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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 306006018
Report Date: 07/10/2025
Date Signed: 07/10/2025 11:56:16 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 CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

FACILITY NAME:	IVY TERRACE AT SANTA ANA		FACILITY NUMBER:	306006018
ADMINISTRATOR/ DIRECTOR:	TORRES, JUDITH		FACILITY TYPE:	740
ADDRESS:	3730 S. GREENVILLE AVENUE		TELEPHONE:	(714) 641-0959
CITY:	SANTA ANA	STATE: CA	ZIP CODE:	92704
CAPACITY: 72		CENSUS: 40	DATE:	07/10/2025
TYPE OF VISIT:	Case Management - Deficiencies	UNANNOUNCED	TIME VISIT/ INSPECTION BEGAN:	11:15 AM
MET WITH:	Judith Torres		TIME VISIT/ INSPECTION COMPLETED:	12:10 PM

NARRATIVE

This unannounced Case Management – Deficiencies inspection is being conducted by Licensing Program Analyst (LPA) Sean Haddad for the purpose of delivering findings for the investigation into a self-reported incident report received in the Orange County Regional Office (OCRO) on January 18, 2024, regarding Resident #1 (R1). LPA met with Health Services Director (HSD) Nathan Solares and explained the reason for today's inspection. Administrator (AD) Judith Torres appeared via telephone.

During the course of the investigation, Department staff inspected the facility, interviewed residents and staff, and obtained and reviewed copies of the resident roster, staff roster, an Incident Report received January 18, 2024, Facility Incident Reports regarding R1, R1's Physician's Report dated October 3, 2023, R1's Resident Service Plan dated November 27, 2023, R1's Resident Service Plan dated February 18, 2024, R1's Admission Agreement, R1's X-Ray Report dated January 5, 2024, R1's Power of Attorney Paperwork, and R1's Hoag Memorial Hospital Medical Records dated January 13, 2024.

Per the Incident Report received January 18, 2024, R1 suffered a fall on January 4, 2024, was diagnosed with a hip fracture on January 10, 2024, and was noted to have discoloration at the fracture site and transferred to Hoag Memorial Hospital on January 13, 2024. Interviews with AD and Staff #1 (S1) revealed that R1 is diagnosed with dementia, is a known fall risk with a history of falls, and engages in wandering around the facility. Per Facility Incident Reports regarding R1, prior to R1's fall on January 4, 2024, R1 suffered falls on June 10, 2023, and July 26, 2023. AD and S1 reported that there have been multiple instances of R1 being found in other residents' rooms on the floor or otherwise falling, including incidents not resulting in injuries.

NAME OF LICENSING PROGRAM MANAGER: Armando J Lucero
NAME OF LICENSING PROGRAM ANALYST: Sean Haddad

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 07/10/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 07/10/2025

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.

FACILITY NAME: IVY TERRACE AT SANTA ANA **FACILITY NUMBER:** 306006018
VISIT DATE: 07/10/2025

NARRATIVE

When R1 moved into the facility, R1 was ambulatory, but fractured their hip as a result of their fall on July 26, 2023, and became non-ambulatory. To address R1's fall risk, the facility conducted regular checks (either hourly or every two hours), encouraged R1 to stay in the common area near staff, and installed a small bedrail on R1's bed, but the bedrail was on the other side of the bed where R1's spouse sleeps. AD recommended replacing R1's shoes to R1's responsible party for better stability, but R1's responsible party refused. S1 stated that R1 did not have a fall mat and S1 recommended a hospital bed which was refused by R1's responsible party. Department staff reviewed R1's Physician's Report dated October 3, 2023, which indicates R1 has a hip fracture and dementia, uses a wheelchair due to their hip fracture, and is non-ambulatory due to both physical and mental condition. Department staff reviewed R1's Resident Service Plan dated November 27, 2023, which states that R1 is unable to communicate, engages in wandering behavior without sense of purpose or knowledge of their location, and asses R1's fall risk as "wheel chair bound ;back from SNF from a fall with fractured hip." Department staff reviewed R1's Resident Service Plan dated February 18, 2024, which states that R1 is unable to communicate, engages in wandering behavior without sense of purpose or knowledge of their location, and asses R1's fall risk as "wheel chair use ;back from SNF from a fall with fractured hip. resident does have moments gets up and tries to walk [themself] without asking for help. resident came back from SNF with weight bearing orders."

Per AD and S1, on January 4, 2024, at around 6:40AM, Staff #2 (S2) found R1 in another resident's room on the floor, naked, covered in urine, and R1 was unable to communicate to staff what happened. When interviewed, S2 stated that on January 4, 2024, the morning staff had conducted their first check at around 6:00AM. S2 conducted their first check at around 6:10AM and saw R1's spouse was still in bed and assumed R1 was in bed with their spouse. A short time later, S2 was unable to find R1, searched for R1, and found R1 face down in another resident's room, naked, and lying in their own urine. After S1 conducted an assessment on R1, S2 gave R1 a shower during which R1 complained about pain. Per S2, a few days later R1 had a bruise on their left shoulder and in the days following the fall, when S2 would take R1 to the bathroom, R1 would complain about pain. Per AD and S1, when R1 was found on the floor on January 4, 2024, S1 conducted an assessment, did not notice any injury, and noted that R1 did not complain about pain, although R1 did complain about pain shortly afterwards while being showered by S2. Facility staff contacted R1's doctor and responsible party. R1's doctor requested an x-ray which was taken on January 5, 2024. R1's Admission Agreement indicates that staff are trained to call 9-1-1 if an injury or other circumstance results in an imminent threat to a resident's health.

NAME OF LICENSING PROGRAM MANAGER: Armando J Lucero
NAME OF LICENSING PROGRAM ANALYST: Sean Haddad
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 07/10/2025

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 07/10/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

FACILITY EVALUATION REPORT (Cont)

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

NARRATIVE

Regarding the facility's protocol for unwitnessed falls, AD and S1 stated that if the resident shows any sign of pain, the resident should be sent to the hospital. S1 added that in the case of a resident complaining about pain after an unwitnessed fall, the facility will notify their doctor and let their doctor make the medical decision, and that on January 4, 2024, R1's doctor did not recommend sending R1 to the hospital but did order an x-ray. However, AD stated that R1's doctor recommended sending R1 to the hospital on January 4, 2024, after being notified of the fall and per R1's X-Ray Report dated January 5, 2024, the doctor who reviewed R1's X-Ray also recommended further evaluation after diagnosing R1 with a left femur fracture. When asked why R1 was not sent to the hospital on January 4, 2024, AD and S1 stated that this was because R1's responsible party did not want R1 sent to the hospital. On January 10, 2024, R1 was noted to have bruises, the x-ray results came back and revealed that R1 had a hip fracture, and R1's doctor recommended sending R1 to a hospital for treatment. However, R1's responsible party did not want R1 sent to the hospital unless the injury and pain progressed. Per R1's Power of Attorney Paperwork, R1's family member had the power of attorney to make medical decisions for R1. However, per Title 22 regulations, R1's family member did not have the power to prevent the facility from sending R1 to the hospital to receive necessary medical assessment and treatment under these circumstances. Per AD, on January 10, 2024, R1 was not complaining about pain. However, per S1, on January 10, 2024, R1 was complaining about pain so R1's doctor prescribed pain pills in addition to recommending that R1 be sent to a hospital. Interviews with AD and S1 revealed that R1 was not sent to the hospital on January 10, 2024, as recommended by R1's doctor. On January 13, 2024, R1 was noted to have bruises around the injury site which looked yellow and R1 was transferred to Hoag Memorial Hospital. Department staff reviewed R1's Hoag Memorial Hospital Medical Records dated January 13, 2024, which corroborated that R1 sustained a hip fracture and required surgery. Per AD, the facility's protocol for fractures is to immediately send the resident to the hospital. However, per S1, R1 was not sent to the hospital on January 10, 2024, because R1's responsible party did not want R1 sent to the hospital and instead R1's medical treatment for their hip fracture was delayed for three days until January 13, 2024. The investigation revealed that the facility did not provide adequate care and supervision to meet R1's needs in light of R1's known fall risk and wandering behavior which resulted in R1 sustaining a hip fracture, the facility did not seek proper medical attention for R1 on January 4, 2024 as required by the facility's fall protocol and R1's doctor's recommendation, and the facility delayed medical treatment for R1's hip fracture for three days against R1's doctor's recommendation.

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NARRATIVE

Based on the information obtained during the course of the investigation, deficiencies are being cited per Title 22 Division 6 of the California Code of Regulations. See LIC809D. Immediate civil penalties are being assessed. See LIC421IM. A Civil Penalty is pending determination by the Community Care Licensing Division (CCLD) per Health & Safety Code section 1569.49(f). An exit interview was conducted and a copy of this report and appeal rights was discussed with and provided to facility representative.

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Citations on this Visit Report are Under Appeal!

Created By: Sean Haddad On 07/10/2025 at 11:47 AM
Link to Parent Document Below:

FACILITY NAME: IVY TERRACE AT SANTA ANA **FACILITY NUMBER:** 306006018
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 07/10/2025

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Under Appeal Type A 07/11/2025 **Section Cited** CCR 87464(f)(1)	87464 Basic Services … (f) Basic services shall at a minimum include: (1) Care and supervision… This requirement was not met as evidenced by: Based on interviews conducted and documents obtained during investigation,	Licensee stated they will create a fall care plan protocol, train staff on the protocol, and submit proof to LPA by POC due date.
	the licensee did not ensure R1 received adequate care and supervision to meet R1's needs considering R1's known fall risk and wandering behavior, resulting in R1 sustaining a hip fracture, which posed an immediate safety risk to persons in care.	
Under Appeal Type A 07/11/2025 **Section Cited** CCR87465(a)(1)	87465 ... (a) … (1) The licensee shall arrange, or assist in arranging, for medical and dental care appropriate ... This requirement was not met as evidenced by: Based on interviews conducted and	Licensee stated they will create a protocol for obtaining medical treatment for residents, will train staff on the protocol, and submit proof to LPA by POC due date.

	6 7	documents obtained during investigation, licensee did not obtain immediate	6 7	CIVIL PENALTY ASSESSED
	8 9 10 11 12 13 14	medical treatment for R1 when R1 suffered an unwitnessed fall and delayed R1's medical treatment for three days after R1 was diagnosed with a hip fracture against R1's doctor's recommendation, which posed an immediate health risk to persons in care. .	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.

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