injury. Review of Resident 9's clinical record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder (a mental disorder that causes individuals to hear and see things that are not there), conversion disorder with seizures or convulsions (a mental disorder that causes medical symptoms in individuals with no explanation), neuroleptic induced Parkinsonism (a disorder of the musculoskeletal system caused by certain medications), and history of falling. Review of Resident 9's minimum data set (MDS, a required assessment done by skilled nursing facilities) Section GG (for functional abilities) indicated Resident 9 was marked for using a wheelchair as an assistive device, with level of function marked as 3- Partial/moderate assistance-Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or limbs, but provides less than half the effort. Review of Resident 9's clinical record indicated there was no documentation on the use of a transfer pole for her. Review of Resident 81's clinical record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses of Schizoaffective Disorder, prediabetes (the stage before a person develops full diabetes, which is a disorder that affects the regulation of blood sugar levels), and other hyperlipidemia (a disease that increase the levels of fats in the blood). Review of Resident 81's MDS Section GG indicated Resident 81 was marked for using a wheelchair as an assistive device, with level of function marked as 6-Independent-Resident completes the activity by themselves with no assistance from a helper. Review of Resident 81's clinical record indicated there was no documentation on the use of a transfer pole for her. During an observation on 10/27/25 at 12:31 PM, Resident 81 was seen in her room sitting in a wheelchair near her bed. A transfer pole was observed on the left hand side of resident's bed. During an observation on 10/27/25 at 12:43 PM, Resident 9 was seen in her room sitting up in her bed. A transfer pole was observed on the left hand side of the resident's bed. During an interview with certified nursing assistant (CNA) G on 10/27/25 at 12:52 PM, CNA G said both Resident 9 and Resident 81 had the transfer poles in their rooms for as long as he can remember. During a concurrent interview and record review with the director of nursing (DON) on 10/30/25 at 3:29 PM, the DON confirmed that there was no documentation on the use of the transfer poles for both Resident 9 and Resident 81. The DON also said Currently, we do not have a document to document on the use of a transfer pole, and that this is something that needs to be included in PCC [point click care, an electronic health record software]. Review of facility policy titled Proper Use of Side Rails, revised October 2010, indicated .An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: Bed mobility; and Ability to change positions, transfer to and from bed or chair, and to stand and toilet. The use of side rails as an assistive device will be addressed in the resident care plan.		

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 11/05/2025
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)		
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure three residents (Resident 52, Resident 83, & Resident 95) received their therapeutic diet (specialized meal plan designed to treat or manage specific medical conditions) as ordered by the Registered Dietician and Physician when Resident 52, Resident 83, & Resident 95 did not receive their fortified item during lunch tray line. This failure had the potential for Resident 52, Resident 83, & Resident 95 to not receive their total calories as ordered in their diet, which could contribute to weight loss overtime. During a review of the facility Fortified Lunch Menu dated 10/29/25 indicated, fortified item (foods prepared or modified to meet the increased nutritional needs of residents in a skilled nursing facility, ensuring they get more calories and protein than they might from standard foods) was 1.2 ounce melted margarine. During a record review of Resident 52's meal tray ticket 10/29/25, at 12:03p.m ticket indicated, Fortified. During an observation of lunch tray line in the kitchen on 10/29/25, at 12:03p.m., staff were observed to plate Resident 52's lunch tray and place it on the cart without adding the fortified item. During an interview with the Certified Dietary Manager (CDM) on 10/29/25, at 12:03p.m, the CDM stated Resident 52's tray did not have the fortified item. The CDM stated, she would add the item to the tray. During a record review of Resident 83's meal tray ticket 10/29/25, at 12:03p.m ticket indicated, Fortified. During an observation of a lunch tray line in the kitchen on 10/29/25, at 12:03p.m., staff were observed to plate Resident 83's lunch tray and place it on the cart without adding the fortified item. During an interview with the CDM on 10/29/25, at 12:03p.m, the CDM stated Resident 83's tray did not have the fortified item. The CDM stated, she would add the item to the tray. During a record review of Resident 95's meal tray ticket 10/29/25, at 12:03p.m ticket indicated, Fortified. During an observation of a lunch tray line in the kitchen on 10/29/25, at 12:21p.m., staff were observed to plate Resident 95's lunch tray and began to serve him in the dining room without adding the fortified item. During an interview with the CDM on 10/29/25, at 12:03p.m, the CDM stated Resident 95's tray did not have the fortified item. The CDM stated, she would add the item to the tray. During an interview on 10/29/25, with the Registered Dietician (RD), the RD stated, it is his expectation that all residents receive the diet ordered to them for each meal.		

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 11/05/2025
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain equipment and environment in safe operating and sanitary condition when a toilet paper holder was left open in one resident bathroom (Resident Bathroom A). This failure had the potential to adversely affect the health and safety of the residents in Resident Bathroom A. During an observation on 10/27/25 at 8:59 AM, the toilet paper holder in Resident Bathroom A was seen open, with the toilet paper exposed. During a second observation on 10/29/25 at 10:58 AM, the toilet paper holder in Resident Bathroom A was still seen open as during the first observation. During an interview with the maintenance person (MAIN) on 10/29/25 at 1:13 PM, the MAIN confirmed the toilet paper holder in Resident Bathroom A was open and supposed to be closed.		