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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 157202769
Report Date: 04/12/2025
Date Signed: 04/12/2025 12:05:25 PM

Unfounded

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on **02/26/2025** and conducted by Evaluator Melinda Medina

PUBLIC	COMPLAINT CONTROL NUMBER: 24-AS-20250226161353

FACILITY NAME:	CARRINGTON OF SHAFTER		**FACILITY NUMBER:**	157202769
ADMINISTRATOR:	ALICIA WEBB		**FACILITY TYPE:**	740
ADDRESS:	250 EAST TULARE AVENUE		**TELEPHONE:**	(661) 746-6521
CITY:	SHAFTER	**STATE:** CA	**ZIP CODE:**	93263
CAPACITY:	64	**CENSUS:** 45	**DATE:**	04/12/2025
		UNANNOUNCED	**TIME BEGAN:**	10:28 AM
MET WITH:	Amanda Jaime		**TIME COMPLETED:**	12:20 PM

ALLEGATION(S):

1	Staff physically abusing resident
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INVESTIGATION FINDINGS:

1	On 4/12/2025, Licensing Program Analyst (LPA) M. Medina conducted an unannounced subsequent
2	complaint visit to conduct additional interviews and deliver findings to complaint. LPA arrived and
3	contacted Administrator by telephone who arrived a short time later to conduct complaint visit with LPA.
4	
5	This Department investigated the allegation of staff physically abusing resident. During the investigation,
6	this department conducted facility tour, conducted interviews, and reviewed records. Based on review of
7	Resident 1 (R1) records and interviews, it was documented that R1 received injury while being
8	transferred from bed to wheelchair. Hospice records document that R1 has thin, frail skin, and is at high
9	risk for skin tears.
10	
11	This Department has found that the above allegations are UNFOUNDED, meaning they were false, could
12	not have happened, and/or were without reasonable basis. We have therefore dismissed the complaint.
13	
	No deficiencies issued during this complaint visit . Exit interview conducted. A copy of this report was
	provided to Administrator for facility records

Unfounded	Estimated Days of Completion:

SUPERVISORS NAME: Alexandria Walton
LICENSING EVALUATOR NAME: Melinda Medina
LICENSING EVALUATOR SIGNATURE:

DATE: 04/12/2025

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 04/12/2025

This report must be available at Child Care and Group Home facilities for public review for 3 years.