

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 315003016
Report Date: 08/06/2025
Date Signed: 08/06/2025 01:48:55 PM

Unfounded

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/23/2025** and conducted by Evaluator Cassandra Mikkelson

	COMPLAINT CONTROL NUMBER: 59-AS-20250623154126
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FACILITY NAME: SENIOR CARE VILLA OF LOOMIS	FACILITY NUMBER: 315003016
ADMINISTRATOR: ILONA CORPUS	FACILITY TYPE: 740
ADDRESS: 3400 CHISOM TRAIL	TELEPHONE: (916) 652-8000
CITY: LOOMIS	STATE: CA
CAPACITY: 35	ZIP CODE: 95650
	CENSUS: 28
	DATE: 08/06/2025
	UNANNOUNCED TIME BEGAN: 01:30 PM
MET WITH: Christina Brown, Resident Care Coordinator	TIME COMPLETED: 01:50 PM

ALLEGATION(S):

1	Staff neglect resulted in a resident's death
2	Staff did not ensure a resident was properly fed while in care
3	Staff did not report incidents involving a resident
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INVESTIGATION FINDINGS:

1	Licensed Program Analyst (LPA) Cassandra Mikkelson arrived at the facility unannounced and met with
2	Christina Brown to deliver findings for the above complaint allegation.
3	
4	During the investigation, LPA conducted interviews, conducted a tour of the facility, and reviewed
5	documentation pertinent to the investigation.
6	
7	The results of the investigation are as follows:
8	
9	*** Report continued on 9099-C***
10	
11	
12	
13	

Unfounded

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Laura Munoz
NAME OF LICENSING PROGRAM ANALYST: Cassandra Mikkelson
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 08/06/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/06/2025

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
SACRAMENTO NORTH ASC, 9835 GOETHE ROAD, SUITE 100
SACRAMENTO, CA 95827

COMPLAINT INVESTIGATION REPORT (Cont)

FACILITY NAME: SENIOR CARE VILLA OF LOOMIS

FACILITY NUMBER: 315003016

VISIT DATE: 08/06/2025

NARRATIVE

1 **Staff neglect resulted in a resident's death**

2

3 Records reviewed indicate that Resident R1's death was not due to facility neglect. Medical records
4 reviewed do not indicate there was staff neglect for R1. The Death certificate does not indicate that R1's
5 death was questionable in any manner. Therefore, the allegation staff neglect results in a resident's
6 death is unfounded.

7

8 **Staff did not ensure a resident was properly fed while in care**

9

10 Records reviewed indicated that R1 was eating meals appropriately. Interviews conducted with staff
11 indicated that R1 was eating meals and did not refuse meals while in care. Staff encouraged R1 to eat
12 and drink on a daily basis. Therefore, the allegation that staff did not ensure a resident was properly fed
13 while in care is unfounded.

14

15 **Staff did not report incidents involving a resident**

16

17 Records reviewed indicate that staff were contacting R1's responsible party (RP) when an incident
18 occurred. Internal incident reports documented contact with R1's RP indicating that when an incident
19 occurred staff was contacting R1's RP to report the incident and update on R1's status. Therefore, the
20 allegation staff did not report incidents involving a resident is unfounded.

21

22 Based on records reviewed and interviews, LPA finds the above allegations to be UNFOUNDED-
23 meaning that the allegations were false, could not have happened and/or is without reasonable basis.
24 Exit interview conducted with the Administrator. Copy of report was given to facility.

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NAME OF LICENSING PROGRAM MANAGER: Laura Munoz
NAME OF LICENSING PROGRAM ANALYST: Cassandra Mikkelson
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 08/06/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/06/2025