

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306005310
Report Date: 07/29/2026
Date Signed: 07/29/2026 10:44:03 AM

Unsubstantiated

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on 04/02/2025 and conducted by Evaluator Michael Tea

	COMPLAINT CONTROL NUMBER: 22-AS-20250402151104
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FACILITY NAME:	QUEEN'S HOME 2	FACILITY NUMBER:	306005310
ADMINISTRATOR:	MAGHBOULEH, KATAYOUN	FACILITY TYPE:	740
ADDRESS:	26545 AVENIDA DESEO	TELEPHONE:	(949) 716-1907
CITY:	MISSION VIEJO	ZIP CODE:	92691
CAPACITY:	6	DATE:	07/29/2026
	STATE: CA	UNANNOUNCED TIME BEGAN:	09:00 AM
	CENSUS: 6	TIME	
MET WITH:	Arlene Mahinay	COMPLETED:	11:00 AM

ALLEGATION(S):

1	Allegation 1: Facility refused to allow resident back without payment
2	Allegation 3: Facility administrator was yelling in the facility
3	Allegation 4: Facility neglected to report pressure injury
4	Allegation 5: The facility does not maintain room temperature to sixty eight degrees
5	Allegation 6: Facility does not provide food of good quality
6	
7	
8	
9	

INVESTIGATION FINDINGS:

1	On this day, Licensing Program Analyst (LPA) Michael Tea made an unannounced visit to conclude and deliver findings for a complaint investigation. LPA Tea was greeted and granted entry by facility staff and
2	explained the purpose of the visit. Licensee (LE) Kathy Maghbouleh and Administrator (AD) Arya
3	Maghbouleh were unavailable during today's visit. However, the Licensing Program Analyst (LPA) spoke
4	with management staff by telephone.
5	
6	
7	The Department received a complaint on April 2, 2025. During the investigation, LPA Tea conducted
8	interviews and reviewed facility records, emails, admission documents, hospital records, home health
9	records, and other documents.
10	
11	It was alleged that the facility refused to allow Resident 1 (R1) to return without payment. During the
12	investigation, LPA interviewed AD Maghbouleh, who denied refusing R1's return to the facility. AD
13	Maghbouleh stated that while R1 was temporarily admitted to a skilled nursing facility (SNF), the Assisted
	(Complaint Investigation Report continued on LIC9099C)

Unsubstantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Lourdes Montoya	
LICENSING EVALUATOR NAME: Michael Tea	
LICENSING EVALUATOR SIGNATURE:	DATE: 07/29/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 07/29/2026

This report must be available at Child Care and Group Home facilities for public review for 3 years.
LIC9099 (FAS) - (06/04) Page: 1 of 7
Control Number 22-AS-20250402151104

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: QUEEN'S HOME 2	FACILITY NUMBER: 306005310
	VISIT DATE: 07/29/2026

NARRATIVE	
1	Living Waiver (ALW) Program no longer reimbursed the facility for room and board. AD Maghbouleh
2	explained that if the family wished to continue reserving R1's room, they would have been responsible
3	for paying privately in accordance with the Admission Agreement. AD Maghbouleh further stated the
4	facility never initiated an eviction and held the room while discussing the matter with the family.
5	
6	LPA reviewed email correspondence between the facility and Community Care Licensing, which showed
7	the facility was advised that R1 retained the right to the room until the family voluntarily vacated the
8	facility or the facility completed the eviction process in accordance with Title 22 regulations. LPA also
9	reviewed an email dated March 1, 2025, from R1's family stating that R1 would not be returning to
10	Queen's Home 2 following discharge from the SNF and that they would retrieve R1's personal
11	belongings. The facility documented that the family removed R1's belongings and chose another
12	placement for R1.
13	
14	Based on interviews and records reviewed, the evidence did not show that the facility refused to allow
15	R1 to return. Although the family would have been responsible for paying privately to hold R1's room
16	while R1 remained at the SNF, the records showed the family chose another placement before any
17	eviction action was taken.
18	
19	It was alleged that the facility administrator was yelling in the facility. LPA interviewed LE Maghbouleh
20	and AD Maghbouleh, who both denied yelling at residents or family members. AD Maghbouleh
21	acknowledged that discussions with the family occasionally became tense due to disagreements
22	regarding R1's care and medical treatment but stated conversations remained professional. LPA
23	interviewed facility staff, residents, and other pertinent witnesses. Interviews did not corroborate that the
24	Administrator or Licensee yelled at residents or visitors. Interviews provided different accounts of the
25	conversations between the facility administrators and the family.
26	
27	It was alleged that the facility does not maintain room temperature to sixty-eight degrees. LPA
28	interviewed the Licensee, Administrator, staff, and residents regarding the allegation. The Licensee and
29	Administrator stated the home's heating and air conditioning systems were operational and routinely
30	maintained. Staff denied any concerns regarding indoor temperatures.
31	
32	(Complaint Investigation Report continued on LIC9099C)

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LIC9099 (FAS) - (06/04) Page: 2 of 7
Control Number 22-AS-20250402151104

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

7100
ORANGE, CA 92868

FACILITY NAME: QUEEN'S HOME 2

FACILITY NUMBER: 306005310

VISIT DATE: 07/29/2026

NARRATIVE

1 During the investigation, LPA toured the facility and observed no conditions indicating excessively hot or
2 cold indoor temperatures. At the time of the visit, the indoor temperature throughout the facility ranged
3 between 68 and 78 F degrees, which is within a safe and comfortable range. Residents interviewed
4 stated the home was comfortable and did not report concerns regarding room temperature. LPA did not
5 observe or obtain documentation showing the facility failed to maintain a safe and comfortable indoor
6 temperature.
7 It was alleged that the facility does not provide food of good quality. LPA interviewed the Licensee,
8 Administrator, staff, and residents and toured the kitchen and food storage areas regarding the
9 allegation. The Administrator stated residents receive three nutritious meals each day with snacks
10 available between meals. Staff stated meals are prepared daily and modified when needed to meet
11 physician-ordered dietary requirements.
12
13 During the facility tour, LPA observed an adequate supply of fresh produce, meat, dairy products, and
14 pantry items. Food was properly stored, and the kitchen and food preparation areas were clean and
15 sanitary. Residents interviewed stated they enjoyed the meals served and did not express concerns
16 regarding the quality or quantity of food provided.
17
18 It was alleged that the facility neglected to report a pressure injury. LPA reviewed Hospital records,
19 which showed R1 was admitted on January 13, 2025. During the hospitalization, hospital staff identified
20 a pressure injury to R1's right heel. The hospital records documented the pressure ulcer as present
21 upon admission and later described the wound as unstageable. The hospital records included
22 documentation that the wound was present upon admission and referenced information reported by
23 R1's family member regarding a prior ulcer. However, the hospital records did not determine when the
24 pressure injury developed, identify its cause, conclude that Queen's Home 2 caused the injury. The
25 records further did not document that the facility had been notified of the pressure injury before or during
26 R1's hospitalization. The discharge records included orders for continued skilled nursing and wound
27 care after R1 left the hospital.
28
29 LPA reviewed Home Health (HH) records for R1, which showed HH provided skilled nursing services
30 before R1's hospitalization and a second HH agency provided services after hospitalization. The records
31 did not document a pressure injury before R1 was hospitalized and showed HH's services transferred to
32 another home health agency after being hospitalized.
(Complaint Investigation Report continued on LIC9099C)

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LICENSING EVALUATOR NAME: Michael Tea

LICENSING EVALUATOR SIGNATURE:

DATE: 07/29/2026

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FACILITY REPRESENTATIVE SIGNATURE:

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LIC9099 (FAS) - (06/04)

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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
ORANGE COUNTY RO, 770 THE CITY DR., SUITE
7100
ORANGE, CA 92868

FACILITY NAME: QUEEN'S HOME 2

FACILITY NUMBER: 306005310

VISIT DATE: 07/29/2026

NARRATIVE

1 During the investigation, LPA interviewed an HH case manager, who stated they primarily provided
2 behavioral health support, medication management, and coordination of care while R1 resided at
3 Queen's Home 2. The case manager stated they did not observe neglect by facility staff and believed
4 the facility appropriately cared for R1.
5
6 LPA reviewed HH records for the second HH agency, which showed they began providing skilled nursing
7 and wound care after R1 was discharged from the Hospital. The records documented wound
8 assessments, dressing changes, wound measurements, pressure-relieving interventions, caregiver

9 education regarding repositioning and skin integrity, and ongoing monitoring of the pressure injury.
10 However, the records did not establish when the pressure injury developed or identify Queen's Home 2
11 as the source of the wound.
12
13 LPA interviewed a representative from the second HH, who confirmed they provided wound care, skilled
14 nursing, and safety services for R1 after hospital discharge. The representative stated the wound was
15 identified as unstageable but could not confirm whether their HH notified Queen's Home 2 that R1 had a
16 pressure injury. LPA made multiple attempts by telephone and email to contact the assigned case
17 manager and other clinical case managers but was unsuccessful. As a result, LPA was unable to verify
18 whether they informed the facility of the pressure injury before or during the provision of wound care
19 services.
20
21 LPA interviewed three facility staff members, who consistently stated they were unaware that R1 had
22 developed a reportable pressure injury while residing at the facility. Staff stated they routinely
23 communicated with home health providers regarding residents' medical conditions and regularly asked
24 visiting clinicians for updates on any changes in wounds or skin condition. Staff consistently stated that if
25 they had been informed R1 had developed a reportable pressure injury, they would have immediately
26 notified management so the incident could be documented and reported to Community Care Licensing.
27
28 LPA interviewed AD Maghbouleh and LE Maghbouleh, who stated the facility was never informed by
29 either HH agencies that R1 had developed a pressure injury while residing at Queen's Home 2. They
30 stated the facility first became aware of the pressure injury after R1 was hospitalized.
31
32 Although medical records confirmed that R1 had a heel pressure injury and later received wound care
through Home Health, the investigation did not establish when the pressure injury developed, whether it
(Complaint Investigation Report continued on LIC9099C)

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: QUEEN'S HOME 2	FACILITY NUMBER: 306005310
	VISIT DATE: 07/29/2026

NARRATIVE	
1	developed while R1 was residing at Queen's Home 2, or that the facility knew R1 had a reportable
2	pressure injury and failed to report it. Based on interviews and records reviewed, LPA did not obtain
3	sufficient evidence to determine that the facility neglected to report R1's pressure injury.
4	
5	Based on interviews conducted and records reviewed during the investigation, LPA did not obtain
6	sufficient evidence to support the above allegations. Therefore, the above allegations are determined to
7	be UNSUBSTANTIATED, meaning that although the allegations may have occurred or may be valid,
8	there is not a preponderance of evidence to prove that the alleged violations occurred.
9	
10	No deficiencies are cited at this time. An exit interview was conducted with House Manager Arlene
11	Mahinay in person and with Administrator Arya Maghbouleh by telephone. A copy of this report and the
12	Confidential Names List were provided to the facility.
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SUPERVISORS NAME: Lourdes Montoya

LICENSING EVALUATOR NAME: Michael Tea

LICENSING EVALUATOR SIGNATURE:

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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 **04/02/2025** and conducted by Evaluator Michael Tea

COMPLAINT CONTROL NUMBER: 22-AS-20250402151104

FACILITY NAME: QUEEN'S HOME 2

ADMINISTRATOR:MAGHBOULEH, KATAYOUN

ADDRESS: 26545 AVENIDA DESEO

CITY: MISSION VIEJO

CAPACITY: 6

MET WITH: Arlene Mahinay

STATE:CA

CENSUS: 6

UNANNOUNCED

FACILITY NUMBER:

FACILITY TYPE:

TELEPHONE:

ZIP CODE:

DATE:

TIME BEGAN:

TIME COMPLETED:

306005310

740

(949) 716-1907

92691

07/29/2026

09:00 AM

11:00 AM

ALLEGATION(S):

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Allegation 2: Facility did not inform family regarding care or services for resident

INVESTIGATION FINDINGS:

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On this day, Licensing Program Analyst (LPA) Michael Tea made an unannounced visit to conclude and deliver findings for a complaint investigation. LPA Tea was greeted and granted entry by facility staff and explained the purpose of the visit. Licensee (LE) Kathy Maghbouleh and Administrator (AD) Arya Maghbouleh were unavailable during today's visit. However, the Licensing Program Analyst (LPA) spoke with management staff by telephone.

The Department received a complaint on April 2, 2025. During the investigation, LPA Tea conducted interviews and reviewed facility records, emails, admission documents, hospital records, home health records, and other relevant documents.

It was alleged the facility did not inform the family regarding Resident 1's (R1) care or services. LPA interviewed AD Maghbouleh and reviewed facility records, incident reports, hospital records, and correspondence regarding the allegation. AD Maghbouleh stated R1's family remained actively involved in

(Complaint Investigation Report continued on LIC9099C)

SUPERVISORS NAME: Lourdes Montoya

LICENSING EVALUATOR NAME: Michael Tea

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LIC9099 (FAS) - (06/04)

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Control Number 22-AS-20250402151104

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: QUEEN'S HOME 2

FACILITY NUMBER: 306005310

VISIT DATE: 07/29/2026

NARRATIVE

1 R1's care throughout R1's residency and was routinely informed of R1's condition, physician
2 recommendations, medication changes, behavioral concerns, and services provided by the facility.
3 LPA also interviewed R1's treating physician, who stated they regularly communicated with R1's family
4 regarding R1's medical condition, treatment recommendations, and overall care. The physician stated
5 the family was actively involved in discussions regarding R1's care but frequently disagreed with
6 recommended treatment plans and often preferred alternative or holistic approaches instead of
7 prescribed medical treatment. The physician stated these disagreements did not prevent communication
8 with the family regarding R1's care.

9
10 Facility records showed the family was contacted whenever R1 experienced a medical emergency
11 requiring hospitalization. Documentation also showed the family participated in care decisions and
12 regularly communicated with the facility regarding R1's treatment. Hospital records identified R1's family
13 as emergency contacts and responsible parties and reflected ongoing communication among the facility,
14 R1's physician, home health providers, and the family.

15
16 Therefore, the above allegation has been determined to be UNFOUNDED, meaning the allegation is
17 deemed false, could not have happened, and/or are without a reasonable basis.

18
19 No deficiencies are cited at this time. An exit interview was conducted with House Manager Arlene
20 Mahinay in person and with Administrator Arya Maghbouleh by telephone. A copy of this report and the
21 Confidential Names List were provided to the facility.
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SUPERVISORS NAME: Lourdes Montoya

LICENSING EVALUATOR NAME: Michael Tea

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