

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 019200956

Report Date: 02/11/2026

Date Signed: 02/11/2026 01:47:12 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION OAKLAND ASC, 1515 CLAY STREET, STE. 310 OAKLAND, CA 94612
COMPLAINT INVESTIGATION REPORT	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **12/06/2024** and conducted by Evaluator James Sampair

PUBLIC	COMPLAINT CONTROL NUMBER: 15-AS-20241206141605
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FACILITY NAME: ELDER ASHRAM	FACILITY NUMBER: 019200956
ADMINISTRATOR: MEESHIA MARY T SANTOS	FACILITY TYPE: 740
ADDRESS: 3121 FRUITVALE AVE	TELEPHONE: (510) 842-3192
CITY: OAKLAND	STATE: CA
CAPACITY: 90	ZIP CODE: 94602
	DATE: 02/11/2026
	UNANNOUNCED TIME BEGAN: 09:00 AM
MET WITH: Assistant Executive Director Janelle Ubilas	TIME COMPLETED: 02:00 PM

ALLEGATION(S):

1	Questionable Death.
2	Lack of supervision resulting in resident fall sustaining a fracture.
3	Resident had unexplained weight loss.
4	Facility failed to assist resident with grooming.
5	Facility did not have enough staff to properly care for the residents.
6	Facility did not report resident fall incidents, hospitalization and death to CCL.
7	
8	
9	

INVESTIGATION FINDINGS:

1	On 02/11/2026, at 9:00 AM, Licensing Program Analyst (LPA) James Sampair arrived unannounced to
2	deliver findings on the allegation above. The LPA informed Assistant Executive Director (AED) Janelle
3	Ubilas of the reason for the visit.
4	
5	The Department's investigation included but was not limited to a review of facility records, a review of
6	email correspondence between Resident R1's family and staff, and a review of hospital records. The
7	Department interviewed facility managers, facility care partners, facility residents, and R1's family.
8	
9	Continued on LIC 9099-C2 . . .
10	
11	
12	
13	

Unsubstantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Harpreet Humpal

LICENSING EVALUATOR NAME: James Sampair
LICENSING EVALUATOR SIGNATURE:

DATE: 02/11/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/11/2026

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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CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
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OAKLAND ASC, 1515 CLAY STREET, STE. 310
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COMPLAINT INVESTIGATION REPORT (Cont)

FACILITY NAME: ELDER ASHRAM

FACILITY NUMBER: 019200956

VISIT DATE: 02/11/2026

NARRATIVE

1 . . . Continued from LIC 9099-C1

2

3 The complaint alleges Resident R1's death was questionable.

4 On 01/01/2023, R1 sustained a fall and was transported to the hospital. Medical records indicate that,
5 upon admission, R1 was diagnosed with a closed fracture of the right hip. On 01/02/2023, R1 was
6 transferred to another hospital with the same admission diagnosis. On 01/03/2023, R1 underwent
7 surgical repair of the right hip fracture. On 01/08/2023, R1 was discharged to hospice for comfort care
8 due to poor quality of life and inability to participate in life-sustaining therapies. On 01/15/2023, R1 was
9 discharged from hospice following death at the hospital on 01/14/2023. Final active problems included a
10 closed fracture of the right hip and many other health conditions. R1 did not return to Elder Ashram after
11 his fall on 01/01/2023

12 R1's death certificate lists the immediate cause of death as acute hypoxia respiratory failure, with the
13 time between its onset and R1's death listed as days. There were two underlying causes listed:
14 pneumonia and sepsis, both with the time interval between onset and death listed as days.

15 According to interviews, review of facility records, and a review of R1's medical records, there was not
16 enough information to state that R1's death was questionable, nor that facility staff were at cause. The
17 data analyzed does not support this allegation.

18

19 The complaint alleges that lack of supervision from staff resulted in Resident R1 falling and thereby
20 sustaining a fracture while in care.

21 Prior to R1's admission to the facility, the resident appraisal of 12/03/2022 noted that R1 "is a big fall risk
22 so needs to be helped and watched". R1 was admitted to the facility on 12/05/2022. On 12/10/2022,
23 12/16/2022, 12/21/2022, and 01/01/2023, R1 sustained falls. R1 was transported to the hospital
24 emergency department (ED) after each fall. R1 sustained a laceration on his chin and injuries to his
25 forehead on 12/16/2022 and 12/21/2022. 12/16/2022 hospital discharge instructions state, "frequent falls
26 and instability are likely due to dementia and dehydration / deconditioning." On 12/21/2022, R1 was
27 transported to the ED by his son W2. On 01/01/2023, R1's fall resulted in a closed fracture of the right
28 hip.

29 On 12/10/2022 and 12/16/2022, facility staff submitted Physician's Fax Reports to R1's physician.

30 Facility did not receive a reply to the 12/10/2022 fax with new orders. On 12/16/2022, R1's physician
31 replied and stated, "Have upcoming appointment with him this week. No new recommendations now."

32

Continued on LIC 9099-C3

SUPERVISORS NAME: Harpreet Humpal

LICENSING EVALUATOR NAME: James Sampair

LICENSING EVALUATOR SIGNATURE:

DATE: 02/11/2026

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/11/2026

LIC9099 (FAS) - (06/04)

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COMPLAINT INVESTIGATION REPORT (Cont)

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FACILITY NUMBER: 019200956

VISIT DATE: 02/11/2026

NARRATIVE

1 . . . Continued from LIC 9099-C2
 2
 3 On 12/16/2022, according to reviewed email correspondence, facility staff communicated concerns to
 4 W2 regarding R1's high fall risk, frequent falls, medication concerns, current level of care, and the need
 5 for reassessment for a higher level of care, as well as the need to schedule a care conference. On the
 6 same date, a second email was sent to W2 indicating that R1's one-on-one supervision was extended
 7 due to R1's increased ambulation that resulted in his continued falls. On 12/21/2022, W2 emailed facility
 8 staff regarding a medication prescribed by R1's physician and advised that the medication could
 9 increase R1's risk of falling. Facility staff subsequently expressed concern that the medication could
 10 further elevate R1's fall risk.
 11 According to interviews, review of facility records, and a review of R1's medical records, there was no
 12 indication that lack of supervision from staff resulted in Resident R1 falling and thereby sustaining a
 13 fracture while in care. The data analyzed does not support this allegation.
 14
 15 The complaint alleges that R1 had unexplained weight loss of 20 lbs.
 16 R1's weight in his Physician's Report dated 10/27/2022 is 138 lbs. It was 39 days between the
 17 Physician's Report and the date R1 was admitted into Elder Ashram on 12/5/2022. There is no record of
 18 R1's weight upon admission nor during the 27 days R1 lived at Elder Ashram. Upon admission into the
 19 hospital on 1/1/2023, R1's weight was recorded as 124 lbs. and 9 oz. That was a loss of 13 lbs. and 3
 20 oz. R1 lived at Elder Ashram fewer days than the number of days between the Physician's Report and
 21 his admission into the hospital on 1/1/2023. The data analyzed does not support this allegation.
 22
 23 The complaint alleges that facility staff failed to assist R1 with grooming.
 24 The AED stated that the staff worked as a team to groom R1, because he was physically aggressive.
 25 They used different strategies for approaching him and for working with him. If he was not okay with one
 26 staff member at one time, then another staff member would come a little later. He hit and punched staff
 27 when they assisted him during grooming. Nonetheless, they kept his body and his clothes clean. The
 28 data analyzed does not support this allegation.
 29
 30 Continued on LIC 9099-C4
 31
 32

SUPERVISORS NAME: Harpreet Humpal
LICENSING EVALUATOR NAME: James Sampair
LICENSING EVALUATOR SIGNATURE: _____ **DATE:** 02/11/2026

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NARRATIVE

1 . . . Continued from LIC 9099-C3
 2
 3 The complaint alleges that the facility did not have enough staff to properly care for the residents.
 4 Four staff members were interviewed at Elder Ashram about possible understaffing during December
 5 2022 and January 2023. The AED stated that during the time R1 was at the facility, between December
 6 2022 and January 2023, the shift coverage and resident population remained the same. She also stated
 7 that Elder Ashram has never had issues with understaffing. Staff member S1, a Licensed Vocational
 8 Nurse, stated that the facility is understaffed "sometimes," but it is only from shift to shift and never for
 9 an extended amount of time. Staff member S2, a Care Partner, stated that there has never been an
 10 understaffing issue. Executive Director (ED) Maria Lourdes Riera stated that the facility has never been

11 understaffed for an extended period. A review of complaints concerning understaffing at this facility
12 supported these statements, because none were substantiated. The data analyzed does not support
13 this allegation.

14
15 The complaint alleges that the facility did not report resident fall incidents, hospitalization, and death to
16 Community Care Licensing (CCL).

17 A review of the records shows that the facility did make the required reports to CCL. The data analyzed
18 does not support this allegation.

19
20 Although the allegations may have happened, or were valid, there is not a preponderance of evidence to
21 prove them; therefore, the allegations are **UNSUBSTANTIATED**.

22
23 Exit interview conducted and a copy of this report was provided.
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