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	08/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 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 observation, interview and record review the facility failed to ensure a resident received adequate supervision to prevent an elopement for one of three sampled residents (Resident 1) when Resident 1 eloped and found on the street after being monitored by the nursing staff.This failure placed residents at risk for further elopement. Findings: Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 8/6/24, indicated the resident had severe impairment in daily decision-making skills.Review of Resident 1's Nurse's Note, dated 6/22/25 at 2:43 p.m., indicated the resident was alert with confusion, had an episode of going to another resident's room, and tried to awaken a resident by touching and shaking.Review of Resident 1's care plan, dated 6/22/25, indicated to monitor behavior of going to other resident room, with an approach to redirect resident to her room or activity room. On 6/24/25, a care plan was developed addressing the resident was at risk for elopement/wandering related to dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with an approach to monitor whereabouts frequently and the care plan did not specify how often to monitor. On 6/30/25, another care plan was developed indicating a wander guard (device to put on the resident to prevent elopement) was placed on Resident 1's right wrist to alert staff when resident attempted to leave alarmed exits.Review of the Nurse's Note, dated 8/5/25 at 7:25 p.m., indicated around 6:20 p.m., the resident was missing greater than 15 minutes. Around 8:30 p.m., a staff found the resident on the ground in a parking lot across a bookstore, was noted to have a bump on her forehead, abrasion on left knee, and bruise on left elbow.Review of the Interdisciplinary Team (IDT, members of health team that meet to discuss and plan resident care) Note, dated 8/6/25 at 1:59 p.m., indicated the resident was unable to recall the incident, walked, independently, and had poor safety awareness. It indicated to ensure the resident was wearing an active wander guard, and approaches to monitor hourly with frequent checks, and change room near a nursing station were noted. During an interview on 8/14/25 at 12:25 p.m., Resident 1 did not respond when she was asked about her elopement.During an interview on 8/18/25 at 1:20 p.m., the Director of Nurses (DON) who reviewed the record stated the resident was not placed on hourly or more frequent monitoring until after the elopement (8/6/25) because she did not have behavior of trying to leave and she did not think the resident would elope. On 8/18/25 at 3 p.m., an interview and tour of the facility was conducted with the maintenance director (MD). The MD stated he reviewed the facility's cameras for about six hours to figure out how Resident 1 eloped, she exited from the assisted living second floor (AL2) and walked along the building because she was found near a bookstore in that direction. The tour included the path from Resident 1's unit to the exit outside the facility (AL2); from St [NAME] Unit to St [NAME] Unit, to AL2, which had five turns in the facility. The MD then confirmed there were no alarms at St [NAME], St [NAME] and AL2. The MD stated on 8/7/25 (day after elopement), a wander guard alarm was installed to the exit door of AL2. The path to where Resident 1 exited showed the final turn in AL2 was a long hallway where assisted living residents resided. The AL2 door led to a concrete stairway with a landing in the middle of stairs, at the bottom of the stairs to the left was a metal grate approximately three feet in height, and to the left was the ALS building in a forest like secluded setting with redwood trees that led to a side street. The MD stated Resident 1's elopement path in the building was about five blocks long. The path along the building from AL2 to the street was at least two city blocks in length. Resident 1's wander guard alarm did not sound during elopement because there were no installed alarms at where she walked.During an observation at the time of the tour on 8/18/25 at 3 p.m., the alarm to AL2 was activated and it took four minutes and 45 seconds for the assisted living supervisor (ALS) to respond. The MD then acknowledged the response time was long. During an interview on 8/18/25 at 3:19 p.m., the ALS stated some skilled nursing facility residents dine and attend activities in AL2, she did not know which resident were confused, and if a confused resident asked for help we call the nurse's station.Review of the facility and assisted living floorplan with the MD on 8/20/25 at 4 p.m. indicated there were eleven exits outside the facility, and five exits to the first floor of assisted living were not alarmed.During an interview on 8/20/25 at 4 p.m., the assistant director of nurses (ADON) stated any exit door for a confused resident was not safe and the nursing staff should have monitored the residents to prevent elopement.Review of the Elopement policy, revised April 2021, did not provide guidance for what to do to prevent elopement.