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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006204
Report Date: 09/12/2025
Date Signed: 09/12/2025 05:29:35 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION ORANGE COUNTY RO, 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 **06/06/2025** and conducted by Evaluator Michael Tea

	COMPLAINT CONTROL NUMBER: 22-AS-20250606123601

FACILITY NAME:	WILLOW VIEW GARDENS MEMORY CARE & ASSISTED LIVING			**FACILITY NUMBER:**	306006204
ADMINISTRATOR:	ESPINAL, ALMA			**FACILITY TYPE:**	740
ADDRESS:	2025 N BUSH ST			**TELEPHONE:**	(714) 541-3357
CITY:	SANTA ANA	**STATE:** CA		**ZIP CODE:**	92706
CAPACITY:	130	**CENSUS:** 77		**DATE:**	09/12/2025
		UNANNOUNCED		**TIME BEGAN:**	08:00 AM
MET WITH:	Alma Espinal			**TIME COMPLETED:**	05:45 PM

ALLEGATION(S):

1	- Staff did not provide mail to resident in care
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INVESTIGATION FINDINGS:

1	On this day, Licensing Program Analyst (LPA) Michael Tea made an unannounced visit to conclude and
2	deliver findings for a complaint investigation. LPA Tea was greeted and granted entry by facility staff and
3	explained the reason for the visit. Executive Director (ED) Alma Espinal arrived later to assist with the
4	visit.
5	
6	The Department received a complaint on June 6, 2025. During the investigation, LPA Tea spoke to facility
7	staff and residents and reviewed and collected pertinent documents and information.
8	
9	It was alleged that staff did not provide mail to resident in care. Per interviews with residents, six out eight
10	residents stated that there were no issues with mail services. Most of the residents received their
11	expected mail. A few of the residents complained that their mail was either stolen or went missing. One
12	resident was waiting for a checkbook, and they had never received it. Despite that issue, a staff member
13	was able to get them a replacement checkbook. One resident said before their mail was opened but since then it

(Complaint Report continued on LIC9099-C)

Unsubstantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
NAME OF LICENSING PROGRAM ANALYST: Michael Tea
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 09/12/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 09/12/2025

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

Control Number 22-AS-20250606123601

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT (Cont)**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

FACILITY NAME: WILLOW VIEW GARDENS MEMORY CARE & ASSISTED LIVING

FACILITY NUMBER: 306006204

VISIT DATE: 09/12/2025

NARRATIVE

has improved, and they have no issues. Staff interviewed said there were no problems with mail. The mail is at the front desk and only staff have access to the mail. They file the mail by room number and the residents' mail are locked and secure. ED Espinal said only Memory Care does not receive their mail. She stated packages are given to the residents at the end of the day and they never deny any residents mail service. It is the responsibility of the residents to ask and get their mail.

Therefore, based on LPA Tea's observations and interviews conducted and records reviewed the allegation staff did not provide mail to resident in care has been determined to be UNSUBSTANTIATED meaning that although the allegation may have happened or is valid, there is not a preponderance of the evidence to prove that the alleged violation occurred.

No deficiencies cited at this time and an exit interview was conducted with Executive Director Alma Espinal. A copy of the report was provided to the facility.

NAME OF LICENSING PROGRAM MANAGER: Alisa Ortiz
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LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 09/12/2025

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

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ALLEGATION(S):

1	- Staff mismanaged resident's medications
2	- Staff did not prevent resident from harming another resident in care
3	- Staff did not provide housekeeping services to resident in care in a timely manner
4	- Staff did not safeguard resident's personal items
5	- Staff did not provide toileting assistance to resident in care in a timely manner
6	- Staff spoke inappropriately to resident in care
7	- Staff did not implement proper hand hygiene procedures
8	
9	

INVESTIGATION FINDINGS:

1	On this day, Licensing Program Analyst (LPA) Michael Tea made an unannounced visit to conclude and
2	deliver findings for a complaint investigation. LPA Tea was greeted and granted entry by facility staff and
3	explained the reason for the visit. Executive Director (ED) Alma Espinal arrived later to assist with the
4	visit.
5	
6	The Department received a complaint on June 6, 2025. During the investigation, LPA Tea spoke to facility
7	staff and residents and reviewed and collected pertinent documents and information.
8	
9	It was alleged that staff mismanaged resident's medications. Per interviews with residents, eight out of
10	eight residents agree that they have no issues nor complaints of medication. All have similarly agreed
11	that medication is given on time and that the staff follows the doctor’s order. One resident, Resident 1
12	(R1) says they have no complaints about the medication but R1 says it is difficult to wait for someone to
13	assist them with medication. R1 feels they are independent to handle their own medication. R1 states
	they can
	(Complaint Report continued on LIC9099-C)

Unfounded	Estimated Days of Completion:

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NARRATIVE

handle their own medication, they can read, they administer their own insulin, so they want to request the doctor if they can handle their own medication. All staff agree that there is no mismanagement of medication. They try their best to give the medication on time but of course there is a delay at times because there are things that arise during their shift, like helping another staff assist with another residents and emergencies. One staff member stated they follow doctor's order, and they have a lot of in-service trainings for medication and they use a MAR to document medication dosage. Nurse Consultant, Amie Pangilinan which is similar to a Health Service Director position, stated that she monitors her MedTech staff and so far, there are no medication errors. Her in-service training focuses on logging medication refusals and addressing questions about medication that MedTech staff have.

It was alleged that staff did not prevent resident from harming another resident in care. LPA spoke to residents and eight out eight residents, although a few of them have never seen residents fight, they all have similarly agreed that staff at the facility try their best to prevent resident from harming another resident or further escalation. Some residents have seen staff stepping in and telling them to stop. R1 stated during a bingo game another resident got upset and hit their hand. The staff did intervene and later the resident who hit R1's hand came to apologize for what had happened because of the staff intervention. All staff interviewed have agree that when they see residents arguing they try to de-escalate the situation. One staff said they try to talk to them to calm them down and separate them. Then the staff offers solutions to the resident, like asking if the resident can sit at this table for the time being. All staff feel they are doing a good job of protecting residents.

It was alleged that staff did not provide housekeeping services to residents in care in a timely manner. Eight of eight residents interviewed said that facility provides adequate housekeeping services to them in a timely manner. The residents interviewed have stated that they thoroughly clean their rooms once a week on specific days. The bed linens are changed weekly, and staff do their laundry. Granted that most of the time staff are busy, when housekeeping requests are made, the residents mention they try their best to complete their requests. R1 stated that the staff missed wiping the dust underneath their mattress, but overall, they did a good job. All staff LPA interviewed as well agree that they try their best to clean and keep up with the resident's housekeeping request, despite they can be demanding. One of the housekeepers who clean R1's room said that R1 appreciates them cleaning their room and on days when she is not there she gets upset at

(Complaint Report continued on LIC9099-C)

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other staff because they do not clean their room like the housekeeper that cleans their room regularly. Staff have all stated that resident rooms have a scheduled day where they clean their room. They clean the room as needed for spills, accidents, and soiled bedding.

It was alleged that staff did not safeguard resident's personal items. Per interviews with residents, seven

out of eight residents have felt their personal belongings were safeguarded by the staff. They never had issues with anyone stealing their personal belongings. R1 stated they left money on their night stand, and it was still there. R1 stated staff are honest, hard-working people who would never risk their jobs to steal something from residents and protect them from other residents. All staff interviewed have similarly acknowledge that they do their best to safeguard residents' personal belongings. Two staff interviewed would make sure that the residents' doors were closed. They would question any resident who is going into someone else's room and redirect them out of the resident's room. Often residents misplaced their stuff. They would say their stuff had been stolen and at the end of the day they would find it later because they do not remember where it was or it was misplaced.

It was alleged that staff did not provide toileting assistance to resident in care in a timely manner. Per investigation, eight of eight residents interviewed feel the facility does a great job in assisting resident with toileting. Some residents interviewed say they do not need toileting assistance but however they said they never heard of any of issues with toileting assistance amongst other residents living at the facility. One resident spoken said one time they were sick the staff did a great job in assisting them to the restroom when they needed help. Another resident said they help them change their diapers and their clothes with no problem. R1 stated that the staff come right away to assist their roommate with toileting services. Just at night time, due to staff shortages it is a bit longer response. All staff interviewed have said that they do their best to help residents with toileting assistance. At times they are busy helping a lot of residents, but they do their best and change their diapers and clean them up. One staff member said unfortunately mishaps happen because residents have diarrhea, again they try their best to assist residents with their toileting needs.

It was alleged that staff spoke inappropriately to resident in care. All residents interviewed unanimously agree they have never been spoken to inappropriately. They were treated with respect by the facility staff. R1 said the staff have never even raised their voices at them. R1 has seen residents treat staff disrespectfully. All staff interviewed have all agreed that they have always treated residents with respect and are careful with what they say to residents. One staff interviewed stated that they treat the residents like family just like how
(Complaint Report continued on LIC9099-C)

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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
ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100
ORANGE, CA 92868

FACILITY NAME: WILLOW VIEW GARDENS MEMORY CARE & ASSISTED LIVING
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NARRATIVE

they would treat or talk to their own mother because the staff has had experience taking care of their mother who had Alzheimer's for ten years.

It was alleged that staff did not implement proper hand hygiene procedures. Per interviews with residents, seven out of eight residents felt that the staff implemented proper hand hygiene because they saw the staff wearing gloves most of the time especially when handling food, when cleaning their room. Residents have seen the staff wash their hands routinely. However, one resident, R1 has seen a staff who helped in the kitchen use their bare hands to scoop the ice. R1 acknowledge that to the staff and refused the ice. All the staff interviewed have said they do practice proper hand hygiene, they wash their hands and wear gloves, when necessary, especially cleaning and handling with food. LPA interviewed one of the kitchen staff and said when they handle or serve food and take out the trash they always wear gloves. They said they would never use their bare hands to scoop ice because there are two ice scoopers in the kitchen for them to use to scoop ice for the residents. They wash their hands, and they have convenient soap dispenser and sink to wash their hands. They are afraid to get sick from residents and protect their health by wearing gloves and washing their hands frequently. During all visits, LPA has observed staff such as caregivers have gloves on. LPA also observed all kitchen staff wearing and using

gloves in the kitchen as well.

Therefore, based on LPA Tea's observations, interviews conducted, and records reviewed the allegations that facility staff mismanaged resident's medications, staff did not prevent resident from harming another resident in care, staff did not provide housekeeping services to resident in care in a timely manner, staff did not safeguard resident's personal items, staff did not provide toileting assistance to resident in care in a timely manner, staff spoke inappropriately to resident in care, and staff did not implement proper hand hygiene procedures has been determined as UNFOUNDED, meaning the allegations are false, could not have happened and/or is without a reasonable basis.

No deficiencies cited at this time and an exit interview was conducted with Executive Director Alma Espinal. A copy of the report was provided to the facility.

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