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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306000347
Report Date: 06/04/2026
Date Signed: 06/04/2026 05:35:25 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

This is an official report of an unannounced visit/investigation of a complaint received in our office on **07/28/2025** and conducted by Evaluator Joseph Alejandre

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20250728090508

FACILITY NAME:	ATRIA SAN JUAN			**FACILITY NUMBER:**	306000347
ADMINISTRATOR:	JAMES CRADDOCK			**FACILITY TYPE:**	740
ADDRESS:	32353 SAN JUAN CREEK RD			**TELEPHONE:**	(949) 661-1220
CITY:	SAN JUAN CAPISTRANO	**STATE:** CA		**ZIP CODE:**	92675
CAPACITY:	140	**CENSUS:** 99		**DATE:**	06/04/2026
		UNANNOUNCED		**TIME BEGAN:**	01:28 PM
MET WITH:	James Craddock			**TIME COMPLETED:**	05:30 PM

ALLEGATION(S):

1	Facility staff did not follow resident's admission agreement
2	Facility staff did not shower resident as needed
3	Facility staff handled resident in a rough manner
4	Facility staff did not ensure resident had clean bed linens
5	Facility staff did not respond to resident's calls for assistance in a timely manner
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Joseph Alejandre made an unannounced visit to deliver the findings of
2	the complaint investigation into the allegations listed above. LPA met with Executive Director James
3	Craddock and explained the reason for the visit.
4	
5	The investigation into the allegation, facility staff did not follow resident's admission agreement, revealed
6	the following. It was reported that facility did not check on Resident 1 (R1) every 2 hours, did not escort
7	resident to breakfast, lunch and dinner, and assist R1 with toileting and dressing. A review of R1's care
8	plan shows R1 did not require assistance with toileting. R1's care plan shows R1 was not on 2 hour
9	checks. As of July 22, 2025 R1 was put on hourly checks due to agitation and wandering. 4 out of 4 staff
10	reported that R1 was helped with dressing daily but sometimes refused to change their clothes. R1's care
11	plan shows R1 required escorting to all meals, breakfast, lunch and dinner. 4 out of 4 staff reported that
12	R1 was always escorted to all meals.
13	

Unsubstantiated	Estimated Days of Completion:

SUPERVISORS NAME: Sheila Santos
LICENSING EVALUATOR NAME: Joseph Alejandre
LICENSING EVALUATOR SIGNATURE:
DATE: 06/04/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 06/04/2026

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

Control Number 22-AS-20250728090508

FACILITY NAME: ATRIA SAN JUAN **FACILITY NUMBER:** 306000347
VISIT DATE: 06/04/2026

NARRATIVE

The Life Guidance Director reported that they are unaware of R1 missing any meals. Witness 1 (W1) reported they had video footage proving the allegation, but it was never provided. None of the evidence gathered supports the allegation. Based on the evidence gathered the allegation, facility staff did not follow resident's admission agreement, is unsubstantiated. Although the allegation may have happened or is valid, there is no preponderance of evidence to prove the alleged violation did or did not occur.

The investigation into the allegation, facility staff did not shower resident as needed, revealed the following. It was reported that R1 only received 3 showers in a 3 and a half week period. R1 moved into the facility on July 3, 2025, and moved out on July 24, 2025. W1 reported that R1 was suppose to receive 3 showers a week but did not receive them. R1 was moved into memory care on July 11, 2025 due to wandering behaviors and to have more supervision. 4 out of 4 staff reported that R1 was combative and always refused showers when approached. 4 out of 4 staff reported that they asked R1 later if they wanted to shower and R1 usually agreed. None of the staff interviewed remember a specific day or time R1 missed a shower. R1 moved out of the facility and their location is unknown so they could not be interviewed. Facility does not keep shower records. 4 out of 4 staff reported they do not know how many showers R1 received during their stay at the facility. The Life Guidance Director reported that staff do all they can to make sure residents are showered regularly but in the case of R1, R1 could be combative and hit staff so if R1 refused a shower and hit staff they could have missed a shower even though the facility attempted to provide one. All staff interviewed reported that if someone missed a shower they would attempt to provide one the next day. None of the evidence gathered supports the allegation. Based on the evidence gathered the allegation is unsubstantiated. Although the allegation may have happened or is valid, there is no preponderance of evidence to prove the alleged violation did or did not occur.

The investigation into the allegation, facility staff handled resident in a rough manner, revealed the following. It was reported that Staff 1 (S1) handled R1 in a rough manner. No dates or times were provided for when S1 handled R1 in a rough manner. W1 reported there was video footage of S1 handling R1 in a rough manner. No video footage was ever provided. S1 denied the allegation. 4 out of 4 staff interviewed including S1 reported that they have never witnessed any resident being handled in a rough manner. The Life Guidance Director reported they were unaware of any resident being handled in a rough manner and have never witnessed any resident being handled in a rough manner.

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Control Number 22-AS-20250728090508

NARRATIVE

R1 moved out of the facility and their location is unknown so they could not be interviewed. Based on the evidence gathered the allegation is unsubstantiated. Although the allegation may have happened or is valid, there is no preponderance of evidence to prove the alleged violation did or did not occur.

The investigation into the allegation, facility staff did not ensure resident had clean bed linens, revealed the following. It was reported that R1 had urine soaked sheets that were not changed. W1 reported that R1's sheets were soiled with urine and Staff 1 (S1) made R1's bed and left the soiled sheets on the bed and they were not changed until the next day. No dates or times for this incident were provided. W1 reported they had video footage of the incident but it was never provided. S1 denied the report. 4 out of 4 staff interviewed including S1 reported that beds would never be made with soiled sheets and all bedding is changed when it is soiled. 4 out 4 staff interviewed including S1 reported that bedding is changed regularly for all residents. During the initial 10-Day visit LPA inspected resident rooms and did not observe any soiled linens in resident rooms. Based on the evidence gathered the allegation is unsubstantiated. Although the allegation may have happened or is valid, there is no preponderance of evidence to prove the alleged violation did or did not occur.

The investigation into the allegation, facility staff did not respond to resident's calls for assistance in a timely manner revealed the following. It was reported that R1 fell on July 21, 2025, at 2:15 am and was on the floor until 5:00 am and facility staff did not respond to R1's call for help in a timely manner. Witness 1 (W1) reported they had video footage to prove the allegation but it was never provided. A review of facility records shows that on R1's progress notes, R1 had been put on 1 hour status checks on July 21, 2025, due to agitation. The records show that R1 was checked at 2:00 am on July 22, 2025 and then at 3:00 am R1 was found on the floor. Staff called 911 and R1 was transported to the hospital. Staff 1 (S1) who was present at the facility at the time of the incident reported that they did not hear R1 or any resident call for assistance. A review of call logs for the signal system shows that R1 did not hit the call button in their room. The facility reported the incident to R1's responsible party and the Agency. The incident report shows R1 fell on July 22, 2025. Based on the evidence gathered the allegation is unsubstantiated. Although the allegation may have happened or is valid, there is no preponderance of evidence to prove the alleged violation did or did not occur. An exit interview was conducted and a copy of the report provided.

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LICENSING EVALUATOR NAME: Joseph Alejandre
LICENSING EVALUATOR SIGNATURE:
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