

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 342700722
Report Date: 08/06/2026
Date Signed: 08/06/2026 04:35:39 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SACRAMENTO SOUTH 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 04/14/2026 and conducted by Evaluator Michael Bilger

	COMPLAINT CONTROL NUMBER: 27-AS-20260414100625
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FACILITY NAME:	WELLQUEST OF ELK GROVE	FACILITY NUMBER:	342700722
ADMINISTRATOR:	ELENA CUEVAS	FACILITY TYPE:	740
ADDRESS:	8871 E STOCKTON BLVD	TELEPHONE:	(916) 689-1000
CITY:	ELK GROVE	ZIP CODE:	95624
CAPACITY:	170	DATE:	08/06/2026
	STATE: CA	UNANNOUNCED TIME BEGAN:	03:57 PM
	CENSUS: 133	TIME	04:45 PM
MET WITH:	Luna Garcia	COMPLETED:	

ALLEGATION(S):

1	Untrained staff providing care to residents
2	Staff are not providing adequate food service to residents
3	Staff are not ensuring residents are eating
4	Staff are not providing activities for residents
5	Staff did not prevent residents from wandering into other residents rooms resulting in physical
6	altercations
7	Staff are not properly assessing residents
8	Staff are inappropriately increasing rent without additional care
9	

INVESTIGATION FINDINGS:

1	On 8-6-2026 at 3:57pm, Licensing Program Analyst (LPA) Michael Bilger arrived unannounced to deliver
2	and discuss findings for the allegations noted above. LPA met with business office manager Luna Garcia
3	and explained the purpose of the visit. Administrator Mike Telani was present via phone conference.
4	During this investigation, LPA conducted interviews with five staff members and reviewed facility file
5	documentation including physician reports and needs and service plans for seven residents in care,
6	facility admissions agreement, activities calendar, facility menu, and various staff training records.
7	Additionally, LPA conducted a facility observation on 7-20-2026 as part of this investigation.
8	Allegation: Untrained staff providing care to residents. LPA conducted interviews, record reviews, and
9	observations as noted above. Staff interviews conducted on 7-20-2026 and 7-27-2026 revealed
10	adequate and sufficient training has been provided for purpose of meeting needs of residents residing in
11	the memory care unit. A review of staff training records on 7-20-2026 further revealed additional evidence
12	of adequate training. During an observation conducted on 7-20-2026, LPA observed various facility staff
13	on duty conducting care in accordance with training received. Interviews conducted did not reveal any
	corroborated evidence of untrained staff providing care. As a result, the preponderance of evidence
	standard is not met, and this allegation is UNSUBSTANTIATED. {Cont. on 9099C}

SUPERVISORS NAME: Liza King

LICENSING EVALUATOR NAME: Michael Bilger

LICENSING EVALUATOR SIGNATURE:

DATE: 08/06/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/06/2026

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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Control Number 27-AS-20260414100625

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

**COMPLAINT INVESTIGATION REPORT
(Cont)**CALIFORNIA DEPARTMENT OF SOCIAL
SERVICES
COMMUNITY CARE LICENSING DIVISION
SACRAMENTO SOUTH ASC, 9835 GOETHE
ROAD, SUITE 100
SACRAMENTO, CA 95827

FACILITY NAME: WELLQUEST OF ELK GROVE

FACILITY NUMBER: 342700722

VISIT DATE: 08/06/2026

NARRATIVE

1 Allegation: Staff are not providing adequate food service to residents. LPA conducted interviews, record
2 reviews, and observations as noted above. Based on staff interviews conducted on 7-20-2026 and 7-27-
3 2026, it was revealed that staff demonstrated awareness of various residents' dietary needs. LPA's
4 review of physician reports and needs and service plan for various residents in care on 7-27-2026
5 further revealed residents identified dietary needs. During an observation on 7-20-2026, it was revealed
6 that staff are demonstrating knowledge of various diets of residents and rendering assistance as
7 needed. As a result, the preponderance of evidence standard is not met, and this allegation is
8 UNSUBSTANTIATED.

9
10 Allegation: Staff are not ensuring residents are eating. LPA conducted interviews, and observations as
11 noted above. Based on interviews and observations conducted, it was revealed that residents are
12 consistently receiving assistance with feeding as necessary. LPA's observation on 7-20-2026 revealed
13 residents received staff assistance based on diet restrictions and food texture, while staff ensure
14 residents were eating sufficiently. Interviews did not reveal any corroborated evidence of staff not
15 ensuring residents are eating. As a result, the preponderance of evidence standard is not met, and this
16 allegation is UNSUBSTANTIATED.

17
18 Allegation: Staff are not providing activities for residents. LPA conducted interviews, record, reviews, and
19 observation as noted above. Based on interviews, it was revealed that staff have been consistently
20 offering activities and engaging with residents. A review of facility's activities calendar on 7-27-2026
21 revealed various adequate activities offered within memory care. An observation conducted on 7-20-
22 2026 revealed staff involvement with residents in care for various activities based on resident's ability to
23 participate. Interviews conducted did not reveal any corroborated statements or evidence to reveal staff
24 not providing activities to residents. As a result, the preponderance of evidence standard is not met, and
25 this allegation is UNSUBSTANTIATED.

26
27 Allegation: Staff did not prevent residents from wandering into other residents' rooms resulting in
28 physical altercations. LPA conducted interviews and record reviews as noted above. Based on
29 interviews and record reviews, it was revealed that select residents were identified to have history of
30 altercation with peers. Record reviews further revealed appropriate interventions in place for residents
31 identified. Additionally, LPA's observation on 7-20-2026 revealed staff appropriately interacting and
32 attempting to redirect residents as necessary for safety. Interviews conducted did not reveal any
corroborated statements from staff not attempting to prevent residents from inappropriate interactions
with peers. As a result, the preponderance of evidence standard is not met, and this allegation is
UNSUBSTANTIATED. {Cont. on 9099C}

SUPERVISORS NAME: Liza King

LICENSING EVALUATOR NAME: Michael Bilger

LICENSING EVALUATOR SIGNATURE:

DATE: 08/06/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/06/2026

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

FACILITY NAME: WELLQUEST OF ELK GROVE	FACILITY NUMBER: 342700722
	VISIT DATE: 08/06/2026

NARRATIVE	
1	Allegation: Staff are not properly assessing residents. LPA conducted interviews and record reviews as noted above. Based on interviews and record reviews, it was revealed that licensee has utilized appropriate assessment forms and included adequate information necessary to properly determine initial level of care needs for residents in care. Interviews conducted did not reveal corroborated statements of instances in which residents are not properly assessed. Furthermore, it was revealed through interviews that facility conducts on-going assessments to determine any level of care change in residents. As a result, the preponderance of evidence standard is not met, and this allegation is UNSUBSTANTIATED. Allegation: Staff are inappropriately increasing rent without additional care. LPA conducted interviews and record reviews as noted above. Based on review of admissions agreement reviewed on 7-27-2026, it was revealed that facility increases rent based on regulatory requirements including a 90-day notice for general rate increases, and two business day notice for level of care increase including a description of care involved. As a result, the preponderance of evidence standard is not met, and this allegation is UNSUBSTANTIATED. A finding of unsubstantiated means the allegation may have happened or is valid, but there is not a preponderance of the evidence to prove that the alleged violation occurred. An exit interview was conducted with business office manager and a copy of this report was provided. Appeal rights provided.
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SUPERVISORS NAME: Liza King	
LICENSING EVALUATOR NAME: Michael Bilger	
LICENSING EVALUATOR SIGNATURE:	DATE: 08/06/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 08/06/2026