STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055435	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Saratoga Skilled Nsg & Assisted Lvg	20400 Saratoga-Los Gatos Rd Saratoga, CA 95070

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to timely suspend two certified nurse assistants (CNA) who had an allegations of resident mistreatment in accordance with their abuse policy for two of two sampled residents (Residents 1 and 2). This failure had the potential to place residents at risk for further mistreatment should the allegation be proven.Findings:1.Review of Resident 1's Nurses Notes, dated 5/17/25 at 1:50 p.m., indicated the resident reported CNA A and told Resident 1 to shut up and mind your own business on 5/16/25. The same note indicated Resident 1 stated there were a few other times when the resident was verbally disrespected by the same CNA A and she felt belittled.During an interview on 7/2/25 at 12:29 p.m., the registered nurse (RN) B stated when she learned about Resident 1's allegation she did not suspend CNA A.2.Review of Resident 2's Nurse's Notes, dated 6/13/25 at 6:47 p.m. indicated the resident reported to therapy staff that she was punched and poked on the sides of her abdomen while being changed by CNA B when Resident 2 cannot urinate past 11 p.m.During an interview on 7/3/25 at 12:15 p.m., licensed vocational nurse C (LVN C) stated when she received a message from a therapist regarding the above incident, she changed the assignment and did not suspend the CNA B.During an interview on 7/31/25 at 10:50 a.m., the director of staff development (DSD, person who develops training programs and onboards new staff) stated when a staff member was accused of abusing a resident, licensed nurses were take a statement from the staff member, report the incident and send the staff member home immediately.Review of the Abuse, Neglect or Misappropriation - Report and Investigating policy, revised September 2024, indicated any employee who was accused of resident abuse was to be placed on leave with no resident contact until the investigation was complete.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to meet professional standards of care when staff did not intervene for a resident who was known to feed a roommate with swallowing problems (Residents 1 and 2). For Resident 3 she was not adequately monitored to prevent elopement and there was no policy addressing wander guard (alarm device such as a wrist band that sound when a person exits) maintenance and function for two of four sampled residents (Residents 1, 2 and 3). These failures placed residents at health and safety risk.Findings:1. Review of Resident 2's face sheet (document summarizing a resident's essential medical information) indicated she had diagnoses including dysphagia (difficulty swallowing food or liquid) and dementia (group of thinking and social symptoms that interferes with daily function). Her Minimum Data Set (MDS, an assessment tool, dated 4/18/25, indicated Resident 2 had severe problems with daily decision-making skills.Resident 2 had a physician's order, dated 6/5/25, indicating specific feeding instructions to provide close supervision, assist with cutting items, palpate (touch) resident while giving solids to ensure initiation of swallow, provide verbal cues as needed, slow rate, small bolus (amount) and ensure resident is awake and alert.During an interview on 7/30/25 at 12 noon, the speech language pathologist (SLP, healthcare professional who diagnoses and treats people with communication and swallow disorders) stated Resident 2 required one on one supervision to eat safely, needed to be alert during meals and was at medium risk for aspiration (inhalation of food or liquid into the lungs).Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 3/27/25, indicated the resident had moderate difficulty with daily decision-making skills.During an interview on 7/2/25 at 6:20 p.m., the CNA A stated he witnessed Resident 1 trying to feed her roommate (Resident 2) a lot and also gave Resident 2 fluids.During an interview on 7/3/25 at 12:14 p.m., CNA F stated Resident 1 fed Resident 2 about two to three times a week since they became roommates and did not report it to the charge nurse.Review of Resident 1's record indicated there was no care plan developed addressing Resident 1's behavior of feeding other residents until requested on 7/2/25. During an interview on 7/3/25 at 12:10 p.m., LVN C stated she had heard about Resident 1 feeding Resident 2 once or twice and did not do anything.During an interview on 7/3/25 at 12:58 p.m., LVN D stated she heard Resident 1 fed and applied lotion to her roommate and she informed the social worker to have residents change rooms.Review of Resident 1's Census list form indicated the resident resided in Room A from 4/26/25 to 6/20/25.Review of Resident 2's Census list form indicated the resident resided in Room A from 4/28/25 to 7/1/25.During an interview on 7/30/25 at 10:35 a.m., the director of nurses (DON) stated residents were not allowed to feed other residents and there should have been a room change between the two residents and the room change did not occur and there was no policy addressing who could feed residents. Review of Resident 2's hospital Discharge summary, dated [DATE] at 9:03 p.m., indicated the resident was being treated with a diagnosis including aspiration pneumonia (type of lung infection caused by inhaling something other than air into the lungs).2. Review of Resident 3's face sheet indicated the resident had diagnoses including dementia. Resident 3's MDS, dated [DATE], indicated the resident had severe problems with daily decision-making skills.During an interview on 7/2/25 at 11 a.m. licensed vocational nurse (LVN) C stated Resident 3 was confused, always walking around the facility, looking for exits, and she wandered into other resident rooms about once every shift (8 hours).During an interview on 7/3/25 at 1:30 p.m., LVN D stated Resident 3 was very confused especially in the afternoon after 4 p.m. and she wandered into other resident's rooms.Review of Resident 3's Nurse's Note, dated 3/16/25 at 8:05 a.m., indicated the resident was brought back to her room three times, she was peeking into other resident's rooms, and she had suddenly swiped food from another resident's room and explanation was given to a family member. There was no care plan developed addressing Resident 3's behavior of wandering into other resident rooms.Review of Resident 3's Change in Condition Evaluation (CICE), dated 4/6/25 at 4:01 p.m., indicated a staff reported a family member saw Resident 3 walking outside the facility and was found on Oak Street and brought back to St [NAME] Station.Review of Resident 3's Elopement Evaluation note, dated 4/10/25 at 2:32 p.m., indicated the resident had a history of elopement at home, had wandering behavior likely to affect safety or well-being of self and others and was identified to be at high risk for elopement. A plan was made to apply personal safety alarm device (wander guard), document specific behaviors on the behavior log, monitor location frequently and to notify staff. A care plan was developed on 4/10/25 addressing Resident 3's elopement an approach to monitor resident whereabout, especially during meals, shift changes, or when visitors were presentThere