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	03/16/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure to notify local police, ombudsman (independent official, who advocates residents), and state agency in a timely manner following an allegation of abuse reported by facility's staff member for one out of two sampled resident (Resident 1). This failure had the potential for further abuse and delay implementation of appropriate corrective actions for sampled Resident 1.Findings:Review of Resident 1's face sheet (FS, a document that provides resident's information at a quick glance) indicated Resident 1 was admitted in facility on 4/11/2025.Review of Resident 1's admission diagnoses included dementia (a decline in mental ability such as memory, reasoning, and communication, severe enough to interfere with daily life) and anxiety (persistent and excessive worry and fear of danger).Review of Resident 1's minimum data set (MDS, clinical and functional assessment tool) assessment dated [DATE] indicated Resident 1 had short-term (time period, typically 15-30 seconds) and long-term (time period ranging from hours to a lifetime) memory problem.Review of Resident 1's change of condition (COC, any significant physical, mental or functional condition change from a resident's baseline status) document dated 12/21/2025 indicated, Incident regarding husband, resident, and CNA (certified nursing assistant). Further review of this COC indicated Resident 1's medical doctor (MD) recommended to monitor signs and symptoms for emotional distress for Resident 1 when licensed nursing staff reported above allegation to MD.Review of Resident 1's nurse's notes dated 12/21/2025 indicated, morning shift CNA A reported to licensed vocational nurse C (LVN C) a witnessed an alleged incident of Resident 1's husband made a gestured motion towards the Resident 1's face. Resident 1's husband being rough/upset at the Resident 1 for not sitting in a wheel chair to go to dining hall. This notes also indicated CNA A reported Resident 1 was appeared to be shaken and somewhat fidgeting after the alleged event.Review of Resident 1's all documented person- centered care plans (an individualized, collaborative document that focuses on a resident specific needs, goals, interventions, and preferences) indicated there was a care plan for alleged hand gesture to resident's face, dated 12/21/2025 with interventions.During an interview over the telephone with LVN/supervisor B (LVN/S B) on 2/25/2026 at 2:15 p.m., LVN/S B confirmed above documentation for Resident 1's COC dated 12/21/2025. LVN/S B stated investigation following the abuse allegation indicated no abuse happened to Resident 1, he did not report to necessary entities. LVN/S B also stated not sure facility reported this abuse allegation.During an interview with LVN C on 2/25/2026 at 2:39 p.m., LVN C stated CNA A reported to her of above abuse allegation for Resident 1. LVN C reported this allegation to LVN/S B after separated husband from Resident 1. LVN C stated LVN/S B started the investigation and discussed with facility's administrator (ADMN) and director of nursing (DON) right away. LVN C also stated she was not aware if facility reported this allegation of abuse or not.During an interview with CNA A over the telephone on 2/26/2026 at 10;07 a.m., CNA A stated he witnessed Resident 1's husband pushed Resident 1 to sit in wheelchair (w/c, a mobility device designed for who cannot walk to enabling independence with mobility and transportation) and punched on Resident 1's face near chin area while CNA A was passing by in hallway. CNA A also stated he could see above (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse clearly from hallway. CNA further stated Resident 1's body was shaken and appeared fearful after this incident when CNA A walked in to Resident 1's room to separate husband from Resident 1. CNA A stated what husband did to Resident 1 was an abuse, it should have been reported.During an interview with facility's DON on 3/3/2026 at 2:02 p.m., DON stated based on facility's investigation for abuse allegation indicated there was no abuse happened to Resident 1 and did not report this allegation to ombudsman, law enforcement, and state agency. During a concurrent record review of Resident 1's COC of an allegation on 12/21/2025 and interview with facility's regional administrator (R ADMN) on 3/3/20026 at 3:20 p.m., R ADMN stated he was ADMN for this facility when above allegation happened. R ADMN confirmed he was aware of staff reported an allegation for Resident 1 and her husband. R ADMN stated based on the discretion of allegation's investigation, facility's management considered the allegation was not an abuse and not reported to necessary entities. R ADMN also stated Resident 1's husband was denied the allegation. Review of facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2024, the P&P indicated, 1. If resident abuse, neglect, exploitation, misappropriation of resident's property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.2.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman (an independent, neutral, and resident's advocate); e. Law enforcement officials (government officials including police, responsible for public safety);