

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006019
Report Date: 04/22/2026
Date Signed: 04/22/2026 10:46:14 AM

Substantiated

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 12/20/2024 and conducted by Evaluator Joseph Alejandro

PUBLIC		COMPLAINT CONTROL NUMBER: 22-AS-20241220151126	
FACILITY NAME: CRESCENT LANDING AT GARDEN GROVE MEMORY CARE		FACILITY NUMBER: 306006019	
ADMINISTRATOR: LOPEZ, DARLENE		FACILITY TYPE: 740	
ADDRESS: 11848 VALLEY VIEW STREET		TELEPHONE: (419) 247-2800	
CITY: GARDEN GROVE		ZIP CODE: 92845	
CAPACITY: 72		DATE: 04/22/2026	
		UNANNOUNCED TIME BEGAN: 08:54 AM	
MET WITH: Leah Gutierrez		TIME COMPLETED: 10:30 AM	

ALLEGATION(S):

1	Lack of supervision resulted in resident sustaining serious injuries
2	Lack of supervision resulted in resident sustaining multiple falls
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Joseph Alejandro made an unannounced visit to deliver the findings of
2	the complaint investigation into the allegations listed above. LPA met with Administrator (AD) Leah
3	Gutierrez and explained the reason for the visit.
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5	During the course of the investigation, Department staff inspected the facility, interviewed AD, witnesses,
6	and staff, and obtained and reviewed records, including resident roster, staff roster, staff schedule,
7	Resident 1's (R1) physician's report dated April 5, 2023, R1's care plan dated March 19, 2024, R1's
8	charting notes dated April 24, 2023 to December 15, 2024. R1's incident reports from November 12,
9	2024, and December 6, 2024. R1's certificate of death dated December 18, 2024. R1's hospice nursing
10	assessment dated December 9, 2024. R1's hospice admission form. R1's hospice safety and fall risk
11	assessment dated December 9, 2024. R1's hospice medication list for December 2024. R1's physician's
12	orders dated December 9, 2024. R1's hospice plan of care dated December 9, 2024. R1's Los Alamitos
13	Medical Center Records dated December 6, 2024.

Substantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Sheila Santos	
LICENSING EVALUATOR NAME: Joseph Alejandro	
LICENSING EVALUATOR SIGNATURE:	DATE: 04/22/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 04/22/2026

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 4
Control Number 22-AS-20241220151126

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 (Cont)	

FACILITY NAME: CRESCENT LANDING AT GARDEN GROVE MEMORY CARE	FACILITY NUMBER: 306006019
VISIT DATE: 04/22/2026	

NARRATIVE	
1	The investigation into the allegation, lack of supervision resulted in resident sustaining multiple falls,
2	revealed the following: It was alleged, lack of supervision resulted in resident sustaining multiple falls.
3	Resident 1 (R1) moved to the facility on April 1, 2023. R1 was diagnosed with a major neurocognitive
4	disorder, anxiety and hyperlipidemia. R1's physician's report dated April 5, 2023, lists R1 as non-
5	ambulatory and requires the use of a wheelchair. R1 was given a fall mat next to their bed at the time of
6	move in and had a pendant placed on their wheelchair to alert staff when R1 was not in the wheelchair.
7	4 out of 4 staff interviewed reported that R1 was a fall risk. 4 out of 4 staff interviewed reported that the
8	fall prevention methods were ineffective for R1. R1 sustained a fall on November 12, 2024, and on
9	December 6, 2024. On November 12, 2024, R1 required assistance with incontinence care and needed
10	a diaper change. Staff 1 (S1) and Staff 2 (S2) were assisting R1. The Health and Wellness Director
11	reported that at this time staff were made aware that R1 should be changed on their bed because of
12	their declining condition. Staff 2 reported they wanted to change R1 on their bed, but Staff 1 decided
13	they should change R1 while they are standing and holding onto the handrail in the bathroom. Staff 2
14	agreed and R1 was assisted while they were standing and holding onto a handrail in the bathroom. R1
15	fell toward the ground, Staff 2 could not prevent the fall and R1 fell and hit their head. Staff called 911
16	and R1 was transported to the hospital for evaluation. Staff notified R1's responsible party and Primary
17	Care Physician (PCP). R1 returned later the same day with no new orders. On December 6, 2024, R1
18	suffered an unwitnessed fall. R1 was seen by a phlebotomist for a blood draw at approximately 10:30
19	am on December 6, 2024. Staff interviewed reported that the phlebotomist did not notify staff they were
20	leaving. R1 was left unattended after the blood draw. At approximately 11:00 am Staff 3 found R1 lying
21	next to their wheelchair with a large frontal laceration on their head. Staff 3 called 911 and R1 was
22	transported to the hospital. Staff 3 contacted R1's responsible party and PCP. R1 returned to the facility
23	the same day with no new orders. There are no additional falls reported after December 6, 2024. R1
24	was placed on Hospice on December 9, 2024. R1 passed away on December 15, 2024, at the facility
25	under Hospice care, cause of death, end stage senile degeneration of the brain, underlying causes:
26	none. Other significant conditions contributing to death: none.
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28	During the course of the investigation, the Department obtained sufficient evidence to substantiate the
29	allegation that lack of supervision resulted in residents sustaining multiple falls. The preponderance of
30	evidence standard has been met; therefore, the above allegation is Substantiated. See LIC9099D for
31	cited deficiencies per Title 22 Division 6 of the California Code of Regulations. Immediate civil penalties
32	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).

SUPERVISORS NAME: Sheila Santos	
LICENSING EVALUATOR NAME: Joseph Alejandro	
LICENSING EVALUATOR SIGNATURE:	DATE: 04/22/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 04/22/2026

FACILITY NAME: CRESCENT LANDING AT GARDEN GROVE
MEMORY CARE

FACILITY NUMBER: 306006019

VISIT DATE: 04/22/2026

NARRATIVE	
1	The investigation into the allegation, lack of supervision resulted in resident sustaining serious injuries revealed the following. R1 was seen by a phlebotomist for a blood draw at approximately 10:30 am on December 6, 2024. Staff interviewed reported that the phlebotomist did not notify staff they were leaving. 2 on-duty caregivers were on break when the phlebotomist left. R1 was left unattended after the blood draw. R1 attempted to get up by themselves after being left alone in the room. At approximately 11:00 am Staff 3 found R1 lying next to their wheelchair with a large frontal laceration on their head around 7 cm long. Staff 3 called 911 and R1 was transported to the hospital. Staff 3 contacted R1's responsible party and PCP. R1 returned to the facility the same day with no new orders. There are no additional falls reported after December 6, 2024. R1 was placed on Hospice on December 9, 2024. R1 passed away on December 15, 2024, at the facility under Hospice care, cause of death, end stage senile degeneration of the brain, underlying causes: none. Other significant conditions contributing to death: none. R1 sustained a fall on December 6, 2024, which caused a serious injury. During the course of the investigation, the Department obtained sufficient evidence to substantiate the allegation that lack of supervision resulted in resident sustaining serious injuries. See LIC9099D for cited deficiencies per Title 22 Division 6 of the California Code of Regulations. 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 were discussed with and provided to facility representative.
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SUPERVISORS NAME: Sheila Santos

LICENSING EVALUATOR NAME: Joseph Alejandre

LICENSING EVALUATOR SIGNATURE:

DATE: 04/22/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 04/22/2026

FACILITY NAME: CRESCENT LANDING AT GARDEN GROVE
MEMORY CARE

FACILITY NUMBER: 306006019

DEFICIENCY INFORMATION FOR THIS PAGE:

VISIT DATE: 04/22/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES		PLAN OF CORRECTIONS(POCs)	
Type A 04/23/2026	1	Type A: 87464(f)(1) – 87464 Basic Services ... (f) Basic services shall at a	1	Licensee agrees to train care staff on CCR 87464 and to submit proof of
	2		2	

Section Cited CCR 87464(f)(1)	3 4 5 6 7	minimum include: (1) Care and supervision... This requirement was not met as evidenced by...	3 4 5 6 7	training to LPA. Facility is closed and the above POC is NOT required.
	8 9 10 11 12 13 14	Based on documents and interviews, the licensee did not ensure R1 received care and supervision, as a result R1 suffered multiple falls on November 12, 2024 and December 6, 2024, which caused a serious injury which poses an immediate health and safety risk to persons in care. CIVIL PENALTY ASSESSED.	8 9 10 11 12 13 14	
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Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISORS NAME: Sheila Santos LICENSING EVALUATOR NAME: Joseph Alejandre LICENSING EVALUATOR SIGNATURE:		DATE: 04/22/2026
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FACILITY REPRESENTATIVE SIGNATURE:		DATE: 04/22/2026