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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306001408
Report Date: 12/23/2025
Date Signed: 12/23/2025 04:29:27 PM

Substantiated

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 **10/10/2025** and conducted by Evaluator Brandon Lopez

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20251010214134

FACILITY NAME:	PARK PLAZA			**FACILITY NUMBER:**	306001408
ADMINISTRATOR:	BENJAMIN DAVIS			**FACILITY TYPE:**	740
ADDRESS:	620 S. GLASSELL STREET			**TELEPHONE:**	(714) 997-5355
CITY:	ORANGE	**STATE:** CA		**ZIP CODE:**	92866
CAPACITY:	115	**CENSUS:** 87		**DATE:**	12/23/2025
		UNANNOUNCED		**TIME BEGAN:**	03:50 PM
MET WITH:	Assisted Living Director Christina Gonzalez			**TIME COMPLETED:**	04:45 PM

ALLEGATION(S):

1	Staff did not seek medical attention in a timely manner resulting in resident passing away.
2	Staff did not observe changes in resident's condition.
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INVESTIGATION FINDINGS:

1	On December 23, 2025, Licensing Program Analyst (LPA) Brandon Lopez made an unannounced visit to
2	the facility to deliver the complaint findings. LPA was greeted and granted entry into the facility by staff
3	after explaining the purpose for the visit. Assisted Living Director Christina Gonzalez was present and
4	assisted on today's visit.
5	
6	During the course of the investigation, the Department inspected the facility, interviewed staff, and
7	obtained and reviewed resident records. Regarding the allegation that staff did not seek medical attention
8	in a timely manner resulting in residents passing away, the following has been concluded: Resident #1
9	(R1) was admitted to the facility on July 29, 2023. Per R1's Physician Report dated July 26, 2023, R1
10	had a primary diagnosis of Mild Cognitive Impairment; was non-ambulatory; was unable to manage her
11	own treatment/medication; was confused/disoriented at times; and was unable to leave the facility
12	unassisted. Per the facility's charting notes, R1 had documented falls on September 17, 2023, November
13	9, 2023, and November 21, 2023. CONTINUED ON LIC9099-C

Substantiated	Estimated Days of Completion: 90

SUPERVISORS NAME: Sheila Santos
LICENSING EVALUATOR NAME: Brandon Lopez
LICENSING EVALUATOR SIGNATURE:
DATE: 12/23/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 12/23/2025

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

Control Number 22-AS-20251010214134

FACILITY NAME: PARK PLAZA **FACILITY NUMBER:** 306001408
VISIT DATE: 12/23/2025

NARRATIVE

Per the facility's charting notes dated November 21, 2023, R1 had an unwitnessed fall in her bedroom. R1 was found on the floor at approximately 3:40 AM by a facility staff and was put back in her bed after not observing any injuries and R1 denying any pain. However, it was also noted that R1 was unable to explain what happened. The facility notified R1's Responsible Party via telephone. At 1:53 PM, approximately ten hours after the fall, R1's Responsible Party came to visit and observed R1 was not behaving like herself. 9-1-1 was then called and R1 was transported to the hospital for further treatment. R1 was admitted to the hospital with a diagnosis of an intracranial hemorrhage and R1 remained in the hospital from November 21, 2023, to November 30, 2023. R1 passed away at the hospital on November 30, 2023. Per R1's certificate of death, the listed causes of death are non-traumatic intracranial hemorrhage and hypertension.

The Department conducted four staff interviews. Staff interviews conducted confirmed that R1 was placed back in her bed after sustaining her unwitnessed fall on November 21, 2023, and that 9-1-1 was not immediately called. Staff interviews also confirmed that there was a delay in calling 9-1-1 for R1 after her fall on November 21, 2023, due to R1 not complaining of any pain or declining medical attention. However, per R1's Physician Report dated July 26, 2023, R1 was unable to manage her own treatment and was confused/disoriented at times. Therefore, R1 was unable to decide if medical attention was necessary and there should not have been a delay in approximately ten hours for 9-1-1 to be called for R1 after sustaining an unwitnessed fall.

Regarding the allegation that, staff did not observe changes in resident's condition, the following has been concluded: Based on a review of R1's records, the Department observed that there were there were no re-assessments on file for R1 after she had three documented falls at the facility on September 17, 2023, November 9, 2023, or November 21, 2023, to determine if there was a change in condition or if more supervision was necessary. There were also no records to support that R1 was evaluated by her Primary Care Physician during this period to determine if the resident was at a high risk for falls. Furthermore, there were no documented fall prevention techniques in place despite R1 having three falls between September 17, 2023, and November 21, 2023.

Based on the evidence gathered during this investigation, the Department obtained sufficient evidence to substantiate the allegations that, staff did not seek medical attention in a timely manner resulting in resident passing away and that staff did not observe changes in residents' conditions. The preponderance of evidence standards has been met; therefore, the above allegations are SUBSTANTIATED.

CONTINUED ON LIC9099-C

SUPERVISORS NAME: Sheila Santos
LICENSING EVALUATOR NAME: Brandon Lopez
LICENSING EVALUATOR SIGNATURE:
DATE: 12/23/2025

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 12/23/2025

Control Number 22-AS-20251010214134

FACILITY NAME: PARK PLAZA **FACILITY NUMBER:** 306001408
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 12/23/2025

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 12/24/2025 **Section Cited** CCR 87465(g)	87465 Incidental Medical and Dental Care: (g) The licensee shall immediately telephone 9-1-1 if an injury or other circumstance has resulted in an imminent threat to a resident's health including, but not limited to, an apparent life-threatening medical crisis ... This requirement was not evidenced by:	The Assisted Living Director stated that they will conduct an in-service training course with all staff regarding the facility's fall policy to ensure that staff seek immediately medical attention for residents after sustaining falls as necessary. The Assisted Living Director
	Based on interviews and records reviewed, the licensee did not immediately call 9-1-1 after Resident #1 (R1) sustained an unwitnessed fall on November 21, 2023. Facility staff called 9-1-1 approximately ten hours after the fall. This posed an immediate health and safety risk to the resident in care.	agreed to provide LPA proof of training via email or fax by POC date.
Type A 12/24/2025 **Section Cited** CCR 87466	87466 Observation of the Resident: The licensee shall ensure that residents are regularly observed for changes in physical, mental, emotional and social functioning and that appropriate assistance is provided when such observation reveals unmet needs. ... This requirement was not evidenced by:	The Assisted Living Director stated that they will conduct an in-service training course with all facility staff regarding observing changes in residents' conditions. The Executive Director agreed to provide LPA proof of the training via email or fax by POC date.
	Based on interviews and records reviewed, the licensee did not reassess Resident #1 (R1) to determine if there was a change in condition or more supervision was necessary, despite having three falls at the facility This posed an immediate health and safety risk to the resident in care.	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

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FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 12/23/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100
ORANGE, CA 92868

FACILITY NAME: PARK PLAZA **FACILITY NUMBER:** 306001408
VISIT DATE: 12/23/2025

NARRATIVE

See LIC9099D for cited deficiencies per Title 22 Division 6 of the California Code of Regulations. Immediate civil penalties are being assessed in the amount of $500.00. See LIC421IM. A Civil Penalty is pending determination by the Community Care Licensing Division. An exit interview was conducted with Assisted Living Director Christina Gonzalez. A copy of the report and Appeal Rights were provided.

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