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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 306005272
Report Date: 01/23/2026
Date Signed: 01/23/2026 09:50:54 AM

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

FACILITY NAME:	PACIFICA SENIOR LIVING SOUTH COAST		FACILITY NUMBER:	306005272
ADMINISTRATOR/ DIRECTOR:	YAYLENE MAZARIEGOS		FACILITY TYPE:	740
ADDRESS:	2619 ORANGE AVE		TELEPHONE:	(949) 515-0121
CITY:	COSTA MESA	STATE: CA	ZIP CODE:	92627
CAPACITY: 98		CENSUS: 66	DATE:	01/23/2026
TYPE OF VISIT:	Case Management - Deficiencies	UNANNOUNCED	TIME VISIT/ INSPECTION BEGAN:	08:20 AM
MET WITH:	Yaylene Mazariegos		TIME VISIT/ INSPECTION COMPLETED:	10:05 AM

NARRATIVE

Licensing Program Analyst (LPA) Fred Arias conducted an unannounced case management visit to deliver findings on an investigation completed by the Department. LPA was greeted and granted entry into the facility by staff and explained the purpose of the visit.

On June 6, 2025, the Orange County Regional Office received an incident report regarding unwitnessed falls involving Resident 1 (R1) resulting in a closed fracture. The investigation determined the following:

R1 was admitted to the facility on April 30, 2025, and was identified as a high fall risk based on the Preplacement Appraisal and Morse Fall Scale completed on April 28, 2025, by the facility staff. R1 sustained an initial unwitnessed fall on May 26,2025 and a secondary fall on May 30, 2025 per incident reports submitted to the Department. On May 26, 2025, at approximately 1:10 p.m., R1 sustained an unwitnessed fall in the common television room area of the memory care unit. R1 was found on the floor complaining of left ankle pain and was transported to the hospital for evaluation. R1 was diagnosed with a contusion of the lower leg and discharged back to the facility the same day. Hospital discharge instructions on May 26, 2025, directed the facility to ensure R1 was seen by their primary care physician (PCP) within three days. Interview with R1's PCP confirmed the facility did not contact R1's PCP following this incident, and no documented physician follow-up occurred until June 3, 2025.

Continued on LIC809-C dated 01/23/2026

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
NAME OF LICENSING PROGRAM ANALYST: Fred Arias

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 01/23/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 01/23/2026

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

FACILITY EVALUATION REPORT California law requires a public report of each licensing visit/inspection. This report is a record for the facility and the licensing agency. This report is available for public review; therefore, care is taken not to disclose personal or confidential information. Inquiries concerning the location, maintenance, and contents of these reports may be directed to the Licensing Program Analyst or Regional Office whose address and telephone number are listed on the front of this form.

DEFICIENCIES A deficiency is an instance of noncompliance with licensing requirements, including applicable statutes, regulations, interim licensing standards, operating standards, and written directives. Applicants/ licensees must be notified in writing of all licensing deficiencies. Deficiencies are listed on the left side of this form, and the applicable licensing requirement upon which the deficiency is identified. There are two types of deficiencies:

- Type A deficiencies are violations of licensing requirements that, if not corrected, have a direct and immediate risk to the health, safety, or personal rights of persons in care.

- Type B deficiencies are violations of licensing requirements that, without correction, could become a risk to the health, safety, or personal rights of persons in care, a recordkeeping violation that could impact the care of said persons and/or protection of their resources, or a violation that could impact those services required to meet the needs of persons in care.

PLANS OF CORRECTION (POCs) The licensing agency is required to establish a reasonable length of time to correct a deficiency. In order to set the time, the licensing agency must take into consideration the seriousness of the violation, the number of persons in care involved, and the availability of equipment and personnel necessary to correct the violation. Applicants/licensees are requested to provide a specific plan for each violation on the right side of the form across from each deficiency. The more specific the plan, the less chance exists for any misunderstanding in setting time limits and reviewing corrections. The applicant/licensee who encounters problems beyond their control in completing the corrections within the specified time frame may request and may be granted an extension of the correction due date by the licensing agency.

CORRECTION NOTIFICATION The applicant/licensee is responsible for completing all corrections and promptly notifying the licensing agency of corrections. Applicants/licensees are advised to keep a dated copy of any correspondence sent to the licensing agency concerning corrections, or if corrections are telephoned to the licensing agency, the date, person contacted, and information given.

CIVIL PENALTIES The licensing agency is required by law to issue a Penalty Notice, when applicable, to all facilities holding a license issued by the licensing agency, or subject to licensure, except Certified Family Homes, Resource Families, and Foster Family Homes, or any governmental entity.

PENALTY NOTICE GIVEN The statement concerning civil penalties serves as a penalty notice on this Licensing Report and failure to correct cited licensing deficiencies will result in civil penalties. Applicants/ licensees are required to pay civil penalties when administrative appeals have been exhausted and in accordance with any payment arrangements made with the licensing agency.

APPEAL RIGHTS The applicant/licensee has a right without prejudice to discuss any disagreement in this report with the licensing agency concerning the proper application of licensing requirements. The applicant/ licensee may request a formal review by the licensing agency to amend or dismiss the notice of deficiency and/ or civil penalty. Requests for review shall be made in writing within 15 business days of receipt of a deficiency notification or civil penalty assessment. Licensing deficiencies may be appealed pursuant to the procedures in the LIC 9058 Applicant/Licensee Rights.

AGENCY REVIEW The licensing agency review of an appeal may be conducted based upon information provided in writing by the applicant/licensee. The applicant/licensee may request an office meeting to provide additional information. The applicant/licensee will be notified in writing of the results of the agency review within 60 business days of the date when all necessary information has been provided to the licensing agency.

EMAIL REQUIREMENT Adult Community Care Facilities, Residential Care Facilities for the Chronically Ill, and Residential Care Facilities for the Elderly are required to provide and maintain an active email address of record with the licensing agency.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION 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: PACIFICA SENIOR LIVING SOUTH COAST **FACILITY NUMBER:** 306005272
VISIT DATE: 01/23/2026

NARRATIVE

On May 30, 2025, R1's service plan was updated to reflect increased needs, including requiring assistance with transferring and mobility. At the time the service plan was updated, R1's physician had still not been consulted regarding R1's initial fall. At approximately 8:40 p.m. the same day, R1 sustained a second unwitnessed fall in their bedroom and was found on the floor next to their bed. R1 was transported again to the hospital, where diagnostic imaging revealed fractures of the right inferior pubic ramus and right superior pubic ramus.

Interviews conducted with three out of three facility staff members identified as being involved in R1's care during the relevant time periods revealed that none were able to recall the last time they had seen R1 prior to the May 30, 2025, fall. One staff member reported that routine resident checks in the memory care unit are typically conducted every 20 to 30 minutes; However, no staff member was able to provide a specific timeframe or documentation verifying when R1 was last observed before being found on the floor.

The investigation further determined that residents in the memory care unit do not utilize personal call pendants, although the building does have a pull cord system. However, Residents who are unable to cognitively know how to utilize the system and require assistance must verbally call out for help, requiring staff to be within hearing distance. Given R1's documented fall risk, impaired mobility, and need for assistance with transfers, the facility did not implement adequate monitoring or supervision measures to ensure R1's safety.

Based on the totality of evidence obtained, the Department has concluded that the facility failed to provide adequate care and supervision to a known fall-risk resident by not implementing reasonable safety measures or monitoring practices resulting in R1 sustaining an unwitnessed fall and injury.

The following is being cited per California Code of Regulations, Title 22.
A Civil Penalty is pending determination by Community Care Licensing Division as per H&S Code 1569.49(f).

An exit interview was conducted with Executive Director Yaylene Mazariegos, and a copy of this report, the LIC 809-D, the LIC 421IM and Appeal Rights were provided to the facility. A copy will be mailed to the licensee to the address on file.

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
NAME OF LICENSING PROGRAM ANALYST: Fred Arias
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 01/23/2026

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 01/23/2026

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Created By: Fred Arias On 01/23/2026 at 08:35 AM

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT (Cont)**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION , 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

FACILITY NAME: PACIFICA SENIOR LIVING SOUTH COAST **FACILITY NUMBER:** 306005272

DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 01/23/2026

Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Type A 01/24/2026 **Section Cited** CCR 87464(f)(1)	1 2 3 4 5 6 7	Basic Services 87464(f)(1) Basic services shall at a minimum include: Care and supervision as defined in Section 87101(c)(3) and Health and Safety Code section 1569.2(c). This requirement is not met as evidence by:	1 2 3 4 5 6 7	AD stated logs have been implemented to record safety check per resident in memory care. Furthermore, iPad will be issued to staff to ensure residents are being check on an hourly basis in the future. AD will provide copies of logs and in-service training by POC due date.
	8 9 10 11 12 13 14	The Licensee failed to identify fall preventative measures needed to meet R1's needs resulting in R1 sustaining a second fall with closed fracture diagnosis. This poses an immediate risk to resident's health and safety.	8 9 10 11 12 13 14	
Type A 01/24/2026 **Section Cited** CCR87465(a)(1)	1 2 3 4 5 6 7	Incidental Medical and Dental Care 87465(a)(1) The licensee shall arrange, or assist in arranging, for medical and dental care appropriate to the conditions and needs of residents. This requirement was not met as evidence by:	1 2 3 4 5 6 7	AD stated in-service training will be performed with staff specifically on reviewed discharge documents and instructions. AD to provide proof of training by POC due date.
	8 9 10 11 12 13 14	The Licensee did not follow up with R1's primary care physician as instructed per hospital discharge paperwork following R1's fall on 5/26/25. This poses an immediate risk to resident's health and safety.	8 9 10 11 12 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: Alisa Ortiz

NAME OF LICENSING PROGRAM ANALYST: Fred Arias

LICENSING PROGRAM ANALYST SIGNATURE:

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FACILITY NAME: PACIFICA SENIOR LIVING SOUTH COAST **FACILITY NUMBER:** 306005272

DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 01/23/2026

Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Type B 01/30/2026 **Section Cited** CCR 87463(c)(3)	1 2 3 4 5 6 7	Reappraisals 87463(c)(3) … the licensee shall document all of the following in the resident's reappraisal: Interventions to be implemented to minimize the risks to the health and safety of the resident or others associated with the resident's behavioral expression…	1 2 3 4 5 6 7	AD stated R1 is on home health for physical therapy once per week. In addition, R1 has been placed on hour checks which are documented in a log. AD to provide proof of physical therapy and logs by POC due date.
	8 9 10 11 12 13 14	This requirement is not met as evidence by: The Licensee failed to document interventions to be implemented to minimize falls after identifying R1 as a fall risk. This poses a potential risk to resident's health and safety.	8 9 10 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: Alisa Ortiz

NAME OF LICENSING PROGRAM ANALYST: Fred Arias

LICENSING PROGRAM ANALYST SIGNATURE:

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