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Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006017
Report Date: 01/12/2026
Date Signed: 01/12/2026 04:45:22 PM

Unfounded

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 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 **01/06/2026** and conducted by Evaluator Sean Haddad

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20260106164647

FACILITY NAME:	IVY TERRACE AT FULLERTON		**FACILITY NUMBER:**	306006017
ADMINISTRATOR:	JESUS SOTO		**FACILITY TYPE:**	740
ADDRESS:	1510 E. COMMONWEALTH AVENUE		**TELEPHONE:**	(657) 551-3355
CITY:	FULLERTON	**STATE:** CA	**ZIP CODE:**	92831
CAPACITY:	72	**CENSUS:** 31	**DATE:**	01/12/2026
		UNANNOUNCED	**TIME BEGAN:**	10:27 AM
MET WITH:	Jesus Soto		**TIME COMPLETED:**	05:00 PM

ALLEGATION(S):

1	Staff are not administering medication as prescribed.
2	Staff are not ensuring a resident received their meals.
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INVESTIGATION FINDINGS:

1	This unannounced inspection is being conducted by Licensing Program Analyst (LPA) Sean Haddad for
2	the purpose of investigating the above-mentioned complaint allegations. LPA met with Administrator (AD)
3	Jesus Soto, discussed the purpose of the inspection, and explained the allegations.
4	The investigation into the allegations that staff are not administering medication as prescribed and staff
5	are not ensuring a resident received their meals revealed the following: During the course of the
6	investigation, LPA inspected the facility, interviewed AD and staff, and obtained and reviewed copies of
7	the resident roster, staff roster, an incident report received December 31, 2025, Resident #1’s (R1)
8	Medication Administration Records (MAR), R1’s Physician’s Report dated December 24, 2025, R1’s
9	facility care notes, and R1’s hospice care notes.
10	Regarding the allegation that staff are not administering medication as prescribed: it was alleged that R1
11	was being administered medications at the wrong time. LPA inspected the facility, conducted health and
12	safety checks on residents, and observed no health and safety issues. Per an incident report received
13	December 31, 2025, R1 passed away from natural causes while on hospice on December 30, 2025.

Unfounded	Estimated Days of Completion:

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Sean Haddad
LICENSING EVALUATOR SIGNATURE:

DATE: 01/12/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 01/12/2026

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

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: IVY TERRACE AT FULLERTON **FACILITY NUMBER:** 306006017
VISIT DATE: 01/12/2026

	NARRATIVE
1	LPA interviewed AD who denied the allegation. LPA interviewed five staff who did not corroborate the
2	allegation. One staff stated that when R1 began to decline, R1 became unable to swallow their
3	medications, facility staff notified R1's hospice, R1's hospice discontinued all of R1's medications, and
4	R1 passed away within the next few days. LPA reviewed R1's MAR, observed no medication errors, and
5	noted that R1's medications were discontinued on December 30, 2025, as reported by staff. LPA
6	reviewed R1's facility care notes which indicate that on December 28, 2025, R1 was no longer able to
7	swallow their medications and hospice was notified and came to see R1. Based on the information
8	obtained, the changes to the administration of R1's medications were due to R1's decline and were
9	overseen and approved by R1's hospice.
10	Regarding the allegation that staff are not ensuring a resident received their meals: it was alleged that
11	R1 was missing their meals. LPA inspected the facility, conducted health and safety checks on residents,
12	and observed no health and safety issues. Per an incident report received December 31, 2025, R1
13	passed away from natural causes while on hospice on December 30, 2025. LPA interviewed AD who
14	denied the allegation, stating that staff always assisted R1 with their meals, but R1 was on hospice and
15	declining, and if R1 were not eating, staff would not force R1 to eat but would report R1 not eating to
16	hospice staff. LPA interviewed five staff and did not obtain information corroborating the allegation. Per
17	the five staff interviewed, R1 previously ate well, but began having decreased appetite and ability to eat
18	as they declined, but staff continued to offer R1 food and nutritional supplements and worked with
19	hospice, who changed R1's diet, to address R1's dietary needs as they declined. LPA reviewed R1's
20	Physician's Report dated December 24, 2025, which indicates R1 is on hospice and has a special diet
21	of pureed food and nectar thick liquids. LPA reviewed R1's MAR and noted that nutritional supplements
22	were prescribed, given as prescribed, and discontinued on December 30, 2025. LPA reviewed R1's
23	facility care notes which indicate that in early December 2025, R1 was eating a large portion of their
24	meals, in late December 2025, R1 was eating smaller portions of their meals, taking nutritional
25	supplements, and refusing meals, and by December 28, 2025, R1 was no longer eating and hospice
26	was notified and came to see R1. LPA reviewed R1's hospice care notes which indicate R1's hospice
27	visited them multiple times a week and on December 29, 2025, it was noted that R1 was in the process
28	of passing away. Based on the information obtained, the changes to R1's eating were due to R1's
29	decline and were overseen and approved by R1's hospice.
30	The Department has investigated the above allegations and found them to be Unfounded, meaning the
31	allegations were false, could not have happened, or are without reasonable basis. An exit interview was
32	conducted and a copy of this report was discussed with and provided to facility representative.

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Sean Haddad
LICENSING EVALUATOR SIGNATURE:

DATE: 01/12/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 01/12/2026

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

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	UNANNOUNCED	**TIME BEGAN:**	10:27 AM
MET WITH:	Jesus Soto	**TIME COMPLETED:**	05:00 PM

ALLEGATION(S):

1	Staff did not prevent a resident from eloping from the facility.
2	Staff are falsifying incident reports.
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INVESTIGATION FINDINGS:

1	This unannounced inspection is being conducted by Licensing Program Analyst (LPA) Sean Haddad for
2	the purpose of investigating the above-mentioned complaint allegations. LPA met with Administrator (AD)
3	Jesus Soto, discussed the purpose of the inspection, and explained the allegations.
4	
5	The investigation into the allegations that staff did not prevent a resident from eloping from the facility
6	and staff are falsifying incident reports revealed the following: During the course of the investigation, LPA
7	inspected the facility, interviewed AD and staff, and obtained and reviewed copies of the resident roster,
8	staff roster, Resident #2's (R2) Physician's Report dated January 2, 2026, R2's facility care notes, and
9	R2's hospice care notes.
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11	CONTINUED
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Unsubstantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Sean Haddad
LICENSING EVALUATOR SIGNATURE:
DATE: 01/12/2026

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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 CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

FACILITY NAME: IVY TERRACE AT FULLERTON **FACILITY NUMBER:** 306006017
VISIT DATE: 01/12/2026

NARRATIVE

1	Regarding the allegation that staff did not prevent a resident from eloping from the facility: it was alleged
2	that R2 wandered out of the facility and fell on the ground. LPA interviewed AD who denied the
3	allegation, stating that while R2 had falls, R2 did not elope. LPA inspected the facility, conducted a
4	health and safety check on R2, and observed R2 in good health with no injuries. LPA attempted to
5	interview R2, but R2 was unable to communicate. LPA interviewed five staff, none of whom were able to
6	confirm whether or not R2 had ever eloped. Two staff interviewed stated that they heard that R2 had

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32	either eloped or tried to elope in the past, but were unable to provide additional details of when this elopement may have occurred. LPA reviewed R2's Physician's Report dated January 2, 2026, which indicates R2 has dementia with behavioral disturbance, a history of unsafe wandering, and is unable to leave the facility unassisted. LPA reviewed R2's facility care notes which do not document any elopements, although they do document multiple falls with only minor injuries. LPA reviewed R2's hospice care notes which do not document any elopements. The information obtained is conflicting. Regarding the allegation that staff are falsifying incident reports: it was alleged that when R2 wandered out of the facility and fell on the ground, but the facility did not properly report it and instead reported that R2 fell inside of the facility. LPA interviewed AD who denied the allegation, stating that while R2 had falls, R2 did not elope. LPA inspected the facility, conducted a health and safety check on R2, and observed R2 in good health with no injuries. LPA attempted to interview R2, but R2 was unable to communicate. LPA interviewed five staff, none of whom were able to confirm whether or not R2 had ever eloped. Two staff interviewed stated that they heard that R2 had either eloped or tried to elope in the past, but were unable to provide additional details of when this elopement may have occurred. LPA reviewed R2's Physician's Report dated January 2, 2026, which indicates R2 has dementia with behavioral disturbance, a history of unsafe wandering, and is unable to leave the facility unassisted. LPA reviewed R2's facility care notes which do not document any elopements, although they do document multiple falls with only minor injuries. LPA reviewed R2's hospice care notes which do not document any elopements. The information obtained is conflicting. Based on the information gathered during the investigation and review of all documents obtained, the Department is unable to ascertain if the above allegations occurred as reported. Although the allegations may have happened or are valid, there is not a preponderance of evidence to prove or refute the alleged violations occurred; therefore, these allegations are deemed Unsubstantiated. An exit interview was conducted and a copy of this report was discussed with and provided to facility representative.

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Sean Haddad
LICENSING EVALUATOR SIGNATURE:
DATE: 01/12/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 01/12/2026