

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006195
Report Date: 07/28/2026
Date Signed: 07/28/2026 09:42:24 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 **06/16/2026** and conducted by Evaluator Garlli Tat

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20260616142820
FACILITY NAME: WESTMINSTER TERRACE	FACILITY NUMBER: 306006195
ADMINISTRATOR: CARMEN GALICIA	FACILITY TYPE: 740
ADDRESS: 7571 WESTMINSTER BLVD	TELEPHONE: (714) 891-6608
CITY: WESTMINSTER	ZIP CODE: 92683
CAPACITY: 152	DATE: 07/28/2026
	CENSUS: 121 UNANNOUNCED TIME BEGAN: 08:56 AM
MET WITH: Carmen Galicia	TIME COMPLETED: 10:00 AM

ALLEGATION(S):

1	Staff do not ensure resident's care plan is being followed.
2	Staff does not ensure soiled garments are removed from resident's room.
3	Staff do not ensure resident's personal belongings were kept safely secured.
4	Staff did not prevent resident's personal property from being damaged.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Garlli Tat made an unannounced visit to the facility to deliver the
2	findings on the above allegations. LPA met with the Executive Director Carmen Galicia and explained the
3	purpose of the visit.
4	
5	An initial complaint investigation visit took place on June 23, 2026. During the visit, LPA accompanied by
6	staff conducted a tour of the facility's physical plant. LPA requested and obtained the resident and staff
7	roster 06/09/2026, preplacement appraisal dated 05/01/2026, progress notes (03/26/2026-06/20/2026),
8	admission agreement dated 03/26/2026, physician's report dated 03/23/2026, service plan (03/26/2026),
9	resident personal property and valuables, authorization and agreement to handle resident funds dated
10	03/26/2026. Four resident interviews and five staff interviews were conducted.
11	
12	The investigation revealed the following: Continued on LIC9099-C.
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Unsubstantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Sheila Santos	
LICENSING EVALUATOR NAME: Garlli Tat	
LICENSING EVALUATOR SIGNATURE:	DATE: 07/28/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 07/28/2026

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 5
Control Number 22-AS-20260616142820

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: WESTMINSTER TERRACE	FACILITY NUMBER: 306006195
	VISIT DATE: 07/28/2026

NARRATIVE	
1	Regarding the allegation that Staff did not ensure resident's care plan is being followed, it was reported
2	that resident is neglected and does not get changed for hours. Resident #1 (R1) stated that they are
3	stuck in soiled briefs for a long time before staff comes and changes them. Per review of R1's
4	physician's report, R1 is diagnosed with Multiple Sclerosis, is nonambulatory, and unable to care for
5	their own toileting needs. Per review of progress notes, it was noted that resident has been refusing
6	assistance with personal hygiene on March 31, April 15, April 19, April 22, May 4, May 5, May 14, June
7	5, and June 13, 2026. It was reported on multiple occasions that R1 is verbally aggressive and uses
8	profanity against staff. Two out of four residents interviewed stated they are changed daily, or as
9	requested. Two out of four residents responded with unrelated information. Five out of five staff,
10	including the administrator, reported R1 refuses to be changed. The administrator reported that R1 has
11	developed a rash due to the soil they have been sitting on. None of the evidence gathered supports the
12	allegation.
13	
14	Regarding the allegation that Staff does not ensure soiled garments are removed from the resident's
15	room, it was reported that staff leaves soiled diapers and towels in resident's room. Per review of R1's
16	admission agreement dated March 26, 2026, the facility will provide weekly housekeeping services and
17	the resident agrees to keep their room in a clean and sanitary condition. One out of four residents stated
18	that sometimes there are soiled diapers or towels left in the room. Two out of four residents denied the
19	allegation. One out of four residents provided irrelevant information on the allegation. Three out of five
20	staff denied the allegation. Two out of five staff stated that soiled garments are placed in a bag and
21	disposed of at a later time because the washers are in use.
22	
23	Regarding the allegation that Staff do not ensure resident's personal belongings were kept safely
24	secured, it was reported that staff threw away personal towels and damaged clothing items while
25	assisting resident with changing shirts. When LPA interviewed R1, it was reported that staff steal their
26	clothes after washing them and comes into their room to take their pants and shirts. Per review of
27	admission agreement, theft will result in staff's immediate loss of privileges to enter the facility to provide
28	services to any resident. It was further stated that the facility shall not be responsible for the loss of any
29	personal property belonging due to theft, unless the loss or damage was caused by the facility's
30	negligence or that of employees. Two out of four residents stated they have had belongings stolen at the
31	facility. Two out of four residents stated they have not had belongings stolen. Three out of five staff
32	interviewed denied the allegation. One out of five staff interviewed did not provide relevant information.
	One out of five staff interviewed stated that there was a time where R1's cushion pillow was washed and
	dried, but staff did not know who it belonged to because there was not a room number attached to the
	laundry bag. The item was later returned to R1. Cont. on LIC9099-C.

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FACILITY NAME: WESTMINSTER TERRACE

FACILITY NUMBER: 306006195
VISIT DATE: 07/28/2026

NARRATIVE	
1	Because the item was later returned to the R1, no personal belongings were stolen or thrown away by
2	staff.
3	
4	Regarding the allegation that Staff did not prevent resident's personal property from being damaged, it
5	was reported that clothing items were damaged while assisting to change resident's shirts. When LPA
6	interviewed R1, it was reported that clothes get damaged after washing. Per review of R1's admission
7	agreement, the facility shall not be responsible for the loss of any personal property belonging due to
8	theft, fire, or any other cause, unless the loss or damage was caused by the facility's negligence or that
9	of employees. Two out of four residents interviewed stated there have been instances where their
10	laundry has been damaged after washing. One out of four residents denied the allegation. One out of
11	four residents did not provide relevant information. Three out of five staff denied the allegation. Two out
12	of five staff did not provide relevant information. There was no evidence stating that R1's belongings
13	were damaged.
14	
15	Based on the evidence gathered during the investigation, the allegations are found to be
16	Unsubstantiated , meaning that although the allegations may have happened or are valid, there is not a
17	preponderance of evidence to prove the alleged violations did or did not occur.
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19	An exit interview was conducted, and a copy of the present report was provided to the Executive
20	Director. Appeal Rights were reviewed. .
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CAPACITY: 152	DATE: 07/28/2026
STATE: CA	UNANNOUNCED TIME BEGAN: 08:56 AM
CENSUS: 121	

ALLEGATION(S):

1	Staff does not ensure residents are accorded access to their own money.
2	Staff does not ensure resident is accorded rights to choose a room to share with another resident.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Garlli Tat made an unannounced visit to the facility to deliver the
2	findings on the above allegations. LPA met with the Executive Director Carmen Galicia and explained the
3	purpose of the visit.
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5	An initial complaint investigation visit took place on June 23, 2026. During the visit, LPA accompanied by
6	staff conducted a tour of the facility's physical plant. LPA requested and obtained the resident and staff
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10	dated 03/26/2026. Four resident interviews and five staff interviews were conducted.
11	
12	The investigation revealed the following: Continued on LIC9099-C.
13	

Unfounded	Estimated Days of Completion:
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NARRATIVE	
1	Regarding the allegation that Staff does not ensure residents are accorded access to their own money, it
2	was reported that the facility staff won't allow the residents control over their own money. R1 reported
3	facility staff take too long to pay residents the difference after rent is deducted from their Social Security
4	check. Per review of Authorization and agreement to handle resident funds dated March 26, 2026, R1
5	agreed to authorize the facility to transfer the P&I amount to their bank account after deducting the
6	monthly rent. Three out of four residents interviewed denied the allegation that facility denies residents
7	access to their money. One out of four residents interviewed did not provide relevant information. Four
8	out of five staff did not provide relevant information regarding the allegation. One out of five staff
9	reported that R1 signed an agreement to allow the facility act as their representative payee. R1 was
10	unhappy with how late the P&I was deposited into their account. The rate in which the P&I is deposited
11	is not under the control of the facility. It was reported that R1 will return to acting as their own payee
12	starting next month. None of the evidence gathered supports the allegation.
13	
14	Regarding the allegation that Staff does not ensure resident is accorded rights to choose a room to
15	share with another resident, it was reported that staff moved a resident to a different room without telling
16	them why. R1 stated their roommate was moved to a different room without being told in advance or the
17	reasoning behind it. Per review of admission agreement, residents in privately operated residential care
18	facilities for the elderly shall have the right to reasonable accommodation of their preferences
19	concerning room and roommate choices and to written notice of any room changes at least 30 days in

20 advance unless a room change is agreed to by the resident, required to fill a vacant bed, or necessary
21 due to an emergency. One out of four residents stated they were moved without prior notice. One out of
22 four residents stated they have not been moved without prior notice. Two out of four residents did not
23 provide relevant information. Two out of five staff interviewed, who had knowledge regarding the
24 allegation, stated R1's previous roommate requested to be moved to a different room because they
25 didn't want to share a room with R1. Three out of five staff interviewed did not provide relevant
26 information.
27
28 Based on the evidence gathered, the allegation is deemed **Unfounded**, meaning that the allegation was
29 false, could not have happened and/or is without a reasonable basis. The Department has therefore
30 dismissed the complaint.
31
32 An exit interview was conducted with the Executive Director and a copy of this LIC9099 report was left
at the facility.

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