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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 372004738
Report Date: 03/20/2025
Date Signed: 03/20/2025 03:03:52 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108

This is an official report of an unannounced visit/investigation of a complaint received in our office on **03/11/2024** and conducted by Evaluator Sabel Martinez

	COMPLAINT CONTROL NUMBER: 08-AS-20240311111904

FACILITY NAME:	CANYON VILLAS			**FACILITY NUMBER:**	372004738
ADMINISTRATOR:	BOLLER, VONDA			**FACILITY TYPE:**	740
ADDRESS:	4282 BALBOA AVENUE			**TELEPHONE:**	(858) 273-1306
CITY:	SAN DIEGO	**STATE:** CA		**ZIP CODE:**	92117
CAPACITY:	133	**CENSUS:** 92	UNANNOUNCED	**DATE:**	03/20/2025
				TIME BEGAN:	02:30 PM
MET WITH:	Executive Director Vonda Boller			**TIME COMPLETED:**	03:25 PM

ALLEGATION(S):

1	Staff did not assist residents with incontinence care
2	Staff did not treat resident with dignity
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Sabel Martinez conducted an unannounced complaint investigation
2	visit to deliver findings. The LPA introduced himself and disclosed the purpose of the visit to Executive
3	Director Vonda Boller.
4	
5	Throughout the investigation, the Department secured records and conducted interviews with external
6	and internal sources, including staff and clients.
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8	It was alleged staff did not assist residents with incontinence care. On March 11th, 2024, it was reported
9	to the Department staff were not assisting residents and residents were left in soiled briefs. The LPA
10	interviewed two residents (Resident # 2 (R2) and Resident # 3 (R3)), who were allegedly witnessed to be
11	left in soiled briefs. The LPA was not able to qualify R2, as R2 was not able to answer the LPAs
12	questions. An external source providing services to R2 did not report any concerns regarding lack of
13	incontinence care for R2. (See LIC 9099-C page for continuation of report.)

Substantiated	**Estimated Days of Completion: 0**

NAME OF LICENSING PROGRAM MANAGER: Lizzette Tellez
NAME OF LICENSING PROGRAM ANALYST: Sabel Martinez
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 03/20/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 03/20/2025

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108
COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: CANYON VILLAS **FACILITY NUMBER:** 372004738
VISIT DATE: 03/20/2025

NARRATIVE

R3 was qualified to be oriented during an interview. R3 did not have any concerns with the lack of care and noted staff would assist within a reasonable time.

One source revealed management had discussed call button response times with the facility's receptionist. The call button calls went to the receptionist and the receptionist relayed the calls to staff. Management believed the receptionist was not relaying the calls to staff; therefore, response times were high. This source confirmed the receptionist did relay the calls to floor staff, and several residents and family members had reported concerns with how long it took staff to respond. The response time ranged from five minutes up to forty minutes. Additional interviews with internal sources corroborated several residents had disclosed concerns with how long it took staff to respond to calls for assistance. An additional source reported response times for incontinence care could be up to thirty minutes. Based on the evidence obtained, the allegation was substantiated.

It was alleged staff did not treat a resident with dignity. It was reported to the Department staff made Resident #1 (R1) feel ashamed when R1 requested assistance. An interview with one source revealed staff had made comments about having to assist R1. These comments were not made in the presence of R1, but the comments gave the impression staff did not want to assist R1. An interview with R1 confirmed staff had not refuse to assist R1, but staff had made comments that made R1 feel ashamed to ask for assistance with incontinence care. R1 did not report this concern to management.

An interview with an external source, who regularly visited the facility, reported some residents had reported concerns regarding staff interactions, including staff not treating residents with dignity. An interview with an additional resident also revealed staff had raised their voice and made condescending comments toward the resident.

Although R1 did not report this concern to management, there is enough evidence to substantiate the allegation. The deficiencies were cited in an LIC 9099-D page and a plan of correction was jointly formulated with Executive Director Vonda Boller.

An exit interview was conducted with Executive Director Boller, to whom a copy of this report, LIC 811, LIC 9099D and Licensee/Appeals Rights (LIC 9058), were provided.

NAME OF LICENSING PROGRAM MANAGER: Lizzette Tellez
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DATE: 03/20/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION

FACILITY NAME: CANYON VILLAS **FACILITY NUMBER:** 372004738

DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 03/20/2025

Deficiency Type POC Due Date / Section Number	DEFICIENCIES		PLAN OF CORRECTIONS(POCs)	
Type B 03/20/2025 **Section Cited** CCR 87625(b)(3)	1 2 3 4 5 6 7	87625 (b) In addition to Section 87611, General Requirements for Allowable Health Conditions, the licensee shall be responsible for the following:(3) Ensuring that incontinent residents are kept clean and dry and that the facility remains free of odors from incontinence. This requirement was not met as evidenced by:	1 2 3 4 5 6 7	Executive Director agreed to provide care staff in sevice training regarding incontinence care. Proof of training will be submitted to the LPA by 4/3/25.
	8 9 10 11 12 13 14	Based on interviews, the licensee did not ensure residents were kept clean and dry, which posed a potential health, safety, and personal rights risk to residents in care.	8 9 10 11 12 13 14	
Type B 03/20/2025 **Section Cited** CCR 87468.1(a)(3)	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 have all of the following personal rights: (1) To be accorded dignity in their personal relationships with staff, residents, and other persons. This requirement was not met as ewvidenced by:	1 2 3 4 5 6 7	Executive Director agreed in service training to staff regarding personal rights. Proof of training will be submitted to the LPA by 4/3/25.
	8 9 10 11 12 13 14	Based on interviews, the Licensee did not ensure residents, Inlcuding R1, was treated with dignity, which posed a potential health, safety and personal rights risk to residents in care.	8 9 10 11 12 13 14	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

NAME OF LICENSING PROGRAM MANAGER: Lizzette Tellez
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LICENSING PROGRAM ANALYST SIGNATURE: **DATE:** 03/20/2025

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This is an official report of an unannounced visit/investigation of a complaint received in our office on **03/11/2024** and conducted by Evaluator Sabel Martinez

	COMPLAINT CONTROL NUMBER: 08-AS-20240311111904

FACILITY NAME: CANYON VILLAS **FACILITY NUMBER:** 372004738

ADMINISTRATOR: BOLLER, VONDA **FACILITY TYPE:** 740

ADDRESS:	4282 BALBOA AVENUE			**TELEPHONE:**	(858) 273-1306
CITY:	SAN DIEGO	**STATE:** CA		**ZIP CODE:**	92117
CAPACITY:	133	**CENSUS:** 92		**DATE:**	03/20/2025
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MET WITH:	Executive Director Vonda Boller			**TIME COMPLETED:**	03:25 PM

ALLEGATION(S):

1	Staff did not ensure a resident was turned every 2 hours
2	Staff did not assist a resident with bathing
3	Staff did not ensure resident had clothing
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Sabel Martinez conducted an unannounced a follow up complaint
2	investigation visit, and delivered complaint findings. The LPA introduced himself and disclosed the
3	purpose of the visit to Executive Director Vonda Boller
4	
5	Throughout the investigation, the Department secured records and conducted interviews with external
6	and internal sources, including staff and residents.
7	
8	It was alleged staff did not ensure a resident was turned every two hours. It was reported to the
9	Department Resident # 4's (R4's) hospice care plan indicated R4 was to be assisted with repositioning.
10	Interviews with internal sources, including staff and residents, reported there were no concerns with lack
11	of assistance in repositioning, and staff assisted residents with repositioning. An interview with an
12	external agency providing services to R4 corroborated there were no concerns regarding lack of
13	assistance with repositioning. (See LIC 9099-C for continuation of report.)

Unsubstantiated	**Estimated Days of Completion: 0**

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Control Number 08-AS-20240311111904

FACILITY NAME: CANYON VILLAS **FACILITY NUMBER:** 372004738
VISIT DATE: 03/20/2025

NARRATIVE

1	It was alleged staff did not assist a resident with bathing. It was reported to the Department the facility
2	did not properly assist Resident # 5 (R5) with showers, and this may have led to wounds. Interviews with
3	several internal sources did not reveal any concerns with lack of assistance with showers, nor residents
4	sustaining any wounds as a result. An interview with an external source providing services to R5
5	reported there were no concerns regarding the facility not assisting R5 with showers. This source also
6	noted there were no concerns with R5 developing any wounds due to inappropriate assistance with
7	showers. One source did report the facility did not assist a resident with showers. Interviews revealed
8	contradicting statements on whether staff did, or did not assist this resident.
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10	It was alleged staff did not ensure a resident had clothing. It was reported to the Department the facility
11	did not ensure Resident # 6 (R6) had enough clothing. Interviews with internal sources revealed R6 had
12	enough clothing, but R6 preferred to wear dresses. Sources had witnessed staff redirecting R6 to R6's
13	bedroom to assist with clothing changes. On one occasion, R6 was witnessed in a common are only

wearing undergarments.

Interviews with external sources, including an agency providing services to R6, revealed there were no concerns with R6 not having enough clothing. As R6's health declined, R6 developed anxiety and a concern of R6 undressing was discussed with an external source. It was also revealed the facility communicated with R6's responsible party to request additional clothing. Interviews did not reveal any concerns with staff encouraging R6 to stay in R6's bedroom, nor staff preventing R6 from participating in activities and ambulating through the facility.

Based on the evidence obtained, there was not enough evidence to prove the alleged violations occurred, therefore, the allegations were unsubstantiated.

An exit interview was conducted with Executive Director Vonda Boller, to whom a copy of this report, and Licensee/Appeals Rights (LIC 9058), were provided.

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LICENSING PROGRAM ANALYST SIGNATURE:
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