

# Department of SOCIAL SERVICES

Community Care Licensing

## COMPLAINT INVESTIGATION REPORT

Facility Number: 347005251

Report Date: 02/25/2026

Date Signed: 02/25/2026 10:06:11 AM

### Unsubstantiated

|                                                        |                                                                                                                                                                |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES<br>COMMUNITY CARE LICENSING DIVISION<br>SACRAMENTO NORTH ASC, 2525 NATOMAS<br>PARK DR STE 270<br>SACRAMENTO, CA 95833 |
| <b>COMPLAINT INVESTIGATION REPORT</b>                  |                                                                                                                                                                |

This is an official report of an unannounced visit/investigation of a complaint received in our office on **10/21/2025** and conducted by Evaluator Bethany Mirlohi

|  |                                                       |
|--|-------------------------------------------------------|
|  | <b>COMPLAINT CONTROL NUMBER: 59-AS-20251021095832</b> |
|--|-------------------------------------------------------|

|                                             |                                         |
|---------------------------------------------|-----------------------------------------|
| <b>FACILITY NAME:</b> ATRIA CARMICHAEL OAKS | <b>FACILITY NUMBER:</b> 347005251       |
| <b>ADMINISTRATOR:</b> DAVIS, KAYLA          | <b>FACILITY TYPE:</b> 740               |
| <b>ADDRESS:</b> 8350 FAIR OAKS BLVD         | <b>TELEPHONE:</b> (916) 944-2323        |
| <b>CITY:</b> CARMICHAEL                     | <b>ZIP CODE:</b> 95608                  |
| <b>CAPACITY:</b> 95                         | <b>DATE:</b> 02/25/2026                 |
| <b>MET WITH:</b> Kayla Davis, Administrator | <b>UNANNOUNCED TIME BEGAN:</b> 09:10 AM |
|                                             | <b>TIME COMPLETED:</b> 10:20 AM         |

#### ALLEGATION(S):

|   |                                                                            |
|---|----------------------------------------------------------------------------|
| 1 | Staff did not ensure that resident's dietary needs were met                |
| 2 | Staff did not assist resident with obtaining medical care                  |
| 3 | Staff did not assist resident with ambulating                              |
| 4 | Staff did not communicate with responsible party regarding resident's care |
| 5 | Staff are charging resident for care not rendered                          |
| 6 |                                                                            |
| 7 |                                                                            |
| 8 |                                                                            |
| 9 |                                                                            |

#### INVESTIGATION FINDINGS:

|    |                                                                                                                                                                         |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1  | Licensing Program Analyst (LPA) Bethany Mirlohi arrived unannounced to deliver complaint investigation findings. LPA met with Kayla Davis during today's investigation. |
| 2  |                                                                                                                                                                         |
| 3  | LPA investigated allegation, "Staff did not ensure that resident's dietary needs were met." LPA                                                                         |
| 4  | interviewed relevant parties and staff and reviewed resident medical documentation and facility                                                                         |
| 5  | documentation. Relevant party stated facility staff were not feeding R1 properly or regularly once R1                                                                   |
| 6  | began to decline on hospice care. LPA interviewed administrator in which she stated R1's diet changed                                                                   |
| 7  | to puree, and administrator was getting it approved, and the food supplies ordered when R1 moved out.                                                                   |
| 8  | LPA interviewed hospice staff in which they stated the facility never stopped feeding R1 but due to their                                                               |
| 9  | policies they were unable to physically feed R1 and were unable to meet their needs. Hospice                                                                            |
| 10 | recommended R1 to move to a higher level of care. LPA reviewed hospice documentation in which it                                                                        |
| 11 | stated R1's food intake was declining but no documentation was observed showing concerns about                                                                          |
| 12 | facility staff not meeting R1's dietary needs.                                                                                                                          |
| 13 | Continuation on 9099-C.                                                                                                                                                 |

|                        |                                      |
|------------------------|--------------------------------------|
| <b>Unsubstantiated</b> | <b>Estimated Days of Completion:</b> |
|------------------------|--------------------------------------|

**SUPERVISORS NAME:** Troy Ordonez  
**LICENSING EVALUATOR NAME:** Bethany Mirlohi  
**LICENSING EVALUATOR SIGNATURE:**

**DATE:** 02/25/2026

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 02/25/2026

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** 59-AS-20251021095832

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES  
COMMUNITY CARE LICENSING DIVISION  
SACRAMENTO NORTH ASC, 2525 NATOMAS PARK DR STE 270  
SACRAMENTO, CA 95833

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** ATRIA CARMICHAEL OAKS

**FACILITY NUMBER:** 347005251

**VISIT DATE:** 02/25/2026

### NARRATIVE

1 LPA interviewed care staff in which they stated R1's appetite began to decline while on  
2 hospice care but R1 was still able to eat finger foods and staff continuously offered food.  
3 Due to the information gathered LPA finds allegation to be Unsubstantiated.  
4

5 LPA investigated allegation, "Staff did not assist resident with obtaining medical care".  
6 LPA interviewed relevant parties and staff and reviewed resident medical  
7 documentation and facility documentation. LPA interviewed relevant party in which  
8 they stated R1 was on hospice care but R1 was declining rapidly due to an untreated  
9 Urinary Tract Infection(UTI). Relevant Party stated once R1 was moved, new care staff  
10 observed signs of an UTI and R1 was treated and began to regain their strength. LPA  
11 interviewed care staff in which they stated they did not observe any signs of an UTI.  
12 Care staff stated they changed R1 every 2 hours or as needed. LPA interviewed hospice  
13 staff in which they stated they had no concerns with R1 receiving proper continence  
14 care. Hospice staff stated once R1 did move, new facility staff did report signs of a UTI  
15 and antibiotics were provided to R1 to resolve the issue. LPA reviewed hospice  
16 documentation, and found no concerns related to an UTI or continence care. LPA  
17 reviewed facility documentation, and found no concerns or documentation concerning  
18 continence care or an UTI. Due to the information gathered, LPA finds allegation to be  
19 Unsubstantiated.  
20  
21  
22  
23

24 LPA investigated allegation, "Staff did not assist resident with ambulating". LPA  
25 interviewed relevant parties and staff and reviewed resident medical documentation  
26 and facility documentation. LPA interviewed relevant party in which R1 began needing  
27 more caregiver assistance toward the end of their stay and staff would not help R1 out  
28 of bed and R1 became bedbound. Relevant party stated that once R1 moved out of the  
29 facility and received treatment for an UTI, R1 was no longer bedbound. LPA  
30 interviewed care staff in which they stated R1 was ambulatory and walking around  
31 facility until August 2025 while on hospice care.  
32

Continuation on 9099-C.

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LIC9099 (FAS) - (06/04)

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**COMPLAINT INVESTIGATION REPORT  
(Cont)**

FACILITY NAME: ATRIA CARMICHAEL OAKS

FACILITY NUMBER: 347005251

VISIT DATE: 02/25/2026

**NARRATIVE**

1 R1's health was declining and by September 2025 R1 was unsafe to ambulate  
2 independently and was bedbound. Caregiver stated they would try to get R1 out of bed  
3 but R1 was too weak to be moved into a wheelchair. R1 moved out of the facility on  
4 September 17<sup>th</sup>. LPA interviewed hospice staff in which they stated facility staff were  
5 assisting R1 with ambulating until September 2025 when R1 was needing more  
6 assistance to transfer and the facility had limitations with providing a lift assist. Hospice  
7 staff stated R1 needed a higher level of care and was moved shortly after. LPA reviewed  
8 facility documentation in which resident was ambulating in and out of bed until  
9 September 2<sup>nd</sup>, and a care conference was scheduled with responsible parties  
10 concerning R1's decline. LPA reviewed hospice documentation, and there was no  
11 documentation showing facility staff were not assisting resident with ambulation. Due  
12 to the information gathered, LPA finds allegation to be unsubstantiated.

13 LPA investigated allegation, "Staff did not communicate with responsible party  
14 regarding resident's care". LPA interviewed relevant parties and staff and reviewed  
15 resident medical documentation and facility documentation. Relevant party stated  
16 facility staff would not communicate with R1's responsible party regarding resident's  
17 care and billing. LPA interviewed care staff and memory care manager in which they  
18 stated they spoke to R1's responsible party several times a week and had a care  
19 conference with responsible party prior to R1's move out. Memory care manager  
20 provided LPA emails and text messages to and from R1's responsible party showing  
21 communication. LPA interviewed hospice staff in which they stated a care conference  
22 was held on 9/4/25 with facility staff, hospice, and responsible party over the phone  
23 concerning R1's health concerns. Hospice staff stated they scheduled another in-person  
24 meeting with responsible party and no one from the facility showed up. Due to the  
25 information gathered LPA finds allegation to be Unsubstantiated.

Continuation on 9099-C.

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LICENSING EVALUATOR NAME: Bethany Mirlohi

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(Cont)**

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VISIT DATE: 02/25/2026

**NARRATIVE**

1 LPA investigated allegation, "Staff are charging resident for care not rendered". LPA interviewed relevant  
2 parties and administrator and reviewed documentation. R1 was placed on hospice in June 2025 and  
3 their rates increased. Relevant party stated they were charged for services that were not rendered from  
4 facility staff and therefore the responsible party should be reimbursed for that. LPA interviewed  
5 administrator in which she stated once R1 moved out of the facility the responsible party requested for a  
6 refund. Normally facility requires a 30-day notice during the move out process but administrator stopped

7 the fees on 9/17/25, the day R1 moved out. No further refund was issued. LPA interviewed staff in which  
8 they stated they provided proper care to R1. LPA interviewed hospice staff in which they stated there  
9 were no concerns about neglect but R1 needed to move out to higher level of care. Due to the  
10 information gathered LPA finds allegation to be UNSUBSTANTIATED.  
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12 Although the allegations may have happened or are valid, there is not a preponderance of evidence to  
13 prove that the alleged violations occurred, and the findings are unsubstantiated.  
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15 Exit interview was conducted and copy of report provided.  
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