

Department of  
**SOCIAL SERVICES**

*Community Care Licensing*

# COMPLAINT INVESTIGATION REPORT

Facility Number: 331881349  
Report Date: 08/19/2025  
Date Signed: 08/19/2025 03:26:35 PM

## Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION RIVERSIDE ASC, 1650 SPRUCE ST STE 200 MS29-27 RIVERSIDE, CA 92507
<b>COMPLAINT INVESTIGATION REPORT</b>	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **10/16/2024** and conducted by Evaluator Valerie Flores

	<b>COMPLAINT CONTROL NUMBER: 18-AS-20241016142418</b>
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<b>FACILITY NAME:</b> MANZANITA VILLAGE AT RANCHO BELAGO	<b>FACILITY NUMBER:</b> 331881349
<b>ADMINISTRATOR:</b> TAYLOR, KAMESHI	<b>FACILITY TYPE:</b> 740
<b>ADDRESS:</b> 27900 BRODIAEA AVENUE	<b>TELEPHONE:</b> (951) 379-0100
<b>CITY:</b> MORENO VALLEY	<b>STATE:</b> CA <b>ZIP CODE:</b> 92555
<b>CAPACITY:</b> 125	<b>CENSUS:</b> 125 <b>DATE:</b> 08/19/2025
<b>MET WITH:</b> Assistant Director, Anna Martinez	<b>UNANNOUNCED TIME BEGAN:</b> 03:05 PM
	<b>TIME COMPLETED:</b> 03:45 PM

**ALLEGATION(S):**

1	Facility staff was negligent in resident's death
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**INVESTIGATION FINDINGS:**

1	On 8/19/2025, Licensing Program Analyst (LPA) Valerie Flores arrived at the facility unannounced for the purpose of delivering findings of the listed allegations. LPA Flores met with Assistant Director, Anna Martinez, and a tour of the facility was conducted.
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4	On 4/12/2023, Community Care Licensing (CCL) received a complaint alleging facility staff was negligent in resident's death. Information obtained through interviews revealed staff attempted to assist Resident #1 (R1) with showering, while doing so R1 became agitated, R1's agitation is related to R1s cognitive impairment which became noticeable after a change in R1s medication. This is consistent with Needs/Service Plan-File Review. According to information obtained R1 did not want to shower. Staff would assist R1's showering needs during the evening for R1 to be presentable at church services, at the request of R1's Responsible party. R1's shower schedule would vary depending on R1's mood. R1's agitation increased, and staff attempted to mitigate the situation by using a "change of face" technique.
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**Unsubstantiated**

**Estimated Days of Completion:**

**NAME OF LICENSING PROGRAM MANAGER:** Anthony Perez

**NAME OF LICENSING PROGRAM ANALYST:** Valerie Flores

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 08/19/2025

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 08/19/2025

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  
RIVERSIDE ASC, 1650 SPRUCE ST STE 200 MS29-27  
RIVERSIDE, CA 92507

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** MANZANITA VILLAGE AT RANCHO BELAGO

**FACILITY NUMBER:** 331881349

**VISIT DATE:** 08/19/2025

### NARRATIVE

1 The change of face technique is a non-confrontational behavior intervention used when a resident  
2 becomes agitated during an interaction with a particular staff. The approach involves substituting the  
3 current staff with a different staff member, often leading to a reset in the residents emotional state.  
4 Through interviews, it was alleged that while showering R1, R1 took a step backwards, lost their  
5 balance, fell, and struck their head on the wall. The facility staff attempted to catch R1 prior to the fall but  
6 their attempt was unsuccessful. The facility's protocol does not allow staff to move the residents after an  
7 injury as it may harm the residents. The ambulance was immediately called, however, a valid signed, Do  
8 Not Resuscitate (DNR) was located in R1's file. Through observations, the facility's bathrooms complied  
9 with Title 22, regulation 87303, as showers were equipped with non-skid mats and grab bars. In  
10 addition, information obtained through interviews revealed that the facility's protocol after any client falls,  
11 the service plan will be updated based on any specific need. This is to prevent any further falls and  
12 address safety measures. Residents will also participate in a re-evaluation provided by a medical  
13 professional after so many fall incidents. No reassessment was completed due to R1 passing.  
14 Furthermore, the facility complied with all protocols pertaining to R1's needs and service plan, such as  
15 conducting checks on R1 and assisting R1 with their medications. Staffs training records were current,  
16 Staff implemented de-escalation techniques pertaining to R1's agitated state at the time of the incident.  
17 According to the autopsy received by the Coroner's Office, the reported cause of death was accidental  
18 and due to blunt force trauma.  
19 Based on observations, interviews and records reviewed, the allegation of staff was negligent in  
20 resident's death is unsubstantiated. A finding that is unsubstantiated means although the allegation may  
21 have happened and/or is valid, there is not a preponderance of evidence to prove the alleged violation  
22 did or did not occur, therefore the allegation is unsubstantiated at this time.  
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24 An exit interview was conducted where a copy of this report was reviewed and provided to Assistant  
25 Director, Anna Martinez.  
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**NAME OF LICENSING PROGRAM MANAGER:** Anthony Perez

**NAME OF LICENSING PROGRAM ANALYST:** Valerie Flores

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 08/19/2025

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 08/19/2025