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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 312700574
Report Date: 11/25/2025
Date Signed: 11/25/2025 01:13:14 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SACRAMENTO NORTH ASC, 9835 GOETHE ROAD, SUITE 100 SACRAMENTO, CA 95827

This is an official report of an unannounced visit/investigation of a complaint received in our office on **09/29/2025** and conducted by Evaluator Sabrina Calzada

PUBLIC	COMPLAINT CONTROL NUMBER: 59-AS-20250929150828

FACILITY NAME:	ANSEL PARK SENIOR LIVING COMMUNITY		**FACILITY NUMBER:**	312700574
ADMINISTRATOR:	PAYNE, KEITH		**FACILITY TYPE:**	740
ADDRESS:	1200 ORCHID DRIVE		**TELEPHONE:**	(916) 250-0770
CITY:	ROCKLIN	**STATE:** CA	**ZIP CODE:**	95765
CAPACITY:	100	**CENSUS:** 79	**DATE:**	11/25/2025
		UNANNOUNCED	**TIME BEGAN:**	11:00 AM
MET WITH:	Keith Payne, Administrator		**TIME COMPLETED:**	01:15 PM

ALLEGATION(S):

1	Staff did not assist resident in a timely manner after a fall.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Calzada arrived unannounced to complete an investigation for a
2	complaint received on September 29, 2025. LPA initially met with the concierge and later met with
3	Administrator, Keith Payne, stating the reason for today's inspection.
4	
5	During the course of the investigation, LPA interviewed the Administrator, (2) Med-Techs and a family
6	member of resident (R1). LPA attempted multiple times to interview (S1), the assigned caregiver to (R1)
7	on the morning of September 26, 2025 when (R1) fell in the bathroom. LPA reviewed documentation
8	relating to (R1) including their physician's report, service plan, incident report and the 911 report for that
9	incident. The results of the investigation are as follows:
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11	Resident (R1) moved to the Assisted Living side of the community on December 31, 2022. The
12	physician's report (dated 12/22/2023) states resident has a primary diagnosis of Hypertension, Diabetes
13	Melliutus II and a secondary diagnosis of anxiety, depression and has mild cognitive impairment.
	*cont 812C-1..

Substantiated	Estimated Days of Completion:

SUPERVISORS NAME: Maribeth Senty
LICENSING EVALUATOR NAME: Sabrina Calzada
LICENSING EVALUATOR SIGNATURE:
DATE: 11/25/2025

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

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

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
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FACILITY NAME: ANSEL PARK SENIOR LIVING COMMUNITY
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VISIT DATE: 11/25/2025

NARRATIVE

1 9099C-1. The physician's report also notes (R1) is ambulatory and independent with bathing, dressing, feeding and toileting but needs assistance with taking all medications.

The results of the investigation are as follows:

Staff did not assist resident in a timely manner after a fall. *The allegation states that resident's (R1's) family was contacted by the facility around 1:00 PM to report that (R1) had fallen and was being transported to the hospital, and that (R1) was on the ground in the shower for approximately five hours before staff was made aware.*

The facility's internal incident report states that on September 26, 2025, at 12:30 pm, staff (S1) went to check on (R1) due to the front desk not seeing (R1) earlier in the day. When (S1) went to check on (R1), she found (R1) on the floor in the shower. (R1) was unable to recall any details of the fall. (S1) came running out of (R1's) room calling for additional staff to assist. The report notes (R1) was pulled off the wall as their neck was in an uncomfortable position, and their vitals were taken. 911 was called and took (R1) to the emergency room due to being confused, high blood pressure and pain in their hip/neck/arm. Family was contacted at this time.

The 911 report from local fire states they **received a call from the facility on September 26, 2025, at 12:30 pm**, for an unwitnessed ground level fall, and they arrived to the facility at 12:42 pm. (R1) was found lying on the shower floor of their apartment. Staff on the scene reported (R1) was last seen at baseline at approximately 7:30 am earlier that day, and when (R1) was checked again, shortly before 12:30 pm, (R1) was found on the floor. The report notes *"trauma assessment reveals pain to patient's left hip, increase of pain upon manipulation of the leg".* No other trauma was noted as well as no bleeding. The report also states *"vitals on scene reveal hypertensive blood pressure but patient believed to have missed morning medications due to fall".* Resident was taken to the emergency room for further medical evaluation.

Resident (R1's) care plan (dated September 16, 2025), notes resident is independent with mobility and ambulation, does not require assistance with bathing and is at moderate potential for falls. The care plan also states that (R1) **requires assistance with all aspects of taking medications and a Med-Tech will administer (R1's) scheduled and PRN medications.**

***cont on 9099C-2..**

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NARRATIVE

9099C-2.. The Medication Administration Record (MAR) was reviewed for the month of September, 2025, and shows (R1) was prescribed multiple (7) scheduled medications at/around 8:00 am. **One of (R1's) morning medications, Glipizide 10mg,** is used to treat Diabetes Mellitus II, and a second morning medication, **Metropolol Succinate 50 mg,** is used to treat high blood pressure. The MAR documentation notes the Med-Tech's initials entered for the morning medications, as if they were given; however, an interview with the Med-Tech (S2) confirmed that (R1's) medications were left on the counter in their room around 7:00 am.

Another Med-Tech who was interviewed stated, "I watch them take their meds- we are not supposed to leave meds on the counter" and confirmed that sometimes this happens with other Med-Techs". This same Med-Tech staff explained that (R1) **"follows a strict schedule with their showers and is usually finished by 7:30 am with their shower" and confirmed (R1) is "independent" with showers.** This staff explained that **7:30 am is the "usual medication time for (R1) and they are sitting in their chair waiting for the Med-Tech" to arrive to administer their medications.**

Staff (S2) confirmed that she was the Med-Tech on duty on the morning of September 26, 2025, and she **went to give (R1) their medications at 7:00 am,** but (R1) was "on the toilet". (S2) stated (R1) had a "robe and underwear on" while in the bathroom and that she told (R1) she "would return soon", and (R1) said "okay". (S2) explained (R1) is independent with all except for medications- there is no standby needed" and confirmed she left (R1's) medications on the counter" in their room but alerted (R1) who said okay". (S2) explained that **although she didn't have time to circle back and check on (R1) later that morning, the caregiver should have checked on (R1) every two hours.**

(S2) further stated she went to assist (S1) and observed (R1) to be "laying on their back with their neck raised, and their head was on the wall". (S2) stated she got (R1's) vitals and they called 9-1-1 instantly. (S2) stated it appeared that (R1) fell when stepping into the shower" as (R1's) hair was "not wet and they had not showered". Staff further stated that (R1) doesn't normally use the pendant and has called staff "by accident" only before. Staff also confirmed (R1's) shower was a "walk-in" type, without a step, and "thinks (R1) became dizzy and fell back" when trying to walk in. (S2) **confirmed that (R1) "didn't take their medications on the morning of the fall and may have missed their noon meds that day also.** The MAR does not indicate (R1) had any scheduled medications at noon in the month of September.

*cont on 9099C-3.

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NARRATIVE

9099C-3.. (R1's) family member confirmed that (R1) is "independent with showers" and takes them regularly at 7:30 am. The family member commented further she is "not sure" if (R1) is able to take meds on their own and "needs staff support to watch (R1) take them". The family member stated she has "seen little cups of Metamucil powder left out" in (R1's) room before.

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6 7 8	The family member indicated she was previously told by a facility manager that staff was trained to go and look in a resident's room if they are not at a meal, asserting "(R1)does not go to lunch but does go to breakfast and dinner".
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10 11 12	**Based on information obtained, the allegation is found to be SUBSTANTIATED- A finding that the complaint is Substantiated means that the allegation is valid because the preponderance of the evidence standard has been met.**
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14 15 16	**Per California Code of Regulations, Title 22, Division 6, Chapter 8, the following (1) citation is issued on the 9099-D page.**
17	
18 19 20	**As a result of resident's injury, the violation warrants a civil penalty assessment based on Health and Safety Code §1569.49. At this time, the civil penalty assessment is under review. LPA will return at a future date to assess a civil penalty, if warranted.**
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22	Exit interview. Copy of report and appeal rights provided.
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FACILITY NAME: ANSEL PARK SENIOR LIVING COMMUNITY **FACILITY NUMBER:** 312700574
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 11/25/2025

Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Type A 11/26/2025 **Section Cited** CCR 87464(f)(4)	1 2 3 4 5 6 7	87464 Basic Services (f) Basic services shall at a minimum include: (4) Personal assistance and care as needed by the resident and as indicated in the pre-admission appraisal, with those activities of daily living such as dressing, eating, bathing and assistance with taking prescribed medications, as specified in Section 87608, Postural Supports. This requirement is not met as evidenced by:	1 2 3 4 5 6 7	Licensee/Administrator agrees to conduct staff training on correctly administering medications. Will train staff again on checking on all residents in Assisted Living at least every 2 hours.
	8 9 10 11 12	Based on interviews conducted and documentation reviewed, the Licensee did not ensure that (R1) was provided with assistance in taking their precribed medications on the morning of	8 9 10 11 12	Training plan and date to be scheduled by tomorrow 11/26/25- email LPA. Training itself is due by 12/9/25.

	13 14	September 26, 2025, which posed an immediate health and safety risk to residents in care. (R1) missed taking multiple prescribed medications, including those for diabetes and high blood pressure, and fell when trying to get in the shower, sustaining a hip fracture. (R1) was not checked on by staff from approximately 7:00 am until 12:30 pm, when they were found on the floor near the shower.	13 14	
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

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