

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306006222
Report Date: 08/21/2025
Date Signed: 08/21/2025 08:32:59 AM

Unfounded

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 **08/31/2023** and conducted by Evaluator Jessica Cho

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20230831115602
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FACILITY NAME: IVY AT WELLINGTON, THE	FACILITY NUMBER: 306006222
ADMINISTRATOR: OLSON, KATHLEEN	FACILITY TYPE: 740
ADDRESS: 24903 MOULTON PARKWAY	TELEPHONE: (949) 458-2311
CITY: ALISO VIEJO	STATE: CA
CAPACITY: 305	ZIP CODE: 92653
	CENSUS: 124
	DATE: 08/21/2025
MET WITH: Gerry Vadnais- Senior Executive Director	UNANNOUNCED TIME BEGAN: 07:45 AM
	TIME COMPLETED: 08:45 AM

ALLEGATION(S):

1	Lack of supervision resulted in resident on resident sexual abuse.
2	Facility is allowing resident to violate gun policy.
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INVESTIGATION FINDINGS:

1	This unannounced inspection is being conducted by Licensing Program Analyst (LPA) Jessica Cho for
2	the purpose of delivering findings for the investigation into the above identified complaint allegations. LPA
3	met with Administrator (AD) Gerry Vadnais and explained the reason for today's inspection.
4	
5	The investigation conducted by LPA Sean Haddad into the allegations that lack of supervision resulted in
6	resident on resident sexual abuse and facility is allowing resident to violate gun policy revealed the
7	following: During the course of the investigation, Department staff inspected the facility, interviewed AD,
8	residents, staff, and witnesses, and obtained and reviewed copies of the resident roster, staff roster,
9	Resident #1's (R1) Admission Agreement, R1's Physician's Report dated November 17, 2021, R1's
10	Resident Appraisal dated March 17, 2022, R1's Level of Care Assessment dated November 2, 2021,
11	R1's Mini-Mental State Examinations conducted on November 23, 2021, and March 17, 2022, R1's
12	Physician's Report dated June 14, 2023, R1's Medical Records, R1's Care Notes, Resident #2's (R2)
13	Physician's Report dated June 17, 2023, and R2's Admission Agreement.

Unfounded

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Lourdes Montoya

NAME OF LICENSING PROGRAM ANALYST: Jessica Cho

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 08/21/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/21/2025

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

LIC9099 (FAS) - (06/04)

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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: IVY AT WELLINGTON, THE

FACILITY NUMBER: 306006222

VISIT DATE: 08/21/2025

NARRATIVE

1 Regarding the allegation that lack of supervision resulted in resident on resident sexual abuse: it was
2 alleged that in June 2023, R1 reported that their spouse R2 recently sexually abused them and that R2
3 has been sexually abusing them for years. Per R1's Admission Agreement, R1 and R2 moved into the
4 same room in the facility in November 2021. Review of R1's Physician's Report dated November 17,
5 2021, and R1's Resident Appraisal dated March 17, 2022, revealed that R1 did not have any diagnoses,
6 was ambulatory, had no functional impairments, and was able to communicate their needs. R1's Level of
7 Care Assessment dated November 2, 2021, indicates R1 had no care needs and R1's Mini-Mental State
8 Examinations conducted on November 23, 2021, and March 17, 2022, indicate R1 had no cognitive
9 impairment. Per R1's Physician's Report dated June 14, 2023, R1's health began to decline and R1 was
10 diagnosed with hyperthyroidism, grave's disease, anxiety, and depression, R1 was still ambulatory, R1
11 was not able to communicate their needs, R1 had functional impairments relating to self-care and
12 medication management, and R1 had complications from their recent thyroid disorder diagnosis. LPA
13 reviewed R1's Medical Records which indicate that in June 2023, R1 was seen by medical providers
14 often, had multiple hospitalizations, and had multiple medication changes as their medical condition
15 changed. LPA reviewed R1's Care Notes which document that in June 2023, R1 was checked on
16 regularly by staff, had contact with their family, told staff they were doing well and reported no problems,
17 but did report medical problems and received medical care when necessary. When interviewed, AD
18 stated that R1 had never reported any issues of abuse, staff had never suspected any abuse involving
19 R1 and R2, and that if any abuse had been suspected, the facility would have investigated it
20 immediately. Interviews with eight facility staff revealed that staff did not see any indications of abuse
21 and R1 never reported any issues. LPA reviewed R2's Physician's Report dated June 17, 2023, which
22 indicates R2 had a right lower extremity amputation. Per AD, R2 had an amputated leg and needed a
23 wheelchair to move around. Per AD, R1 moved out of the facility on June 27, 2023, and R2 moved out
24 of the facility in February 2024. R1 was interviewed by local law enforcement, did not disclose that they
25 were sexually abused by R2, and R1 passed away in September 2023. LPA interviewed R1's family who
26 stated that R1's initial report of abuse in June 2023 was the only time R1 ever reported the issue, and
27 that the facility had no reason to suspect abuse between R1 and R2. When interviewed, R2 denied
28 sexually abusing R1. The information obtained regarding whether R1 was abused by R2 is conflicting
29 and the information obtained did not corroborate that the facility did not provide proper care and
30 supervision as R1 never reported any issues to the facility and facility staff had no reason to suspect
31 abuse between R1 and R2.
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NAME OF LICENSING PROGRAM MANAGER: Lourdes Montoya

NAME OF LICENSING PROGRAM ANALYST: Jessica Cho

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 08/21/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/21/2025

LIC9099 (FAS) - (06/04)

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Control Number 22-AS-20230831115602

**COMPLAINT INVESTIGATION REPORT
(Cont)****FACILITY NAME:** IVY AT WELLINGTON, THE**FACILITY NUMBER:** 306006222**VISIT DATE:** 08/21/2025**NARRATIVE**

1 Regarding the allegation that the facility is allowing resident to violate gun policy: it was alleged that the
 2 facility is allowing R2 to store guns and ammunition at the facility in violation of the facility's gun policy.
 3 LPA reviewed R2's Admission Agreement, which incorporates the house rules which specifically state
 4 that weapons, including firearms, are not allowed in the facility. LPA interviewed AD who confirmed that
 5 guns are not allowed at the facility and stated the facility did not know R2 had guns and ammunition in
 6 their room. Per AD, the facility had received a concerning report regarding R2 and was notified by R2's
 7 family that they had already removed some of R2's guns, but AD was suspicious that there may be
 8 another gun, so AD had R2's room searched and removed an additional gun and ammunition. When
 9 interviewed, R2 stated that the gun that was confiscated had been inadvertently brought to the facility
 10 when they moved in and that they had been intending to relocate it to store it outside of the facility. AD
 11 stated that the facility was unaware R2 had guns in their room, R1 who lived with R2 had never reported
 12 anything, and staff did not see the guns while cleaning R2's room. While R2 did store guns and
 13 ammunition at the facility, the information obtained did not corroborate the allegation because the facility
 14 was unaware of the guns and enforced its gun policy as soon as it learned R2 was violating the policy.
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16 The Department has investigated the above allegations and found them to be Unfounded, meaning the
 17 allegations were false, could not have happened, or are without reasonable basis.
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19 An exit interview was conducted, and a copy of this report was discussed with and provided to Executive
 20 Director Gerry Vadnais.
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NAME OF LICENSING PROGRAM MANAGER: Lourdes Montoya**NAME OF LICENSING PROGRAM ANALYST:** Jessica Cho**LICENSING PROGRAM ANALYST SIGNATURE:****DATE:** 08/21/2025

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

FACILITY REPRESENTATIVE SIGNATURE:**DATE:** 08/21/2025