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	03/03/2026

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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure to develop and implement a person-centered care plan (an individualized, collaborative document that focuses on a resident specific needs, goals, preferences and values) for speech therapy (ST, a specialized healthcare service that diagnoses and treat communication, language, cognitive, and swallowing disorders for residents) for one of 3 sampled resident (Resident 1). This failure had the potential to result in not meeting Resident 1's plan of care needs. Findings:Review of Resident 1's face sheet (FS, a document that provides resident's information at quick glance) indicated Resident 1 was admitted to facility on 10/23/2025.Review of Resident 1's diagnoses included parkinsonism (a condition characterized by slow body movements, stiffness, balance issues and resting tremors (shaking), spasmodic torticollis (a painful, chronic disorder causing involuntary contractions [a sudden, involuntary tightening of muscles, causes pain, stiffness, and reduced movement] of the neck muscles).Review of Resident 1's order review history report indicated an order for ST 3x/week (3 times per week) x 4 weeks for PO (by mouth) trails, education on aspiration (accidental swallowing of food, liquid or saliva into the lungs [[a pair of spongy body organ, primary function for breathing]) precautions, swallow compensatory strategies., ordered, dated 11/7/2025, and discontinued, dated 12/6/2025.Review of Resident 1's ST notes indicated Resident 1 received ST services 3x/week for 4 weeks as ordered above.Review of Resident 1's clinical documentation indicated there was no documented evidence of person-centered care plan for ST services.During a concurrent record review of Resident 1's orders, all care plans and interview with facility's director of rehabilitation (DOR) on 2/25/2026 at 1:20 p.m., DOR confirmed Resident 1 received ST for 4 weeks as ordered. DOR also confirmed there was no person-centered care plan for ST for Resident 1. DOR stated Resident 1 should have a care plan for ST when received ST services. DOR also stated therapy staff should have developed and implemented a care plan for ST for Resident1.During an interview with facility's director of nursing (DON) on 2/25/2026 at 2:56 p.m., DON confirmed there was no care plan for ST for Resident 1. DON stated therapy staff should have developed and implemented a person-centered care plan for ST when Resident 1 received ST.Review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, The interdisciplinary team (IDT, a group of healthcare professionals work together to ensure all aspect of resident's health and care been addressed), in conjunction with the resident and his /her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: receive the services and/or items included in the plan of care; and.

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	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 to provide safe environment to prevent the risk for accident hazard in one of 3 sample resident room (room [ROOM NUMBER]) and in oxygen (O2, colorless, odorless, and tasteless gas essential for life) supplies storage room when: One emergency oxygen tank (E tank, a heavy, portable, and high pressure metal cylinder containing pure medical-grade O2) on floor, free standing, and not secured in a sturdy portable cart (a mobile, wheeled device designed for the quick, safe transport of E tank and prevents accidents by securely holding when not in use) when not in use in room [ROOM NUMBER];Cluttered and not organized O2 supplies storage room in Building 1 with E tanks on floor, free standing, not secured in a portable cart and several room air concentrators (RAC, a medical device that draws in room air, filters and provides purified O2) on floor. Above failures had the potential for accident hazard with or without injury and safety for residents in room [ROOM NUMBER] and staff in facility.Findings:During facility rounds on 2/25/2026 at 12:39 p.m., observed one E tank was not in use, left on the floor in a corner in room [ROOM NUMBER]. Noted this E tank was free standing, not secured in a portable cart.During an interview with facility's license vocational nurse A (LVN A) on 2/25/2026 at 12:42 p.m., LVN A confirmed E tank was not in use, not secured in a cart, left on floor in room [ROOM NUMBER]. LVN A stated E tank should be secured in a metal portable cart for safety when not in use for safety.During observation of facility's storage room for oxygen supplies in Building 1 along with license vocation nurse A (LVN A) on 2/25/2026 at 12:45 p.m., we both observed this storage room was cluttered and unorganized with E tanks, and several RAC machines along with attached long electric cords on the floor. We both also observed 5 E tanks were on floor, free standing, not secured in a portable cart or in a metal rack. Clean and used oxygen equipment storage areas were not separated in this room. During an interview with LVN A on 2/25/2026 at 12:50 p.m., LVN confirmed above observations of unsecured E tanks, and unorganized oxygen supplies in storage room. LVN A stated all 5 E tanks should be placed in a metal rack or in a portable stand for safety. LVN A also stated this room should organized with oxygen supplies to have safe access for staff in an emergency situations.During an interview with director of nursing (DON) on 2/25/2026 at 3:00 p.m., DON stated nursing staff should not left E tanks without stored in a cart or on the floor in resident's room when not in use. DON also stated nursing staff were responsible to place E tanks in a cart or in a rack in storage room when not in use for safety. DON further stated oxygen supplies storage room in Building 1 should be organized and clean and dirty equipment storage areas separated for staff to have access for clean oxygen equipment safely when needed to use for residents.Review of facility's policy and procedure (P&P) titled, Fire Safety and Prevention, revised May 2011, the P&P indicated, Keep all storage rooms clean at all times. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure to maintain standard infection prevention and control practices to prevent the spread of infections when: 1.Unlabeled wash basins left on floor in resident's bathroom and in sink;2.Clean and used equipment storage areas were not separated in oxygen (O2, colorless, odorless, and tasteless gas essential for life) supplies storage room;3.House Keeping staff did not perform hand hygiene after removed gloves. These failures had the potential for all currently residing 84 residents in facility at increased risk of healthcare-associated infections. Findings:1.During an observation on 2/25/2026 at 10:13 a.m., noted two unlabeled wash basins (a plastic basin used for personal care for residents) left next to sink on floor in room [ROOM NUMBER]'s bathroom and one unlabeled wash basin left in sink in Room1.During room [ROOM NUMBER] observation on 2/25/2025 at 10:20 a.m., noted one unlabeled wash basin left in sink in room [ROOM NUMBER].During an interview with certified nursing assistant B (CNA B) on 2/25/26 at 10:25 a.m., CNA B acknowledged above observations. CNA B stated above wash basins currently were in use for residents. CNA B stated wash basins should labeled with resident's name when bathroom and resident room sharing between multiple residents. CNA B also stated wash basins should not be left on floor on in sink when not in use. CNA B further stated nursing staff should have been cleaned wash basins and stored in a resident's closet after each use to prevent risk for using for unassigned resident and spreading infection between residents. During an interview with facility's infection preventionist (IP) on 3/3/2026 at 12:03 p.m., IP stated resident's care items including wash basins should be labeled with resident's name before started using and store in a plastic bag in resident's closet when not in use to prevent the risk for spread of infection between residents. 2. During a concurrent observation of O2 supplies storage room in Building 1and interview with license vocational nurse A (LVN A) on 2/25/2026 at 2/25/2026 at 12:45 p.m., both observed storage room was cluttered and unorganized with multiple free standing emergency O2 tanks (E tank, E tank, a heavy, portable, and high pressure metal cylinder containing pure medical-grade O2) were on floor and multiple room air concentrator (RAC, a medical device that draws in room air, filters and provides purified O2) machines along with attached long electric cords on the floor. We both also noted there was no sign or area dedicated storage area for clean and used equipment in this room. LVN A stated unable to identify clean from used (need to sanitize before reuse for residents) O2 equipment since they were not separated and there was no sign posted in this room for clean and used equipment storage area. LVN A stated nursing staff should be organized all O2 supplies and separated clean from used equipment at dedicated area to follow standard infection control practices.During an interview with facility's IP on 2/25/2026 at 2:22 p.m., IP stated O2 supplies storage room should be cleaned, organized, and used equipment storage area separated from clean equipment area. IP also stated clean oxygen equipment should be placed in a plastic bag to store to protect from dust. IP further stated clean and used equipment storage area sign should have been posted in this area for infection control. 3.During an observation on 2/25/2026 at 1:10 pm., noted housekeeping C (HK C) staff came out of the room [ROOM NUMBER] with gloves on both hands. HK C doffed (removed) both gloves, opened housekeeping cart cabinet door with her right hand and closed while holding doffed (dirty gloves) in her left hand. HK C taken cell phone with her right hand from her uniform's pocket, doffed gloves placed in her uniform's pocket with her left hand. HK C did not perform hand hygiene after removed gloved During an interview with HK C on 2/25/2026 at 1:15 p.m., HK C confirmed above observation. HK C stated she should have discarded removed gloves and washed her hands before reached out to housekeeping cart and cell phone.During an interview with facility's IP on 2/25/3026 at 2:22 p.m., IP stated all staff should perform hand hygiene before and after use of gloves and in between tasks for infection control practice. Review of facility's policy and procedure (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, revised June 2011, the P&P indicated, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge.Review of facility's P&P titled, Fire Safety and Prevention, revised May 2011, the P&P indicated, Keep all storage rooms clean at all times, Store oxygen in clean, dry location. Tag or properly label all oxygen cylinders to indicate the contents of the cylinders. (i.e., full, half-full, empty, etc). Use plugs, caps and plastic bags to protect equipment not in use from dust and dirt.Review of facility's P&P titled, Handwashing/Hand Hygiene, revised August 2019, the P&P indicated, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for following situations: After removing gloves,

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer pneumonia (PNA, an infection in one or both lungs [a pair of spongy organs in the chest that serve as the main components for breathing], that can cause mild to serious illness) vaccine (substance that making body stronger against specific harmful germs) timely for one of five sampled resident (Resident 2). This failure had the potential to negatively affect Resident 2's health and well-being.Findings:Review of Resident 2's clinical record indicated Resident 2 was admitted to facility on 6/2/2021 with diagnoses including congestive heart failure (a chronic and progressive condition where heart muscle too weak to pump blood efficiently, causing fluid to back up into the lungs), chronic kidney (bean shaped organ, that filters waste products from blood to produce urine) disease (a long-term, progressive condition often irreversible loss of kidney function), and hypertension (high blood pressure).Review of Resident 2's immunization audit report indicated Resident 2 received PCV 13 (Prevnar 13, type of PNA vaccine) on 1/13/2019. There was no documented evidence that Resident 2 was offered or received follow up PNA vaccine after received PCV 13.During a concurrent Centers for Disease Control and Prevention (CDC, a federal agency, its core mission to protect public health by controlling and preventing diseases, injury and disability)'s PNA vaccine recommendations and interview with facility's infection preventionist (IP) on 3/3/2026 at 1:01 p.m., IP confirmed CDC recommended one dose of PCV 20 (type of PNA vaccine) or one dose of PVC 21(another of type of PNA vaccine) at least one year after received last PCV 13. IP also confirmed facility did not offer or provide any one those PNA vaccine for Resident 2 as recommended by CDC after Resident 2 received PCV 13 on 1/13/2019. IP stated Resident 2 should have offered and received either PCV 20 or PCV 21 one year after received PCV 13. IP also stated she will offer today for Resident 2.Review of facility's policy and procedure (P&P) titled, Pneumococcal Vaccine, revised March 2022, the P&P indicated, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated.