

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 435202919
Report Date: 05/21/2026
Date Signed: 05/21/2026 02:31:49 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CENTRAL COAST CR/RES, 2580 N. FIRST STREET, STE. 350 SAN JOSE, CA 95131
COMPLAINT INVESTIGATION REPORT	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **03/30/2026** and conducted by Evaluator Murial Han

PUBLIC	COMPLAINT CONTROL NUMBER: 26-AS-20260330133147
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FACILITY NAME:	VILLA TOSCANA A MEMORY CARE COMMUNITY	FACILITY NUMBER:	435202919
ADMINISTRATOR:	MAMTA JAIN	FACILITY TYPE:	740
ADDRESS:	939 W. EL CAMINO REAL	TELEPHONE:	(707) 592-4252
CITY:	MOUNTAIN VIEW	ZIP CODE:	94040
CAPACITY:	70	DATE:	05/21/2026
		UNANNOUNCED TIME BEGAN:	09:30 AM
MET WITH:	Administrator, Mamta "MJ" Jain	TIME COMPLETED:	02:45 PM

ALLEGATION(S):

1	Staff did not prevent resident in care from leaving the facility without supervision
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INVESTIGATION FINDINGS:

1	On May 21, 2026, Licensing Program Analyst (LPA) Murial Han conducted an unannounced visit to deliver the complaint investigation findings. LPA met with the administrator and explained the purpose of today's visit.
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4	Regarding to the allegation of – staff did not prevent resident in care from leaving the facility without supervision, there is no additional information forthcoming from the reporting party. However, during the initial reporting, the reporting party stated that resident in question (R1) resides in the memory care unit and on March 20, 2026 and March 28, 2026, R1 left the facility unattended and was found in a restaurant next to the facility and the 2nd time, R1 was found in the parking lot agitated.
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9	As part of the investigation, LPA interviewed staff members, conducted observations, and reviewed documents.
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11	
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Substantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Cara Smith	
LICENSING EVALUATOR NAME: Murial Han	
LICENSING EVALUATOR SIGNATURE:	DATE: 05/21/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 05/21/2026

This report must be available at Child Care and Group Home facilities for public review for 3 years.
LIC9099 (FAS) - (06/04) Page: 1 of 3
Control Number 26-AS-20260330133147

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: VILLA TOSCANA A MEMORY CARE COMMUNITY	FACILITY NUMBER: 435202919
VISIT DATE: 05/21/2026	

NARRATIVE	
1	LPA interviewed staff #1 (S1) who stated that on the day of the incident (3/20/2026), S1 was working on
2	the 2nd floor where R1 was residing, and R1 was verbalizing multiple times that he/she wanted to leave
3	the unit. When S1 was in the laundry room that was located on the same floor, S1 heard the alarm went
4	off on one of the delayed egress doors and S1 suspected that it was R1 who left the unit. However, S1
5	could not leave the floor as S1 was the only caregiver who was assigned on the floor. Therefore, S1
6	alerted other staff members on the 3rd floor who came to assist and subsequently, R1 was found at the
7	restaurant next to the facility.
8	
9	According to the administrator, R1 was moved to the 3rd floor after the incident for additional supervision
10	as there were more staff members assigned to the 3rd floor.
11	
12	Based on the facility's March staffing schedule, it indicated that S1 was the only caregiver who was
13	assigned to the 2nd floor on 3/20/2026 for 11 residents.
14	
15	During the visit on 4/7/2026, LPA and the administrator tested one of the delayed egress doors on the
16	3rd floor, the alarm went off immediately, but no staff responded. The door opened after 30 seconds, the
17	administrator exited the floor and 2 staff members walked toward the door after 60 seconds. The
18	administrator acknowledged that staff members should have responded to the alarm before the door
19	opened.
20	
21	Regarding the second incident on 3/28/2026, LPA attempted to obtain more information from the
22	administrator, the director and facility staff members but no one remember this incident and there was
23	no documentation of such incident.
24	
25	
26	During the investigation, the administrator acknowledged that she attempted to report this incident via
27	electronically to CCL but it was never sent. This observation will be cited under Case Manager on LIC
28	809 and 809D.
29	
30	After the investigation, this allegation is substantiated as there was insufficient staffing for one caregiver
31	to care for 11 residents resulting in R1 leaving the floor unattended through the delayed egress door and
32	S1 could not follow R1 as S1 had to stay on the floor to care for the other residents.
	 This report is reviewed and discussed with the administrator.
	 A copy is provided with the appeal rights.

SUPERVISORS NAME: Cara Smith	
LICENSING EVALUATOR NAME: Murial Han	
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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: VILLA TOSCANA A MEMORY CARE COMMUNITY
FACILITY NUMBER: 435202919
DEFICIENCY INFORMATION FOR THIS PAGE:
VISIT DATE: 05/21/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 05/22/2026 Section Cited CCR 87468.2(a)(4)	1 87468.2 Additional Personal Rights of 2 Residents..(a) In addition to the 3 rights..4) To care, supervision,. their 4 individual needs and are delivered by 5 staff that are sufficient in numbers, 6 qualifications, and competency to meet 7 their needs. This requirement is not met as evidenced by R1 resides in a memory care unit and on 3/20/2026, R1 left the unit	1 The administrator will develop a plan of 2 correction indicating what action(s) that 3 the facility will implement to ensure 4 there are sufficient staff to delivery the 5 needs and supervision of the residents. 6 In addition what is the action that 7
	8 unattended and S1 was not able to 9 follow R1 as S1 was the only caregiver 10 who was working on the floor so S1 had 11 to stay to care for the other residents. in 12 addition, staff did not respond to the 13 delayed egress door in a timely fashion 14 which posed an immediate health and safety risks to residents in care.	8 the facility will take to ensure staff 9 members are competent with the 10 protocols when the delayed egress 11 door alarms goes off. The plan of 12 correction shall include staff education. 13 The administrator will provide a copy of 14 the plan of correction to CCL by 5/22/2026.
	1 2 3 4 5 6 7	1 2 3 4 5 6 7
	1 2 3 4 5 6 7	1 2 3 4 5 6 7

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISORS NAME: Cara Smith LICENSING EVALUATOR NAME: Murial Han LICENSING EVALUATOR SIGNATURE: DATE: 05/21/2026	
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