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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 342701213
Report Date: 03/04/2026
Date Signed: 03/04/2026 05:54:42 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SACRAMENTO SOUTH 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 **02/05/2026** and conducted by Evaluator Cynthia Tamayo

	COMPLAINT CONTROL NUMBER: 27-AS-20260205131706

FACILITY NAME:	CARLTON SENIOR LIVING SACRAMENTO			**FACILITY NUMBER:**	342701213
ADMINISTRATOR:	WIMMER, KASIE			**FACILITY TYPE:**	740
ADDRESS:	1075 FULTON AVENUE			**TELEPHONE:**	(916) 971-4800
CITY:	SACRAMENTO	**STATE:** CA		**ZIP CODE:**	95825
CAPACITY:	185	**CENSUS:** 143		**DATE:**	03/04/2026
		UNANNOUNCED		**TIME BEGAN:**	03:17 PM
MET WITH:	Kasie Wimmer			**TIME COMPLETED:**	05:10 PM

ALLEGATION(S):

1	Staff does not treat resident with dignity and respect
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INVESTIGATION FINDINGS:

1	On 3/4/26 Licensing Program Analyst (LPA) Cynthia Tamayo arrived unannounced to complete and close
2	the investigation into an allegation noted above. LPA met with Administrator, Kasie Wimmer(S1) and
3	Director of Memory Care Rose De La Garza (S2), LPA stated the purpose of this visit.
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5	Allegation: Staff does not treat resident with dignity and respect
6	It was alleged “staff yelled at resident”, this investigation focused on Resident 1 (R1). Throughout the
7	process, the LPA conducted interviewed staff, collateral interviews, and reviewed all relevant documents
8	related to R1. On 2/3/26, the facility received a report from a witness stating that Resident 1 (R1) was not
9	treated with respect by staff 3 (S3). On 2/10/26, the facility self reported to the Regional Office via an
10	incident report and SOC 341 that on 2/3/26, R1 wondered into another resident’s’ room in which a
11	witnessed reported that they overheard S3 calling R1 “stupid” in a “frustrated” tone. It observed through
12	video footage to assist R1 out of another residents room, however there is no audio in the video footage.
13	The incident was reported to authorized representative, licensing (LPA, Kimberly Villarella), long term
	care ombudsman.
	CONTINUED ON 9099-C

Substantiated	Estimated Days of Completion:

SUPERVISORS NAME: Czarrina A Camilon-Lee
LICENSING EVALUATOR NAME: Cynthia Tamayo
LICENSING EVALUATOR SIGNATURE:
DATE: 03/04/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 03/04/2026

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

Control Number 27-AS-20260205131706

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: CARLTON SENIOR LIVING SACRAMENTO **FACILITY NUMBER:** 342701213
VISIT DATE: 03/04/2026

NARRATIVE

Collateral interview with witness (P1) stated that on 2/3/26 at around 5:25PM they overheard Staff 3 (S3) yell the word “stupid” “why would you do that?” “you’re stupid”, “its so stupid”. Resident 1 (R1) was observed to face away from them in the hallway and it appeared they were trying to wheel their wheelchair way from S3. P1 stated they did not observe whether or not S3 handled R1 in a rough manner.

Staff 1 (S1) and Staff 2 (S2) stated the facility did an internal investigation was initiated immidiatley on 2/3/26 which included reviewing video footage and interviews. The facility determined that S3 did not physically handle R1 in a rough manner. However, S1 stated the encounter observed does not meet the facilities’ standards. P1 stated S3 did not “yell” but they sounded frustrated and called them "stupid louder than regular speaking voice. It was determined by the facility that S3 did not treat R1 with dignity and respect, S1 stated this was an isolated incident in which no other staff has been observed not treat a resident with dignity and respect. S1 also stated preventative measures were taken prior to this incident and immediate measures were taken after the incident on 2/3/26 to ensure staff are trained on re-direction and resident's personal rights. S1 stated all staff including S3 received two days of dementia specific training focusing in redirection for individuals with wondering behaviors. S3 was immediately placed on leave on 2/3/26 and the investigation concluded on 2/10/26, in which it was determined S3's employment would no longer return to the facility.

LPA reviewed video footage in which it was observed, in which it was corroborated that S3 was redirecting the resident out of room 139 and into the hallway. They pushed R1 down the hallway and released the wheel chair handle bars behind R1 simultaneously in which R1 proceeded to continue to wheel themselves down the hallway away from S3. S3 then turned away from R1 and opened the exterior door, it was reported there was someone knocking on the door and video footage confirms that S3 let the individual knocking into the facility. Video footage confirms S3 then proceeds to walk towards another hallway away from R3 and did not return to assist R1.

In response to this incident, the facility held a mandatory meeting for all staff was held on 2/5/26 by S1 regarding Personal rights, expectations, positive approach, re-direction. An additional service was held on 2/4/26 called "Treating Residents with Kindness, Respect, and Professionalism". S1 reported that S3 was terminated as of 2/10/26 and has been disassociated from the facility. Based on interviews and record review of the LPA and review of records the allegation Staff yelled at resident is substantiated. Based on interviews and record review of the LPA and review of records the allegation Staff does not treat resident with dignity and respect is substantiated.

As a result, the allegations above are SUBSTANTIATED. A finding that the complaint is substantiated means that the allegations are valid because the preponderance of the standard has been met. Deficiencies cited on the LIC 9099-D, per Title 22 Regulations. An exit interview was conducted S1 and S2 and a copy of this LIC 9099, LIC 9099-D page and appeal rights provided to facility.

SUPERVISORS NAME: Czarrina A Camilon-Lee
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LICENSING EVALUATOR SIGNATURE:
DATE: 03/04/2026

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FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 03/04/2026

Control Number 27-AS-20260205131706

FACILITY NAME: CARLTON SENIOR LIVING SACRAMENTO **FACILITY NUMBER:** 342701213
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 03/04/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES		PLAN OF CORRECTIONS(POCs)	
Type A 03/05/2026 **Section Cited** CCR 87468.1(a)(1)	1 2 3 4 5 6 7	87468.1 Personal Rights of Residents in All Facilities (a) Residents in all residential care facilities for the elderly shall ...(1) To be accorded dignity in their personal relationships with staff, residents, and other persons.	1 2 3 4 5 6 7	The facility conducted a training on 2/5/26 regarding resident personal rights and has a plan in place to ensure all staff attend on-going dementia training. POC cleared on 3/4/26. The facility will also ensure there is an updated needs and services plan for residents with wondering behaviors available for review by the Department. Staff 1 (S1) stated P1 stated this was an isolated incident with one staff member and as a result the facility has terminated Staff 3 (S3) .
	8 9 10 11 12 13 14	This requirement is not met as evidenced by: Based on record review and interviews, it was found that Staff 3 (S3) did not treat R1 with dignity and respect, as they called R1 "stupid" and did not re-direct them using the training techniques received in "Dementia" Training. This poses an immediate risk to residents in care.	8 9 10 11 12 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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FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 03/04/2026

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

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STATE: CA
ZIP CODE: 95825
CAPACITY: 185
CENSUS: 143
DATE: 03/04/2026
UNANNOUNCED
TIME BEGAN: 03:17 PM
MET WITH: Kasie Wimmer
TIME COMPLETED: 05:10 PM

ALLEGATION(S):

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INVESTIGATION FINDINGS:

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2	the investigation into an allegation noted above. LPA met with Administrator, Kasie Wimmer(S1) and
3	Director of Memory Care Rose De La Garza (S2), LPA stated the purpose of this visit.
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5	It was alleged “staff yelled at resident”, this investigation focused on Resident 1 (R1). Throughout the
6	process, the LPA conducted interviewed staff, collateral interviews, and reviewed all relevant documents
7	related to R1. The facility received a report from a witness stating that Resident 1 (R1) was not treated
8	with respect by staff 3 (S3). On 2/10/26, the facility self reported to the Regional Office via an incident
9	report and SOC 341 that on 2/3/26, S3 wondered into another resident’s’ room in which a witnessed
10	overheard S3 calling R1 “stupid” in a “frustrated tone"
11	
12	CONTINUED ON 9099A-C
13	

Unsubstantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Czarrina A Camilon-Lee
LICENSING EVALUATOR NAME: Cynthia Tamayo
LICENSING EVALUATOR SIGNATURE:
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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMPLAINT INVESTIGATION REPORT (Cont)	COMMUNITY CARE LICENSING DIVISION SACRAMENTO SOUTH ASC, 9835 GOETHE ROAD, SUITE 100 SACRAMENTO, CA 95827

FACILITY NAME: CARLTON SENIOR LIVING SACRAMENTO **FACILITY NUMBER:** 342701213
VISIT DATE: 03/04/2026

NARRATIVE

Staff 1 (S1) and Staff 2 (S2) stated the facility did an internal investigation which included reviewing video footage and interviews.

LPA observed through video footage that S3 was assisting R1 out of another residents room, however there is no audio in the video footage. There is not enough evidence that S1 yelled at R1, was not a preponderance of the evidence obtained to corroborate the allegation "Staff yelled at resident", however it was determined that S3 did not treat R1 with dignity and respect on 2/3/26. S1 stated this was an isolated incident in which no other staff has been observed not treat a resident with dignity and respect. S1 also stated preventative measures were taken prior to this incident and immediate measures were taken after the incident on 2/3/26 to ensure staff are trained on re-direction and resident's personal rights.

Interview with witness (P1) stated that on 2/3/26 at around they overheard. Staff 3 (S3) yell the word “stupid” “why would you do that?” “you're stupid”, “its so stupid”. Resident 1 (R1) was observed to try to wheel their wheel chair way from S3. P1 stated S3 spoke to R1 in an volume higher than a regular speaking voice. The facility was unable to determined if S3 yelled at R1 as there was only one witness however it is determined the incident likely did occur

In response, the facility held a mandatory meeting for all staff was held on 2/5/26 by S1 regarding Personal rights, expectations, positive approach, re-direction. An additional service was held on 2/4/26 called Treating Residents with Kindness, Respect, and Professionalism. The incident was reported to authorized representative, licensing (LPA, Kimberly Villarella), long term care ombudsman. An incident report and SOC 341 was completed.

Based on interviews and record review of the allegation "Staff yelled at resident" is **UNSUBSTANTIATED**
There are no deficiencies cited regarding this allegation per California Code Regulation, TITLE 22. Exit interview was conducted with the facility administrator. Appeal Rights were issued, and a copy of this report was left at the facility. Exit interview was conducted with the S1 and S2. Appeal Rights were issued, and a copy of this report was left at the facility.

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