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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006019
Report Date: 09/26/2025
Date Signed: 09/26/2025 03:06:39 PM

Substantiated

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 **06/13/2025** and conducted by Evaluator Kimberly Lyman

	COMPLAINT CONTROL NUMBER: 22-AS-20250613141313

FACILITY NAME:	IVY TERRACE AT GARDEN GROVE			**FACILITY NUMBER:**	306006019
ADMINISTRATOR:	COLEMAN, KYLE			**FACILITY TYPE:**	740
ADDRESS:	11848 VALLEY VIEW STREET			**TELEPHONE:**	(419) 247-2800
CITY:	GARDEN GROVE	**STATE:** CA		**ZIP CODE:**	92845
CAPACITY:	72	**CENSUS:** 53		**DATE:**	09/26/2025
		UNANNOUNCED		**TIME BEGAN:**	08:50 AM
MET WITH:	Kyle Coleman			**TIME COMPLETED:**	03:30 PM

ALLEGATION(S):

1	Staff did not safeguard a resident's personal belongings
2	Staff did not respond to call system
3	Call system is not operational
4	
5	
6	
7	
8	
9	

INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Kimberly Lyman conducted an unannounced complaint visit to continue
2	the investigation into the above allegations. LPA was greeted and granted entry and explained the reason
3	for the visit.
4	During the course of the investigation, LPA toured the memory care unit and interviewed staff as well as
5	reviewed and obtained pertinent documentation such as facility notes. Regarding the allegations that
6	staff did not safeguard a resident's personal belongings, staff did not respond to call system and call
7	system is not operational, the investigation revealed the following: Resident laundering is as follows: AM/
8	PM shift caregivers wash clothing and NOC shift puts clothing away. Five out of five staff state residents
9	clothing turns up missing on occasion due to names not being on clothing or the status of the residents.
10	Staff confirm Resident 1(R1) had missing items. Staff 1 (S1) states being aware of an incident reported
11	regarding Resident 1's (R1) clothing being missing. Staff state inconsistencies with using R1's personal
12	items for bathing but state bathing supplies are provided by the facility to be used as well. All staff
13	interviewed denied being aware of R1's candy being stolen. CONTINUED ON LIC 9099C DATED
	09/26/2025

Substantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
NAME OF LICENSING PROGRAM ANALYST: Kimberly Lyman
LICENSING PROGRAM ANALYST SIGNATURE: **DATE:** 09/26/2025

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

FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 09/26/2025

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

Citations on this Visit Report are Under Appeal!

Control Number 22-AS-20250613141313

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 GARDEN GROVE **FACILITY NUMBER:** 306006019
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 09/26/2025

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Under Appeal Type A 09/27/2025 **Section Cited** CCR 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 req is not met as evidenced by:	Licenee conducted an in-service during the visit and will forward the documentation by POC due date.
	Based on observation, Licensee failed to ensure residents were provided care and supervision. LPA pulled the emergency cord and received no response. This poses an immediate health and safety risk to residents in care.	
Under Appeal Type B 10/10/2025 **Section Cited** CCR 87303(a)	The facility shall be clean, safe, sanitary and in good repair at all times. Maintenance shall include provision of maintenance services and procedures for the safety and well-being of residents, employees and visitors. This req is not met as evidenced by:	Licensee investigation revealed emergency device needed to be rebooted after insertion of new batteries. Licensee initiated rebooting with outside agency during the visit. CLEARED DURING VISIT
	Based on observation, Licensee failed to ensure facility is in good repair. Emergency call button is not working properly. This poses a potential health and safety risk to residents in care.	

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: Kimberly Lyman
LICENSING PROGRAM ANALYST SIGNATURE: **DATE:** 09/26/2025

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FACILITY REPRESENTATIVE SIGNATURE:	DATE: 09/26/2025

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

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FACILITY NUMBER: 306006019
ADMINISTRATOR: COLEMAN, KYLE
FACILITY TYPE: 740
ADDRESS: 11848 VALLEY VIEW STREET
TELEPHONE: (419) 247-2800
CITY: GARDEN GROVE
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ZIP CODE: 92845
CAPACITY: 72
CENSUS: 53
DATE: 09/26/2025
UNANNOUNCED
TIME BEGAN: 08:50 AM
MET WITH: Kyle Coleman
TIME COMPLETED: 03:30 PM

ALLEGATION(S):

1	Staff did not report a resident's change in medical condition
2	Staff did not ensure a resident was provided assistance with meals
3	Staff are socializing and not providing care and supervision
4	Laundry was not done appropriately
5	Staff are not trained on care plan for a resident
6	There is no staff supervision on weekends or overnight
7	Staff did not address resident's personal hygiene
8	Staff did not meet a resident's incontinence needs
9	Staff did not follow care plan to assign a female for showering
	Staff did not assist a resident with making phone calls
	Staff did not ensure resident was hydrated
	Staff did not provide adequate care and supervision of the residents

INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Kimberly Lyman conducted an unannounced complaint visit to continue
2	the investigation into the above allegations. LPA was greeted and granted entry and explained the reason
3	for the visit.
4	During the course of the investigation, LPA toured the facility and interviewed staff and witness as well as
5	reviewed and obtained pertinent documentation such as facility notes.
6	Regarding the allegation that Staff did not report a resident's change in medical condition, the
7	investigation revealed the following: On or about 03/31/2025, staff reported to Health and Wellness
8	Director that R1 had redness in the groin area. Resident was treated by Dispatch Health on 03/31/2025
9	for a fungal infection in the groin area and was prescribed Nystatin Cream for 7 days. Staff state being in
10	constant communication with the resident's Responsible Party and responded as soon as the rash was
11	noticed. Resident was seen for a Urinary Tract infection on 02/12/2025 and prescribed Cephalexin for 7
12	days.
13	Regarding the allegation that staff did not ensure a resident was provided assistance with meals, the
	investigation revealed the following: CONTINUED ON LIC 9099C DATED 09/26/2025.

Unsubstantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
NAME OF LICENSING PROGRAM ANALYST: Kimberly Lyman
LICENSING PROGRAM ANALYST SIGNATURE: DATE: 09/26/2025

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FACILITY REPRESENTATIVE SIGNATURE: DATE: 09/26/2025

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NARRATIVE

Seven out of seven staff state resident was being assisted but was refusing meals as well as water and tea. Facility charting notes shows staff were documenting amounts of food consumed as well as refusals.

Regarding the allegation that staff are socializing and not providing care and supervision, the investigation revealed the following: Six out of seven staff state staff were not socializing in R1's room. S2 and S3 deny any socializing in the room.

Regarding the allegation that laundry was not done appropriately, the investigation revealed the following: Laundry is done on AM/ PM shift and laundry is put away on NOC shift. Five out of five staff state doing laundry effectively and are not aware of any items becoming gray from laundering. LPA observed the laundry facilities and each wing does their own laundry and has their own machine to prevent items becoming mixed up.

Regarding the allegation that staff are not trained on care plan for a resident, the investigation revealed the following: Five out of five staff state being aware of resident needs and requirements through their job and observing notes and shift change. R1's responsible party provided a list of expectations to staff that were not items on the care plan and were merely requests including certain TV shows and exercise at specific times.

Regarding the allegation that there is no staff supervision on weekends or overnight, the investigation revealed the following: Facility schedule shows 6 caregivers and 2 med techs on 1st and 2nd shift and med tech and 2 caregivers on NOC. Facility states filling call outs with overtime. Seven out of seven staff state staffing is fine and resident needs are being met.

Regarding the allegation that staff did not address resident's personal hygiene, staff did not meet a resident's incontinence needs and staff did not follow care plan to assign a female for showering, the investigation revealed the following: Seven out of seven staff state R1's needs were being met. Incontinence care is provided at a minimum 3 times a shift. Initially R1 was independent of toileting but as the resident declined, more assistance was needed. All staff interviewed denied resident was not provided incontinence care or showering. Facility does not have shower records as facility changed systems prior to complaint. Staff state that initially a male caregiver would shower R1 but after family requested a female, the male did not provide showering. Seven out of seven staff deny a male caregiver showered the resident after the request.

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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 GARDEN GROVE **FACILITY NUMBER:** 306006019
VISIT DATE: 09/26/2025

NARRATIVE

Regarding the allegation that Staff did not assist a resident with making phone calls, the investigation revealed the following: R1's family member requested that staff assist resident with calling the resident's boyfriend. Five out of five staff state that assistance would be offered and the resident would refuse at

times. Staff state due to cognitive decline, resident was unsure of who the resident would be calling and would have anxiety to make the call.

Regarding the allegation that Staff did not ensure resident was hydrated, the investigation revealed the following: Per family request, staff were to ensure resident consumed 72 oz of water per day along with tea. Five out of five staff state encouraging resident to drink water and tea but resident would refuse at times. Resident had a large jug of water at all times to drink from as the resident wanted.

Regarding the allegation that Staff did not provide adequate care and supervision of the residents, the investigation revealed the following: Seven out of seven staff state resident needs are being met. Staff state incontinence care and showering were provided. LPA observed residents in the common area on two different occasions with adequate staffing and residents being assisted. LPA observed residents at meal times being assisted and at activities as well. Seven out of seven staff deny R1 being a victim of an assault from another resident but state that there are behaviors at the facility as it is specifically memory care.
Based on observations and interviews conducted, LPA is unable to corroborate the allegations. Therefore, the allegations are deemed unsubstantiated, meaning that although the allegations may have happened or are valid, there is not a preponderance of the evidence to prove that the alleged violations occurred. An exit interview was conducted and a copy of this report was provided to facility.

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VISIT DATE: 09/26/2025

NARRATIVE

During the visit, LPA pulled the emergency cord in room B5 at 10:20 AM. Staff did not respond to the pull. Further investigation by the facility determined that the devices needed to be rebooted after a change of batteries. Two staff and witness states an incident (date unknown) where R1's emergency cord was pulled and the device was not working. Facility is unable to provide emergency pull records due to a change of system but was able to provide fall monitoring response records with an average response time of 4 minutes. Based on interviews conducted and observation, the preponderance of evidence standard has been met. Therefore the above allegations are found to be SUBSTANTIATED, California Code of Regulations, (Title 22, Division 6, Chapter 8), are being cited on the attached LIC 9099D. An exit interview was conducted and a copy of this report was provided to facility administrator along with appeal rights.

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Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Under Appeal Type B 10/10/2025 **Section Cited** CCR 87468.1(a)(12)	1 2 3 4 5 6 7	In addition to the rights listed in Section 87468.1, Personal Rights of Residents in All Facilities, residents in privately operated residential care facilities for the elderly shall have all of the following personal rights: To wear their own clothes; to keep and use their own personal possessions, including their toilet articles..This req is not met as evidenced by:	1 2 3 4 5 6 7	Licensee to provide an in-service on personal rights and forward proof to LPA by POC due date.
	8 9 10 11 12 13 14	Based on interviews conducted, Licensee failed to ensure R1's personal rights were met. Five out of five staff state resident's clothing items were missing occasionally and resident's private toiletries were sporadically used. This poses a potential health and safety risk to residents in care.	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	

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UNANNOUNCED
TIME BEGAN: 08:50 AM
MET WITH: Kyle Coleman
TIME COMPLETED: 03:30 PM

ALLEGATION(S):

1 2 3 4 5 6 7 8 9	Staff are not following schedule for bedridden residents resulting in bed sores

INVESTIGATION FINDINGS:

1 2 3 4 5 6 7 8 9 10 11 12 13	Licensing Program Analyst (LPA) Kimberly Lyman conducted an unannounced complaint visit to continue the investigation into the above allegations. LPA was greeted and granted entry and explained the reason for the visit. During the course of the investigation, LPA toured the memory care unit and interviewed staff. Regarding the allegation that Staff are not following schedule for bedridden residents resulting in bed sores, the investigation revealed the following: Per review of documentation, R1 did not have a pressure injury nor was bedridden. Interview with Administrator and Health and Wellness Director, there are no residents currently or at time of complaint that have pressure injuries or are bedridden. Facility does not have bedridden fire clearance. Based on interviews conducted, the allegation is deemed UNFOUNDED, meaning that the allegation is false, could not have happened and/or is without a reasonable basis. Exit interview conducted and a copy of this report was left at the facility.

Unfounded	**Estimated Days of Completion:**

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz

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LICENSING PROGRAM ANALYST SIGNATURE:
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