STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055800	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Health and Rehabilitation	350 DE Soto Drive Los Gatos, CA 95032

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. Based on interview and record review, the facility failed to investigate and report an injury of unknown origin for one of 3 residents (Resident 1) when a family member (FM) reported that she saw a bruise on Resident 1's head. This failure had the potential to put residents at risk of injury without an investigation of the cause, and could possibly compromise Resident 1's safety.Findings:Review of Resident 1's clinical record, indicated she was admitted with diagnoses which included Urinary Tract Infection (UTI, an infection in the urinary system), dysarthria (a motor speech disorder caused by neurological damage [stroke, brain injury, or diseases like Parkinson's] that weakens or impairs control over muscles used for speech, including the tongue, lips, and throat), and muscle wasting and atrophy (the loss or thinning of muscle tissue, resulting in reduced muscle mass, weakness, and smaller-looking limbs).During an interview with Resident 1 on 12/10/25 at 2:31 p.m., she stated she could not remember what had happened that gave her the bruise beside her outer right eye.Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 10/4/25, indicated Resident 1 had brief interview for mental status score of 7 (score of 0-7 indicates cognition is severely impaired).During an interview with the treatment nurse (TN) on 12/10/25 at 2:40 p.m., the TN stated Resident 1 had a skin discoloration in the beginning of December of 2025 and it was being monitored.During an interview with the director of nursing (DON) on 12/10/25 at 2:55 p.m., the DON stated Resident 1's FM had stated there was a bruise on her head. The DON stated that she and the assistant director of nursing (ADON) went with Resident 1's FM into the room, and explained to the family that it was not a bruise, it was a greenish discoloration from the vein.During a review of Resident 1's physician orders dated 12/5/25, the physician order indicated skin discoloration beside the outer right eye area, and to observe for signs and symptoms of swelling, skin breakdown, and bleeding every shift for 30 days.A review of Resident 1's care plan, dated 12/5/25, indicated altered skin integrity related to skin discoloration beside right outer eye. The Interventions/Tasks which indicated to Inform responsible party and surrogate decision maker for presence of skin discoloration/bruise and to notify MD for presence of skin discoloration/bruise. During a review of Resident 1's Weekly Non-pressure Ulcer Observation Tool, dated 12/5/25, it indicated that Resident 1's family member stated it looked like Resident 1 had a bruise.The Weekly Non-pressure Ulcer Observation Tool further indicated a skin discoloration beside outer right eye which measured 0.5 centimeters (cm, a small unit of length in the metric system) in length by 0.1 cm in width.During a telephone interview with the DON on 1/30/2026 at 2:03 p.m., the DON stated Resident 1's greenish discoloration, beside the right eye, had went away.During an interview with the DON on 2/4/2025 at 9:57 a.m., the DON stated if a family member would say a resident has a bruise, she would go assess the resident, do the skin assessment, monitor, notify the MD, and investigate. The DON further stated the facility would investigate, interview all the nurses, then go from there if it was an abuse or injury of unknown origin. The DON added, she would let the doctor know, and if there is a suspicion of an abuse facility would report it.During a review of Resident 1's Progress Notes, dated 12/15/25 at 9:52 a.m., the Progress Notes indicated the skin discoloration beside the outer right eye area was resolved and MD was made aware.Further review of Resident 1's Progress Notes and Weekly Non-pressure (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	Ulcer Observation Tool indicated the physician was made aware of the discoloration, however there was no additional documentation how Resident 1 had acquired the discoloration of the outer right eye area.During a review of the facility's policy and procedure (P&P) titled Abuse Reporting Policy, revised 08/2022, the P&P indicated .Type of Abuse: .7. Injury of unknown source is defined as an injury that meets both the following conditions: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time.V. Investigation: a. The facility shall thoroughly investigate allegation of abuse by identifying and interviewing all involved including the alleged victim, alleged perpetrator, witness(es), and other who might have seen, heard, or have knowledge of the allegations, and with documented evidences that support the investigation.b. The facility's abuse prevention coordinator/designee shall initiate the investigation process immediately within the required time frame in accordance to the regulation after the alleged incident occurred - focusing on determining if allegations have occurred, the cause and its extent, and by providing complete and thorough documentation of the investigation and exercising caution in handling possible evidence(s).VII. Reporting/Response: a. The Facility shall report any and all allegation of abuse to the District CDPH, Local Ombudsman, and Local Law enforcement, either by phone, email, or facsimile, within 2-hour timeframe.