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**Department of**

# SOCIAL SERVICES

*Community Care Licensing*

# *COMPLAINT INVESTIGATION REPORT*

**Facility Number:** 306006344
**Report Date:** 07/24/2026
**Date Signed:** 07/24/2026 02:28:49 PM

## Unsubstantiated

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/15/2026** and conducted by Evaluator RoseMarie Ruppert

| | **COMPLAINT CONTROL NUMBER:** 22-AS-20260615121800 |
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| | | | | | |
|---|---|---|---|---|---|
| **FACILITY NAME:** | COGIR OF BREA | | | **FACILITY NUMBER:** | 306006344 |
| **ADMINISTRATOR:** | FAYE, SAMUEL | | | **FACILITY TYPE:** | 740 |
| **ADDRESS:** | 700 MADISON WAY | | | **TELEPHONE:** | (714) 681-0105 |
| **CITY:** | BREA | **STATE:** CA | | **ZIP CODE:** | 92821 |
| **CAPACITY:** | 110 | **CENSUS:** 76 | | **DATE:** | 07/24/2026 |
| | | UNANNOUNCED | | **TIME BEGAN:** | 08:00 AM |
| **MET WITH:** | Susan Allen, Executive Director | | | **TIME COMPLETED:** | 02:45 PM |

**ALLEGATION(S):**

| | |
|---|---|
| 1 | Staff are not administering resident's medication in a timely manner |
| 2 | Staff are not responding to resident's call button in a timely manner |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |

**INVESTIGATION FINDINGS:**

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|---|---|
| 1 | Licensing Program Analyst (LPA) Rose Ruppert made an unannounced visit to deliver findings for a |
| 2 | complaint investigated by the Department. LPA was greeted and granted entry by the Business Office |
| 3 | Director at 8am. LPA met with Executive Director (ED) Susan Allen and explained the purpose of the |
| 4 | visit. The facility currently has a census of seventy-six residents. |
| 5 | |
| 6 | During the investigation LPA reviewed the following documents for Resident #1 (R1). Documents include: |
| 7 | Identification and Emergency Information, Physician's Report dated 5/14/2024, Service Plan dated |
| 8 | 4/22/2025, Assessments dated 5/8/2024 and 4/22/2025, electronic Medication Administration Records for |
| 9 | June and July 2026, Progress Notes and Physician Medication Orders. Resident #1 (R1) moved into the |
| 10 | community on 6/30/2024 with a diagnosis of encephalopathy, per Physician's Report dated 5/14/2024, |
| 11 | and is non-ambulatory. |
| 12 | |
| 13 | (Continued on LIC 9099-C) |

| **Unsubstantiated** | **Estimated Days of Completion:** |
|---|---|

**SUPERVISORS NAME:** Alisa Ortiz
**LICENSING EVALUATOR NAME:** RoseMarie Ruppert
**LICENSING EVALUATOR SIGNATURE:**
**DATE:** 07/24/2026

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

**FACILITY REPRESENTATIVE SIGNATURE:**
**DATE:** 07/24/2026

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



**Control Number** 22-AS-20260615121800

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|---|---|
| **COMPLAINT INVESTIGATION REPORT (Cont)** | |

**FACILITY NAME:** COGIR OF BREA **FACILITY NUMBER:** 306006344
**VISIT DATE:** 07/24/2026

**NARRATIVE**

(Continued from LIC 9099)

On this date LPA obtained six of six staff training and inservice records, and reviewed the Device Activity Report from 6/1-6/19/2026 and Resident Council Minutes for June 2026. LPA interviewed eight of eight residents, six of six staff members and three of three witnesses during the course of the investigation.

It was alleged that Staff are not administering resident's medication in a timely manner. LPA reviewed the electronic Medication Administration Record (eMAR) for Resident #1 (R1) for June through July 2026. Per eMAR, R1 received an as needed (PRN) pain medication at 9:36pm on 6/12/2026. This medication can be given every six hours. Staff interviewed stated that care staff went to the resident after receiving a phone call and relayed to the Medical Technician (Med Tech) that R1 was requesting pain medication.

At 10pm, R1 requested additional pain medications. Staff interviewed stated that it was too soon to give additional pain medications and stated they shared this with R1. Staff continue to support R1 since the resident was experiencing a lot of pain. Progress notes from 6/12/2026 stated R1 requested pain medication at 9:30pm and that it was administered and tolerated well and that staff were monitoring R1 frequently. During the PM shift on 6/12/2026 there were two care staff, the Med Tech and the Med Tech trainee.

Resident Council minutes from a town hall meeting on 5/28/2026 requested additional medication training for Med Techs for accuracy of medications administered. The facility addressed this issue during the 6/17/2026 Resident Council Meeting stating that an additional MedTech was hired for weekends and that staff have ongoing medication training. LPA reviewed four of six care staff training records documenting continuous medication training. Medication inservices were provided to care staff on 9/17/2025 for Medication Administration, checking dosage against orders and MARs and reading labels. On May 21, 2026 an inservice was provided for Incident reports, Giving Medications, alert and progress charting and shift duties. Five of six staff interviewed denied the allegation. One of six staff members could not confirm, nor deny the allegation.

LPA interviewed eight of eight residents Three of eight residents denied the allegation that staff are not administering medications in at timely manner. Two of eight residents confirmed medications are not given in a timely manner Three of eight residents interviewed could not confirm, nor deny if medications were administered timely since they do not use medication services and self administer their own meds. Two of
(Continued on LIC 9099-C1)

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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:** COGIR OF BREA **FACILITY NUMBER:** 306006344
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## NARRATIVE

(Continued from LIC 9099-C)

three witnesses confirmed the allegation. One of three witnesses could not confirm, nor deny the allegation.

It was alleged that Staff are not responding to resident's call button in a timely manner. LPA obtained the June 2026 Device Activity Report for Resident #1 (R1)'s pendant calls. Per report, there were no pendant calls received on June 12, 2026. Eight of eight staff were interviewed and staff reported R1 has a difficult time pressing the pendant due to ongoing skin lesions. Staff stated there was one instance where it was reported to the facility that R1 could not reach the pendant; which was placed on a bedside table. Staff stated they had recently changed R1's shirt and had placed the pendant on the table. Staff then put the pendant on R1's neck. Eight of eight staff denied the allegation.

Staff stated on the evening of 6/12/2026 that a phone call was received stating R1 was requesting medications. Care staff stated they responded to the call within ten minutes and notified the Med Tech and the as needed pain medications were provided. Progress notes from 6/12/2026 stated R1 requested pain medication at 9:30pm and that it was administered and tolerated well and that staff were monitoring R1 frequently.

Four of eight residents interviewed denied the allegation that staff are not responding to resident's call button in a timely manner. One of eight residents confirmed the allegation. Three of eight residents could not confirm, nor deny the allegation since they do not use pendants. Two of three witnesses confirmed the allegation and one witness could not confirm, nor deny the allegation.

Based on LPA interviews, record review and observations, the allegations that Staff are not administering resident's medication in a timely manner and Staff are not responding to resident's call button in a timely manner are Unsubstantiated. The allegations may have happened or are valid, but there is not a preponderance of the evidence to prove that the alleged violation occurred. An exit interview was conducted with Executive Director (ED) Susan Allen and a copy of this report and LIC 811 were provided to the facility.

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