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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 198205367
Report Date: 08/21/2026
Date Signed: 08/25/2026 09:08:59 AM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION EL SEGUNDO ASC, 400 CONTINENTAL BLVD, STE 340 EL SEGUNDO, CA 90245

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/04/2026** and conducted by Evaluator Ernand Dabuet

PUBLIC	COMPLAINT CONTROL NUMBER: 11-AS-20260604155225

FACILITY NAME:	WESTCHESTER VILLA			**FACILITY NUMBER:**	198205367
ADMINISTRATOR:	EVANGELINE AGATEP			**FACILITY TYPE:**	740
ADDRESS:	220 W. MANCHESTER BLVD.			**TELEPHONE:**	(310) 673-1093
CITY:	INGLEWOOD	**STATE:** CA		**ZIP CODE:**	90301
CAPACITY:	174	**CENSUS:** 88		**DATE:**	08/21/2026
		UNANNOUNCED		**TIME BEGAN:**	12:35 PM
MET WITH:	Maria Luisa Mascardo			**TIME COMPLETED:**	03:59 PM

ALLEGATION(S):

1	Resident sustained multiple severe pressure injuries resulting in death due to staff negelct.
2	Staff did not provide adequate food service to resident.
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INVESTIGATION FINDINGS:

1	On August 21, 2026, the California Department of Social Services/Community Care Licensing
2	(CDSS/CCL) Licensing Program Analyst (LPA), Ernand Dabuet, conducted a subsequent unannounced
3	complaint visit. Maria Luisa Mascardo, Administrator, greeted the LPA. (LPA) explained that the purpose
4	of the visit was to investigate the allegations mentioned above.
5	
6	The investigation included interviews, record reviews, and a tour of the facility. Investigation conducted
7	by Investigator Christine Ferris of the CDSS Investigation Branch. Interviews were conducted with Staff
8	#1-Staff #3 (S1-S3), Witness #1 and Witness #2 (W1-W2), and Resident #2 - Resident #8 (R2-R8). The
9	Department reviewed several documents, including the Facility Resident Roster (dated 06/08/26),
10	Personnel Report LIC 500 (dated 06/01/26), (R1's) Admissions Agreement (dated 01/24/24), Medical
11	Assessment LIC 602A (dated 10/27/25), Appraisal/Needs and Service Plan LIC 625 (dated 01/06/25 &
12	01/30/26) Resident Appraisal LIC 603A (dated 01/06/25) and, Unusual Incident Report LIC 624 (dated
13	05/15/26), Death Report LIC 624A (dated 05/31/26), Providence Medical Associates Medical Records
	(dated 2023), Empire Wound Care Progress Notes (dated 05/06/26 through 05/13/26), and California
	Department of Public Health Death Certificate (dated 06/02/26).

(Evaluation Report continues LIC 9099-C)

Unsubstantiated	Estimated Days of Completion:

SUPERVISORS NAME: Janae Hammond
LICENSING EVALUATOR NAME: Ernand Dabuet
LICENSING EVALUATOR SIGNATURE:
DATE: 08/21/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 08/21/2026

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

Control Number 11-AS-20260604155225

FACILITY NAME: WESTCHESTER VILLA **FACILITY NUMBER:** 198205367
VISIT DATE: 08/21/2026

NARRATIVE

INVESTIGATION REVEALED THE FOLLOWING:

Allegation #1: Resident sustained multiple severe pressure injuries resulting in death due to staff neglect.

It is alleged that Resident #1 (R1) sustained severe pressure injuries while in care, which ultimately led to (R1's) death due to staff neglect. Reports indicated that (R1) had significant health issues, including 18 bedsores, four of which were classified as Stage 4 pressure wounds. (R1) passed away on June 3, 2026, after being hospitalized on May 27, 2026. No further details were provided regarding this matter.

On June 29, 2026, between 09:30 AM and 11:00 AM, the Department conducted interviews with staff members identified as Staff #1 through Staff #3 (S1-S3). Three (3) out of the three (3) could not support the claim that (R1's)death was a result of neglect in care with pressure wounds. (S1) explained (R1) resided in a care facility from January 11, 2024 to May 15, 2026, when (R1) was hospitalized and did not return. (R1) was placed on hospice care on April 26, 2026, but the process was delayed due to (R1's) responsible party retiring. (R1) transitioned through several facilities before passing away on May 31, 2026.

While at the facility, (R1) had four monitored wounds: on (R1's) left elbow, right heel, right hip, and sacral area, receiving ongoing care from medical physician and wound care specialists. Community Care Licensing was informed of (R1's) condition and pending hospice placement. Several Unusual Incident/Injury Reports documented (R1's) injuries and treatment, importance of the facility's protocol of reporting any skin issues to the appropriate staff for documentation and care. (S2-S3) reported that (R1) developed pressure injuries during (R1's) stay at a facility and received care from home health caregivers and wound care specialists. Caregivers, including (S3), repositioned (R1) and reported changes in (R1's) condition to (S1 and S2), and (R1's) physician. The facility has a protocol for reporting changes in skin conditions. (S2) expressed no concerns about neglect or inadequate care. While (S3), assists residents with various needs, ensures (R1's) wounds are properly treated, and reports no concerns regarding (R1's) care.

On June 29, 2026, and July 06, 2026, between 09:15AM and 10:30 AM, the Department interviewed with the witness identified as Witness #1 and Witness (W1-W2)). Two (2) out of the two (2) witnesses could not support this claim of neglect in care. (W1) reported to have treated (R1) for about a year and a half, visiting (R1) monthly. (W1) last saw (R1) in late April 2026 and noted (R1's) decline, recommending hospice care, which (W1) initiated. (W1) ordered comfort and wound care for (R1). When asked about the care for (R1) regarding pressure injuries, (W1) said there were no concerns about neglect or poor treatment.

(Evaluation Report continues LIC 9099-C)

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DATE: 08/21/2026

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NARRATIVE

(W1) explained that (R1's) injuries were due to (R1's) declining health and confirmed that the facility provided appropriate care.

(W2) requested that (W1) consider hospice care for (R1) in March 2026, and (W1) agreed. Still, (W1) needed support from another medical physician, to complete the necessary paperwork. This was delayed until May 2026. Just before hospice care began, (R1's) condition did not improve, and (R1) was eventually transferred to a skilled nursing facility and then Long Beach Memorial Hospital, where (R1) passed away. (W2) stated that while (R1) developed pressure injuries, they did not stem from neglect, as such injuries are common during decline. (W2) noted that (R1) had been well cared for at the facility since 2024 until (R1's) last months, when issues arose.

The Department's investigation found insufficient evidence to support claims of neglect or lack of care. According to the medical records from Long Beach Memorial Hospital, (R1's) death was attributed to cardiopulmonary arrest resulting from ventricular fibrillation (V-fib), which may have been linked to underlying coronary artery disease.

The Department could not interview Resident #1 (R1) because (R1) has passed away.

The Department reviewed (R1's) Admissions Agreement (dated 01/24/24), Medical Assessment LIC 602A (dated 10/27/25), Appraisal/Needs and Service Plan LIC 625 (dated 01/06/25 & 01/30/26) Resident Appraisal LIC 603A (dated 01/06/25) and, Unusual Incident Report LIC 624 (dated 05/15/26), Death Report LIC 624A (dated 05/31/26), Providence Medical Associates Medical Records (dated 2023), Empire Wound Care Progress Notes (dated 05/06/26 through 05/13/26), Long Beach memorial Hospital Medical Records (dated 05/31/26 through 06/03/26), 24/7 Home Health Services (dated 04/01/2 through 05/14/26) and California Department of Public Health Death Certificate (dated 06/02/26).

Based on the information gathered, the facility's neglect and lack of care and did not provide an adequate level of care, resulting in Resident #1 (R1) sustaining severe pressure injuries and ultimately dying from these injuries. There is insufficient evidence to support the allegation.

Allegation #2: Staff did not provide adequate food service to resident.

It is alleged that Resident #1 (R1) was not provided with adequate food service. Reports have suggested that (R1) did not receive sufficient food. (R1) was admitted to the hospital on May 27, 2026, where a feeding tube was provided. No additional details concerning this issue were given.

(Evaluation Report continues LIC 9099-C)

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Control Number 11-AS-20260604155225

NARRATIVE

On June 29, 2026, between 09:30 AM and 11:00 AM, the Department conducted interviews with staff members identified as Staff #1 through Staff #3 (S1-S3). Three (3) out of the three (3) could not support the claim that (R1) was not provided with adequate food service. While (R1) was a resident at the facility, (S1-S3) reported that (R1) was constantly monitored by the staff, home health aides, and (R1's) primary care physician. (S1) stated that (R1's) health condition continued to decline, and a few days before hospitalization, (R1) had been consuming only a minimal amount of food for an extended period, which raised concerns about (R1's) health and well-being. The primary reason for (R1's) hospitalization was (R1's) persistent refusal to eat regular meals. As a result of this ongoing issue, (R1's) nutritional intake became severely inadequate, leading healthcare providers to determine that a gastrostomy tube (G-tube) was necessary to ensure (R1) received adequate nutrition. This intervention was essential to support (R1) health and aid in her recovery. (S1) stated that (R1) was provided with three meals and snacks throughout the day and that meals were coordinated with the dietitian.

On June 29, 2026, and August 21, 2026, between 11:15 AM and 01:40 PM, the Department interviewed residents identified as Resident #2 and Resident #8 (R2-R8). Seven (7) out of seven (7) resident members could not corroborate this claim. Residents reported that meals were provided according to the Weekly Menu schedule and that the portion sizes were appropriate in good quality. No residents mentioned experiencing hunger or missing any meals. Interviews confirmed that meals are prepared and served three times a day, with snacks available in between.

The Department could not interview Resident #1 (R1) because (R1) has passed away.

On June 29, 2026, and July 06, 2026, between 09:15 AM and 10:30 AM, the Department interviewed with the witness identified as Witness #1 and Witness (W1-W2)). Two (2) out of the two (2) witnesses could not support this claim. (W1) verified that the facility offered suitable care. (W2) said that (R1) received good care at the facility and did not see any signs of neglect.

The Department reviewed the facility's posted menus and verified that meals provided during the visit matched the planned menu. The Department observed adequate food supply by hand, including perishable and non-perishable items sufficient for the required number of days. No documentation was found indicating missed meals or complaints related to food service.

(Evaluation Report continues LIC 9099-C)

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
EL SEGUNDO ASC, 400 CONTINENTAL BLVD, STE 340
EL SEGUNDO, CA 90245

FACILITY NAME: WESTCHESTER VILLA **FACILITY NUMBER:** 198205367
VISIT DATE: 08/21/2026

NARRATIVE

The Department reviewed (R1's) Admissions Agreement (dated 01/24/24), Medical Assessment LIC 602A (dated 10/27/25), Appraisal/Needs and Service Plan LIC 625 (dated 01/06/25 & 01/30/26) Resident Appraisal LIC 603A (dated 01/06/25) and, Unusual Incident Report LIC 624 (dated 05/15/26), Death Report LIC 624A (dated 05/31/26), Providence Medical Associates Medical Records (dated 2023), Empire Wound Care Progress Notes (dated 05/06/26 through 05/13/26), Long Beach memorial Hospital Medical Records (dated 05/31/26 through 06/03/26), 24/7 Home Health Services (dated

04/01/2 through 05/14/26) and California Department of Public Health Death Certificate (dated 06/02/26). Further review of Weekly Menu (dated 08/04/26 through 08/31/26) and Consultant Dietitian Report (dated 01/27/26).

Based on the information gathered, there is not enough evidence to support the allegation that staff did not provide adequate food service to resident.

Based on the information collected from the facility inspection, observations, interviews, and records analysis, the Department found no evidence to support the above allegations. The allegations may have happened or is valid, but there is not a preponderance of the evidence to prove that the alleged violations occurred. Therefore, the allegations are **Unsubstantiated**.

No deficiencies cited.

An exit interview was conducted with Maria Luisa Mascardo, and copies of the reports were provided.

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