

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 100400070
Report Date: 05/06/2026
Date Signed: 05/15/2026 09:36:28 AM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION FRESNO RO, 1314 E SHAW AVE FRESNO, CA 93710
COMPLAINT INVESTIGATION REPORT	

This is an official report of an unannounced visit/investigation of a complaint received in our office on 02/10/2026 and conducted by Evaluator Sarah Hurt

	COMPLAINT CONTROL NUMBER: 24-AS-20260210143137
FACILITY NAME: CALIFORNIA ARMENIAN HOME	FACILITY NUMBER: 100400070
ADMINISTRATOR: PAUL ROCHA	FACILITY TYPE: 741
ADDRESS: 6720 E KINGS CANYON RD	TELEPHONE: (559) 251-8414
CITY: FRESNO	STATE: CA
CAPACITY: 412	ZIP CODE: 93727
	CENSUS: 48
	DATE: 05/06/2026
	UNANNOUNCED TIME BEGAN: 10:30 AM
MET WITH: Cognitive Care Director, Ashley Mendoza	TIME COMPLETED: 03:30 PM

ALLEGATION(S):

1	Staff did not report incident to licensing.
2	Facility call light system is inoperable.
3	Staff did not provide residents with adequate meal service.
4	Facility did not employ adequate staff to meet the needs of residents in care.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Sarah Hurt conducted an unannounced facility visit to deliver findings on the allegations listed above. LPA met with facility Cognitive Care Director, Ashley Mendoza , and explained the purpose of today's visit.
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5	Regarding the allegation that staff did not report incident to Licensing, Licensing Program Analyst (LPA) conducted interviews and reviewed facility records related to the reported resident fall incident involving resident 1.LPA reviewed a completed Unusual Incident/Injury Report documenting the resident experienced an unwitnessed fall on 01/31/2026 resulting in hospitalization. Facility records reflected the facility completed a written incident report and provided a fax cover sheet and confirmation report indicating a nine-page report was transmitted to the Licensing office on 02/05/2026 with a successful transmission result. Although the incident report was not located in the facility's electronic Licensing file at the time of LPA review, records reviewed did not reveal sufficient evidence to support that the facility failed to report the incident to Licensing..Although the allegation may have happened or is valid, there is not a preponderance of evidence to prove the alleged violation did or did not occur, therefore the allegation is unsubstantiated.
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Unsubstantiated**Estimated Days of Completion:****SUPERVISORS NAME:** See Moua**LICENSING EVALUATOR NAME:** Sarah Hurt**LICENSING EVALUATOR SIGNATURE:****DATE:** 05/06/2026**I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.****FACILITY REPRESENTATIVE SIGNATURE:****DATE:** 05/06/2026**This report must be available at Child Care and Group Home facilities for public review for 3 years.**

LIC9099 (FAS) - (06/04)

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Control Number 24-AS-20260210143137

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL
SERVICES
COMMUNITY CARE LICENSING DIVISION
FRESNO RO, 1314 E SHAW AVE
FRESNO, CA 93710**COMPLAINT INVESTIGATION REPORT
(Cont)****FACILITY NAME:** CALIFORNIA ARMENIAN HOME**FACILITY NUMBER:** 100400070**VISIT DATE:** 05/06/2026**NARRATIVE**

1 Regarding the allegation that the facility call light system is inoperable, Licensing Program Analyst (LPA)
2 conducted interviews and reviewed facility records, including paging system activity reports.
3 Interviews conducted with staff revealed the facility uses a functioning call light system which alerts staff
4 when residents activate pull cords. Staff stated residents are monitored throughout the day and staff
5 respond to resident needs. Staff stated that during WiFi interruptions, staff conduct routine rounds and
6 safety checks on residents. LPA reviewed facility records related to the call light system and observed
7 the system was operational. Although some records reflected longer reset times, the facility staff stated
8 this may occur when staff do not fully reset the pull cord system after responding to residents. Interviews
9 and records reviewed did not reveal sufficient evidence to support that the call light system was
10 consistently nonfunctional or inoperable. Although the allegation may have happened or is valid, there is
11 not a preponderance of evidence to prove the alleged violation did or did not occur, therefore the
12 allegation is unsubstantiated.

14 Regarding the allegation that staff did not provide residents with adequate meal service, Licensing
15 Program Analyst (LPA) conducted interviews and reviewed facility records including facility menus and
16 alternative menu options. Interviews conducted with staff revealed the facility provides residents with
17 three daily meals as well as alternative meal options when requested. Staff stated residents are offered
18 substitutions if they do not prefer the meal being served and residents are encouraged to eat throughout
19 the day. LPA reviewed facility menus which documented a variety of meal options and alternative menu
20 selections available to residents. Interviews and records reviewed did not reveal sufficient evidence to
21 support that residents were not being provided adequate meal service. Although the allegation may
22 have happened or is valid, there is not a preponderance of evidence to prove the alleged violation did or
23 did not occur, therefore the allegation is unsubstantiated.

25 Regarding the allegation that the facility did not employ adequate staff to meet the needs of residents in
26 care, Licensing Program Analyst (LPA) conducted interviews and reviewed facility staffing schedules
27 and records. Interviews conducted with staff revealed the facility maintains staffing coverage throughout
28 each shift and staff stated they are generally able to respond to resident needs in a timely manner. Staff
29 acknowledged there are occasions when resident calls increase during busy periods; however, staff
30 stated assistance is available from other staff members when needed. LPA reviewed staffing schedules
31 and did not observe sufficient evidence to support that the facility failed to employ adequate staff to
32 meet resident needs. Although the allegation may have happened or is valid, there is not a
preponderance of evidence to prove the alleged violation did or did not occur, therefore the allegation is
unsubstantiated.

Exit interview conducted with facility, Cognitive Care Director, Ashley Mendoza, and copy of report
provided

SUPERVISORS NAME: See Moua**LICENSING EVALUATOR NAME:** Sarah Hurt**LICENSING EVALUATOR SIGNATURE:****DATE:** 05/06/2026**I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.**

