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	05/08/2026

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 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 a safe environment when one resident (Resident 1) out of five sampled residents did not receive adequate supervision when Resident 1 was able to leave the facility alone unattended on 4/7/26. This failure resulted in Resident 1 becoming intoxicated due to alcohol consumption while outside the facility and put Resident 1 at risk for physical injury, dehydration, and psychosocial distress. Upon return to the facility, Resident 1 was sent via 911 (emergency services) to acute hospital for evaluation. During an interview on 4/8/26 at 11:03 a.m. with the Director of Nursing (DON), the DON stated Resident 1 left the faciity on 4/7/26 and returned at around 10 p.m. intoxicated (being drunk or under the influence of drugs, where alcohol or substances impair a person's physical and mental abilities). The DON stated Resident 1 was also brought to the hospital to be checked and returned this morning of 4/8/26.During a tour and observation of the facility on 4/8/26 at 12:16 p.m. with the DON, the DON verified:The entrance and exit gate at the back of the facility towards the parking lot and onto the street was unlocked without alarm.The facility doors on the left and right of the gate were also unlocked without alarms.There was no staff supervising the doors and the gate.Multiple doors that open towards the patio and straight to the gate were also unlocked without alarms.There were no staff in the hallways and nurse station in Resident 1's area.During a concurrent observation and interview on 4/8/26 at 12:25 p.m. with Resident 1, Resident 1 was sitting on a chair beside the bed. Resident 1 stated he left the faciity on 4/7/26 at around 12:30 p.m. and nobody saw him or stopped him. Resident 1 also stated he took three bus rides and came back with alcoholic drink.During an interview on 4/8/26 at 1:33 p.m. with Registered Nurse (RN) A, RN A stated she was assigned to care for Resident 1 on 4/7/26 during the morning shift, from 7 a.m. to 3 p.m. RN A stated Resident 1 was wearing Wanderguard (bracelets that trigger door locks or alarms if a resident gets too close to a secured exit) on 4/7/26. RN A also stated it was around 1 p.m. when she noticed Resident 1 did not eat his lunch and started to look for him. RN A stated she did not hear Wanderguard alarm on 4/7/26 and it was supposed to alarm in several places. RN A stated Resident 1 was alert. RN A stated there were unlocked entrance/exit doors that lead to the patio straight to the unlocked entrance/exit gate in Resident 1's area and was not safe for the residents. RN A also stated there were no staff to supervise the exit gate.During an interview on 4/8/26 at 1:46 p.m. with Certified Nurse Aide (CNA) B, CNA B stated she was assigned to Resident 1 on 4/7/26 during the morning shift. CNA B stated she was on her lunch break and stayed in her car from 12:10 to 12:40 p.m. on 4/7/26. CNA stated she told two other CNAs she was going to have her lunch break. CNA B also stated when she came back from lunch to check on Resident 1, Resident 1's lunch tray was still in his room and Resident 1 was not there. CNA B stated she did not hear a Wanderguard alarm on 4/7/26. CNA B also stated entrance/exit doors were always unlocked in Resident 1's area.During an interview on 4/8/26 at 1:51 p.m. with the DON, the DON stated entrance/exit doors were not locked even at night. The DON also verified there were no assigned staff to supervise the doors. The DON stated any alert residents can go in and out of the patio. The DON also stated Resident 1 was very alert.A review of Resident 1's medical record indicated an (continued on next page)

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	admission date of 3/11/26. Resident 1's diagnoses included but were not limited to sepsis due to methicillin resistant staphylococcus aureus (a life-threatening, emergency situation where a stubborn, antibiotic-resistant staph infection spreads into the blood, causing the body's immune system to overreact and damage its own organs); essential [primary] hypertension; difficulty in walking, not elsewhere classified; bipolar disorder, unspecified (a mental health condition characterized by extreme, often unpredictable shifts in mood, energy, and activity levels); and depression, unspecified (a common, serious mood disorder that causes persistent feelings of sadness, worthlessness, and a loss of interest in activities).A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 3/16/26, indicated a brief interview for mental status score of 15 [BIMS, a tool used to assess cognition (knowing, learning, and understanding), a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact].A review of Resident 1's Progress Notes dated 4/7/26 by Licensed Vocational Nurse (LVN) C indicated, At approximately 2052 [8:52 p.m.], patient entered the building and was observed walking in to his room. The supervisor, charge nurse and 2 additional male staff assisted Ln [licensed nurse] during assessment and evaluation. The patient appeared intoxicated and had a grocery bag on the floor. He was asked to show the contents of the bag and initially revealed only sparkling cider then bear [beer] in a can. Upon further inspection and request to show all items, the patient took out a flat bottle of vodka that is 3/4 less full. Patient opened the bottle and drink in front of the staff and pour more vodka into his water jug that's on his table. Due to intoxication state, mood and behavior, supervisor and charge nurse determined that it was unsafe for both the patient and other resident and staff in the unit. 911 was called to request for transport to the hospital for further evaluation.The patient left the building at approximately 2205 [10:05 p.m.] via gurney, accompanied by two ambulance personnel, two sheriffs, and 3 fire department personnel.A review of Resident 1's Elopement assessment dated [DATE] indicated, Elopement Risk: Has attempted to leave the building 1-2 times within a week unattended.A review of Resident 1's hospital medical records indicated Emergency Department admission date of 4/7/26 at 10: 30 p.m. It also indicated, .Re-Evaluation & MDM [Medical Decision Making].The patient was seen on arrival. He was brought to the ED by EMS. EMS and the patient report no recent trauma. Other than ETOH [alcohol] intoxication, there was no abnormal finding.However, the patient was extremely agitated during transport, trying to swing and spit.The patient was observed in the ED [Emergency Department] for several hours. During that time, his mental status and physical coordination gradually improved until he eventually achieved clinical sobriety [a medical determination that a person is no longer impaired by alcohol or drugs, characterized by having a stable mental state, walking without assistance]. Work up was negative other than ETOH intoxication.He was able to ambulate safely and without difficulty and converse normally prior to discharge.Patient advised to refrain from heavy alcohol use in the future. Patient was discharged in stable condition A review of facility's policy and procedure (P&P) entitled Wandering and Elopements revised March 2019, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.A review of facility's policy and procedure (P&P) entitled Safety and Supervision of Residents revised July 2017, the P&P indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Individualized, Resident-Centered Approach to Safety.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.5. Monitoring the effectives ness of interventions shall include the following:.b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed.