

# Department of SOCIAL SERVICES

Community Care Licensing

## COMPLAINT INVESTIGATION REPORT

Facility Number: 306005272  
Report Date: 06/14/2023  
Date Signed: 06/14/2023 11:00:39 AM

**Unsubstantiated**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868
<b>COMPLAINT INVESTIGATION REPORT</b>	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **05/31/2022** and conducted by Evaluator Patricia Velazquez

<b>PUBLIC</b>	<b>COMPLAINT CONTROL NUMBER: 22-AS-20220531161434</b>
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<b>FACILITY NAME:</b> PACIFICA SENIOR LIVING SOUTH COAST	<b>FACILITY NUMBER:</b> 306005272
<b>ADMINISTRATOR:</b> STACIE ANDERSON	<b>FACILITY TYPE:</b> 740
<b>ADDRESS:</b> 2619 ORANGE AVE	<b>TELEPHONE:</b> (949) 515-0121
<b>CITY:</b> COSTA MESA	<b>STATE:</b> CA
<b>CAPACITY:</b> 98	<b>ZIP CODE:</b> 92627
	<b>CENSUS:</b> 41
	<b>DATE:</b> 06/14/2023
	<b>UNANNOUNCED TIME BEGAN:</b> 08:43 AM
<b>MET WITH:</b> Stacie Anderson - Executive Director	<b>TIME COMPLETED:</b> 10:59 AM

**ALLEGATION(S):**

1	The facility failed to provide care and supervision to resident resulting in death
2	
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**INVESTIGATION FINDINGS:**

1	Licensing Program Analyst (LPA) Patricia Velazquez conducted an unannounced subsequent complaint
2	visit to deliver the findings of the investigation regarding the above allegations. LPA Velazquez was
3	greeted, granted entry into the facility and met with Executive Director Stacie Anderson and explained the
4	purpose of the visit.
5	
6	During the investigation interviews were conducted with the Resident (R) 1's family member, R1's
7	responsible party, R1's physician, facility staff, and residents. During the course of the investigation
8	facility records were obtained and reviewed as well as hospital medical records. The facility records
9	reviewed for R1 included an Admission Agreement, Durable Power of Attorney (DPOA) and Durable
10	Power of Attorney for Healthcare documents signed by resident, Physician's Orders for medications
11	dated March 31, 2022, Admission Orders dated January 31, 2022 Physician's Report with date of exam
12	documented as 12/21/2021, Need and Services Plan dated January 27, 2022, Resident Assessment
13	dated February 01, 2022 documenting R1 a Level 4 for care and services and requiring 1 person to
	assist with transfers and four status checks per hour. Records also

**Unsubstantiated**

**Estimated Days of Completion:**

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez  
**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/14/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/14/2023

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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**Control Number** 22-AS-20220531161434

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

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

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** PACIFICA SENIOR LIVING SOUTH COAST

**FACILITY NUMBER:** 306005272

**VISIT DATE:** 06/14/2023

### NARRATIVE

1 documented R1 a fall risk who required the use of a walker to assist with ambulation or use of a  
2 wheelchair. Facility records documented R1's diagnosis of Alzheimer's Dementia and multiple other co-  
3 morbidities. Review of hospital medical records page 7 indicated R1 was admitted to the Emergency  
4 Department on April 11, 2022, with diagnoses of "Nontraumatic Intracerebral Hemorrhage unspecified,  
5 Traumatic Subarachnoid Hemorrhage without loss of consciousness, Fracture of Vault of Skull, initial  
6 encounter for closed fracture, and Dependence on wheelchair." Page 18 of the hospital medical records  
7 documented a Clinical Impression of "Cerebral Hemorrhage, traumatic-including cerebral contusions,  
8 brainstem hemorrhage, subdural hemorrhage, and subarachnoid hemorrhage." R1 died at the hospital  
9 on April 13, 2022. A copy of R1's Death Certificate documented the cause of death as Traumatic  
10 Intracranial Hemorrhage due to Complications of a Ground Level Fall.  
11  
12 Regarding the allegation: The facility failed to provide care and supervision to resident resulting in death  
13 the investigation revealed the following. R1 was admitted to the Memory Care unit of Pacifica Senior  
14 Living South Coast on February 1, 2022. R1 had a history of falls and previously sustained a pelvic  
15 fracture. On April 10, 2022, at approximately 7:15 PM, R1 sustained an unwitnessed fall in their room.  
16 Staff 7(S7) was the first Caregiver who found R1 lying on the floor and notified Staff 5 (S5) of R1's  
17 unwitnessed fall. Upon entering R1's room S5 who was working as a Medication Technician observed  
18 R1 lying on the floor in a supine position with R1 holding their head with their right hand. S5 documented  
19 R1's position by taking a picture and then notifying R1's responsible party via text of R1's fall. S5 also  
20 stated they notified Staff 1 (S1) of R1's fall. S5 stated they assessed R1 for injury and pain, but no pain  
21 was reported by R1. S5 with the assistance of Staff 10 (S10) helped R1 from the floor onto their bed. S5  
22 indicated they assessed R1 by asking R1 if they had hit their head and R1 replied "no". S5 was  
23 questioned regarding the Internal Incident Report they completed on April 10, 2022, where S5 failed to  
24 document the position R1 was found in as well as why S5 did not immediately call 911 following R1's  
25 unwitnessed fall. S5 stated they relied on what the resident was reporting and the family to make the  
26 decision for medical treatment. S1 stated R1 was observed more frequently throughout the night, but no  
27 written record was documented regarding how often R1 was checked and what type of assessment was  
28 conducted. S1 could not provide a response when asked why 911 was not called when S1 received a  
29 photo of R1 lying on the floor holding their head. S1 stated R1 "appeared to be okay with no visible  
30 injury." The last time S5 checked on R1 was at the end of their shift at approximately 10:30 PM and per  
31 S5, R1 was watching a movie. On April 11, 2022, Staff 8 (S8) a Caregiver observed R1 had a change of  
32 condition and appeared more confused but S8 did not request anyone to assess R1. When

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez  
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**DATE:** 06/14/2023

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**DATE:** 06/14/2023

**COMPLAINT INVESTIGATION REPORT**

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**ADMINISTRATOR:** STACIE ANDERSON      **FACILITY TYPE:** 740  
**ADDRESS:** 2619 ORANGE AVE      **TELEPHONE:** (949) 515-0121  
**CITY:** COSTA MESA      **STATE:** CA      **ZIP CODE:** 92627  
**CAPACITY:** 98      **CENSUS:** 41      **DATE:** 06/14/2023  
**MET WITH:** Stacie Anderson - Executive Director      **UNANNOUNCED TIME BEGAN:** 08:43 AM  
**COMPLETED:** 10:59 AM

**ALLEGATION(S):**

- 1 Staff did not seek medical attention after the fall
- 2 Staff did not observe resident for change in condition
- 3 Staff did not report incident to appropriate parties
- 4 Facility did not refund responsible party after the death of the resident
- 5 Facility did not release records to responsible party
- 6
- 7
- 8
- 9

**INVESTIGATION FINDINGS:**

- 1 Licensing Program Analyst (LPA) Patricia Velazquez conducted an unannounced subsequent complaint
  - 2 visit to deliver the findings of the investigation regarding the above allegations. LPA Velazquez was
  - 3 greeted, granted entry into the facility and met with Executive Director Stacie Anderson and explained the
  - 4 purpose of the visit.
  - 5
  - 6 Regarding the allegations: Staff did not seek medical attention after the fall and Staff did not observe
  - 7 resident for change in condition the Department's investigation revealed the following. Resident 1 (R1)
  - 8 was admitted to the Memory Care unit of Pacifica Senior Living South Coast on February 1, 2022. R1
  - 9 had a history of falls and previously sustained a pelvic fracture. On April 10, 2022, at approximately 7:15
  - 10 PM, R1 sustained an unwitnessed fall in their room. Staff 7 (S7) was the first Caregiver who found R1
  - 11 lying on the floor and notified Staff 5 (S5) of R1's unwitnessed fall. Upon entering R1's room S5 who was
  - 12 working as a Medication Technician observed R1 lying on the floor in a supine position with R1 holding
  - 13 their head with their right hand. S5 documented R1's position by taking a picture and then notifying R1's
- responsible party via text of R1's fall. S5 also stated they notified Staff 1 (S1) of R1's fall. S5 stated they assessed R1 for injury and pain, but no pain

**Substantiated****Estimated Days of Completion:**

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez  
**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/14/2023

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**Control Number 22-AS-20220531161434**

## NARRATIVE

1 was reported by R1. S5 with the assistance of Staff 10 (S10) helped R1 from the floor onto their bed. S5  
 2 indicated they assessed R1 by asking R1 if they had hit their head and R1 replied "no". S5 was  
 3 questioned regarding the Internal Incident Report they completed on April 10, 2022, where S5 failed to  
 4 document the position R1 was found in as well as why S5 did not immediately call 911 following R1's  
 5 unwitnessed fall. S5 stated they relied on what the resident was reporting and the family to make the  
 6 decision for medical treatment. S1 stated R1 was observed more frequently throughout the night, but no  
 7 written record was documented regarding how often R1 was checked and what type of assessment was  
 8 conducted. S1 could not provide a response when asked why 911 was not called when S1 received a  
 9 photo of R1 lying on the floor holding their head. S1 stated R1 "appeared to be okay with no visible  
 10 injury." The last time S5 checked on R1 was at the end of their shift at approximately 10:30 PM and per  
 11 S5, R1 was watching a movie. On April 11, 2022, Staff 8 (S8) a Caregiver observed R1 had a change of  
 12 condition and appeared more confused but S8 did not request anyone assess R1. When questioned  
 13 why they had not asked R1 to be re-assessed due to his change of condition, S8 replied, "I didn't think  
 14 of it." S8 with the assistance of Staff 6 (S6), a Medication Technician helped R1 get dressed as R1 was  
 15 expecting visitors that morning. S8 stated while they were dressing R1, S6 observed the back of R1's  
 16 head was red "like a bruise" and when S6 touched R1's head R1 complained of pain. S6 also stated  
 17 when they were initially dressing R1, R1 was moaning as if in pain but S6 attributed the moaning to R1's  
 18 low back pain which R1 had been complaining of the week before. When questioned why R1 was not  
 19 assessed on the morning of April 11, 2022, upon being notified of R1's fall, S6 stated, "I don't know."  
 20 When the reporting party and a nurse arrived to see R1, they were not notified of R1's change of  
 21 condition. The nurse evaluated R1 and noticed a dark blue discoloration on the back of R1's head as  
 22 well as redness around R1's neck. The nurse recommended R1 be transported to the hospital for further  
 23 evaluation. R1 was then transported to hospital via ambulance and was admitted into the Intensive Care  
 24 Unit. R1 subsequently experienced sudden deterioration and died on April 13, 2022.  
 25  
 26 Regarding the allegation facility did not refund responsible party after the death of the resident, the  
 27 Department's investigation revealed the following. Staff 2 (S2) submitted a request for a refund via email  
 28 on April 22, 2022, to the Regional Director of Operations. S2 stated R1's personal belongings were  
 29 picked up on April 15, 2022, with no additional charges being incurred after that date. The refund  
 30 process included submission of copies of the following documents: Refund Request Form dated April  
 31 22, 2022, POA documents, lease agreement, and Resident Detail Ledger. Per S2 the documents were  
 32 uploaded onto a website for further processing. Due to an error S2 had to submit a second refund  
 request on May 18, 2022. S2 further stated the refund process usually takes four to six weeks.

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos

**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/14/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/14/2023

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**Control Number** 22-AS-20220531161434

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CALIFORNIA DEPARTMENT OF SOCIAL  
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 COMMUNITY CARE LICENSING DIVISION  
 CCLD Regional Office, 770 THE CITY DR., SUITE  
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 ORANGE, CA 92868

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** PACIFICA SENIOR LIVING SOUTH COAST

**FACILITY NUMBER:** 306005272

**VISIT DATE:** 06/14/2023

## NARRATIVE

1 The records reviewed included the April 22, 2022, email initiating the refund process, copies of the  
 2 Resident Refund Form dated April 22, 2022, and a second one dated May 18, 2022, and copy of an  
 3 email dated June 1, 2022, sent to S2 confirming completion of the refund request. The refund amount of  
 4 \$2411.18 was made payable to R1's family member and mailed on May 31, 2022. R1's family member  
 5 confirmed the refund was received on June 3, 2022, but it did not include a written explanation of the  
 6 breakdown of charges and credits. Email communication between S1 and R1's family member dated  
 7 August 16, 2022, indicated R1's family was still owed an additional \$1500 as the original refund amount  
 8 was not accurately calculated as verified by S1. S1 proceeded to submit an additional refund request for  
 9 the balance still owed to R1's family. Review of the facility's Admission Agreement page 19 revealed,  
 10 "Within fifteen (15) days after your personal property is removed from your apartment, your estate, or  
 11 other person or entity responsible for payment of fees under this Agreement, will receive a refund of any

12 fees paid in advance covering the period after your personal property has been removed." The facility  
 13 violated its own Admission Agreement by failing to issue a refund in a timely manner.  
 14  
 15 Regarding the allegation: staff did not report incident to appropriate parties, the Department's  
 16 investigation revealed the following. Records reviewed included email communication between facility  
 17 staff and R1's family member, Internal Incident Reports dated April 10, 2022, and one dated April 11,  
 18 2022, screenshots of text communication between S5 and R1's family member regarding R1's fall, and  
 19 phone records documenting communication between the facility and R1's family member. The facility  
 20 provided a copy of their Internal Incident Report completed by S5 and dated April 10, 2022. The report  
 21 documented that R1 stated they fell and landed on their bottom with no head injury or redness noted.  
 22 Upon entering R1's room S5 took a picture documenting R1's position. S5 indicated they proceeded to  
 23 contact the R1's family member via text and included the picture of R1 on the floor. The Internal Incident  
 24 Report further documented R1's physician had been notified of R1's fall via FAX at 9:00 PM on April 10,  
 25 2022, but R1's physician refutes this fact and asserted they did not receive any notification. Both S1 and  
 26 S5 could not provide written documentation confirming R1's physician had been notified of this incident.  
 27 S1 and Staff 4 (S4) confirmed the facility did not submit a written Incident Report regarding R1's fall to  
 28 Licensing as required. S1 and S4 also confirmed the facility did not submit a written Death Report to  
 29 Licensing because S4 stated they did not know it was required because R1 passed away at the hospital.  
 30 LPA Velazquez proceeded to request a Death Report and S4 emailed a copy of the Death Report to LPA  
 31 on June 3, 2022, with a submission date of April 15, 2022, documented which was inaccurate. LPA then  
 32 requested a corrected Death Report be submitted reflecting the actual submission date of June 3, 2022.

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_ **DATE:** 06/14/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:** \_\_\_\_\_ **DATE:** 06/14/2023

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  <b>COMPLAINT INVESTIGATION REPORT (Cont)</b>	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868
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**FACILITY NAME:** PACIFICA SENIOR LIVING SOUTH COAST

**FACILITY NUMBER:** 306005272

**DEFICIENCY INFORMATION FOR THIS PAGE:**

**VISIT DATE:** 06/14/2023

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 06/15/2023 <b>Section Cited</b> CCR 87465(g)	1 Incidental Medical and Dental Care. 2 The licensee shall immediately 3 telephone 9-1-1 if an injury or other 4 circumstance has resulted in an 5 imminent threat to a resident's 6 health...specified in Sections 87469...or 7 (c)(4).	1 Licensee will provide staff an in-service 2 training regarding this regulation by 3 June 25, 2023. Licensee to provide the 4 name of the instructor, their 5 qualifications, and submit written proof 6 of the 7
	8 This requirement is not met as 9 evidenced by: based on resident record 10 review & interviews conducted the 11 licensee failed to call 911 following R1's 12 unwitnessed fall on 04/10/2022. This 13 poses an immediate risk to the health & 14 safety of residents in care.	8 staff training to LPA by POC due date. 9 The licensee to provide LPA a written 10 statement indicating they have read this 11 section of Title 22 regulation and how 12 exactly they intend to adhere to it by 13 POC due date. 14
Type A 06/15/2023 <b>Section Cited</b> CCR 87466	1 Observation of the Resident. The 2 Licensee to ensure that residents are 3 regularly observed for changes in 4 physical, mental, emotional and social 5 functioning and that appropriate 6 assistance is provided 7	1 The Licensee to ensure that residents 2 are regularly observed for changes and 3 that appropriate assistance is provided 4 when such observation reveals unmet 5 needs. Licensee to provide staff an in- 6 service training 7

	8 when such observation reveals unmet 9 needs. This requirement is not met as 10 evidenced by: based on resident record 11 review & interviews conducted the 12 licensee failed to observe R1's change 13 in condition following the unwitnessed 14 fall on 04/10/2022.	8 9 10 11 12 13 14	regarding this regulation. Licensee to provide the name of the instructor, their qualifications, and submit written proof of the staff training to LPA by POC due date of June 25, 2023.
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**Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.**

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_ **DATE:** 06/14/2023

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**FACILITY REPRESENTATIVE SIGNATURE:** \_\_\_\_\_ **DATE:** 06/14/2023

LIC9099 (FAS) - (06/04)

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  <b>COMPLAINT INVESTIGATION REPORT (Cont)</b>	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868
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**DEFICIENCY INFORMATION FOR THIS PAGE:**

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Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 06/16/2023 <b>Section Cited</b> CCR 87211(a)(1)(A)	1 Reporting Requirements. Each 2 Licensee shall furnish...reports as the 3 Department may require...the following: 4 A written report shall be submitted to 5 the licensing agency and to the person 6 responsible for the resident seven days 7 of the occurrence of...events specified in (A)...below. This	1 The Licensee to ensure written reports 2 are submitted to the Department 3 pursuant to this regulation. 4 5 6 7
	8 requirement is not met as evidenced 9 by: based on resident record review & 10 interviews conducted the Licensee 11 failed to submit an Incident & Death 12 Report to Licensing for R1. This poses 13 a potential risk to the health and safety 14 of the residents in care.	8 The Licensee to provide LPA a written 9 statement indicating they have read this 10 section of Title 22 regulation and how 11 exactly they intend to adhere to it by 12 POC due date. 13 14
Type B 06/16/2023 <b>Section Cited</b> HSC 1569.269(a)(21)	1 Enumerated rights; severability. 2 Residents of residential care facilities 3 for the elderly shall have all of the 4 following rights: To have prompt access 5 to review all of their records and to 6 purchase photocopies...records shall be 7 promptly provided, not to exceed two business days.	1 The Licensee to ensure it provides 2 resident records to their responsible 3 party or legal representative pursuant to 4 statute and regulation. 5 6 7
	8 This requirement is not met as 9 evidenced by the Licensee's failure to 10 provide R1's records to their legal 11 representative. This poses a potential 12 risk to the health & safety of residents 13 in care. 14	8 The Licensee to provide LPA a written 9 statement indicating they have read this 10 section of the HSC and how exactly 11 they intend to adhere to it by POC due 12 date. 13 14

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

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos  
**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez

LICENSING PROGRAM ANALYST SIGNATURE: \_\_\_\_\_ DATE: 06/14/2023

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LIC9099 (FAS) - (06/04)

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<b>COMPLAINT INVESTIGATION REPORT (Cont)</b>	

FACILITY NAME: PACIFICA SENIOR LIVING SOUTH COAST  
DEFICIENCY INFORMATION FOR THIS PAGE:

FACILITY NUMBER: 306005272  
VISIT DATE: 06/14/2023

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 06/16/2023 Section Cited HSC 1569.652(c)	1 Termination of admission agreement 2 upon death of resident; removal of 3 resident's property; refund of fees paid; 4 notice of contract termination and 5 refunds...removed. This requirement is 6 not met as 7	1 The Licensee to ensure it provides 2 refunds of funds paid in advance 3 pursuant to statute and regulation. The 4 Licensee to provide LPA a written 5 statement indicating they have read 6 7
	8 evidenced by: based on resident record 9 review and interviews conducted, the 10 Licensee failed to provide a refund of 11 monies due R1's family. This poses a 12 potential risk to the health and safety of 13 residents in care. 14	8 this section of the HSC and how exactly 9 they intend to adhere to it by POC due 10 date. 11 12 13 14
	1 2 3 4 5 6 7	1 2 3 4 5 6 7
	1 2 3 4 5 6 7	1 2 3 4 5 6 7

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

NAME OF LICENSING PROGRAM MANAGER: Sheila Santos  
NAME OF LICENSING PROGRAM ANALYST: Patricia Velazquez  
LICENSING PROGRAM ANALYST SIGNATURE: \_\_\_\_\_ DATE: 06/14/2023

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FACILITY REPRESENTATIVE SIGNATURE: \_\_\_\_\_ DATE: 06/14/2023

LIC9099 (FAS) - (06/04)

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Control Number 22-AS-20220531161434

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<b>COMPLAINT INVESTIGATION REPORT (Cont)</b>	

<b>NARRATIVE</b>	
1	Regarding the allegation: facility did not release records to responsible party, the Department's
2	investigation revealed the following. Records reviewed included email communication between R1's
3	family and facility staff documenting R1's family repeatedly requesting a copy of R1's records including
4	the breakdown of charges and credits for R1. An email dated May 25, 2022, requesting R1's records
5	from R1's spouse was sent to four facility staff with a copy to R1's family member. S1 emailed LPA on
6	August 16, 2022, stating a copy of R1's records had been sent to R1's family on July 11, 2022, several
7	weeks after a written request for records had been submitted to the facility. R1's family member
8	confirmed receipt of R1's records on July 13, 2022.
9	
10	Based on the observations made, interviews which were conducted, and the records reviewed, the
11	preponderance of evidence standard has been met, therefore the following allegations: Staff did not
12	seek medical attention after the fall, Staff did not observe resident for change in condition, Staff did not
13	report incident to appropriate parties, Facility did not refund responsible party after the death of the
14	resident, and Facility did not release records to responsible party, are all deemed SUBSTANTIATED.
15	California Code of Regulations, Title 22, Division 6, Chapter 1 and/or the Health and Safety Code is
16	being cited on the attached LIC 9099 D.
17	
18	
19	
20	
21	An exit interview was conducted with Executive Director Stacie Anderson and a copy of this report along
22	with the LIC 811s, LIC 9098, and appeal rights were provided at the time of this visit.
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<b>NAME OF LICENSING PROGRAM MANAGER:</b> Sheila Santos	
<b>NAME OF LICENSING PROGRAM ANALYST:</b> Patricia Velazquez	
<b>LICENSING PROGRAM ANALYST SIGNATURE:</b>	<b>DATE:</b> 06/14/2023

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<b>FACILITY REPRESENTATIVE SIGNATURE:</b>	<b>DATE:</b> 06/14/2023
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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  <b>COMPLAINT INVESTIGATION REPORT</b> <b>(Cont)</b>	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868
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<b>NARRATIVE</b>	
1	questioned why they had not asked R1 to be re-assessed due to their change of condition, S8 replied, "I
2	didn't think of it." S8 with the assistance of Staff 6 (S6), a Medication Technician helped R1 get dressed
3	as R1 was expecting visitors that morning. S8 stated while they were dressing R1, S6 observed the
4	back of R1's head was red "like a bruise" and when S6 touched R1's head R1 complained of pain. S6
5	also stated when they were initially dressing R1, R1 was moaning as if in pain but S6 attributed the
6	moaning to R1's low back pain which R1 had been complaining of the week before. When questioned
7	why R1 was not assessed on the morning of April 11, 2022, upon being notified of R1's fall, S6 stated, "I
8	don't know." When R1's family member and a nurse arrived to see R1, they were not notified of R1's
9	change of condition. The nurse evaluated R1 and noticed a dark blue discoloration on the back of R1's
10	head as well as redness around R1's neck. The nurse recommended R1 be transported to the hospital
11	for further evaluation. R1 was then transported to the hospital via ambulance and was admitted into the

12 Intensive Care Unit. R1 subsequently experienced sudden deterioration and died on April 13, 2022.

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Based on the observations made, interviews which were conducted and the records that were reviewed, although the allegation may have happened or is valid, there is not a preponderance of evidence to prove the alleged violation did or did not occur, therefore the following allegation: The facility failed to provide care and supervision to resident resulting in death is deemed UNSUBSTANTIATED.

**NAME OF LICENSING PROGRAM MANAGER:** Sheila Santos

**NAME OF LICENSING PROGRAM ANALYST:** Patricia Velazquez

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/14/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/14/2023