

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 374602653

Report Date: 02/27/2026

Date Signed: 02/27/2026 04:05:37 PM

Substantiated

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	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **05/26/2023** and conducted by Evaluator Rebecca A Borunda

	COMPLAINT CONTROL NUMBER: 08-AS-20230526124450
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FACILITY NAME: AEGIS ASSISTED LIVING AT SHADOWRIDGE	FACILITY NUMBER: 374602653
ADMINISTRATOR: LANCE SHENK	FACILITY TYPE: 740
ADDRESS: 1440 SOUTH MELROSE DRIVE	TELEPHONE: (760) 806-3600
CITY: OCEANSIDE	STATE: CA
CAPACITY: 95	ZIP CODE: 92056
	CENSUS: 66
MET WITH: Care Director Ron Puno	DATE: 02/27/2026
	UNANNOUNCED TIME BEGAN: 09:10 AM
	TIME COMPLETED: 12:50 PM

ALLEGATION(S):

1	Staff did not treat residents with dignity
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Rebecca Borunda conducted an unannounced complaint visit to
2	conduct follow up and deliver findings regarding the above-mentioned allegation. LPA identified herself
3	to, was greeted by, and explained the purpose of the visit to Care Director Ron Puno. General Manager
4	Charles Bloom arrived during the visit.
5	
6	During today's visit, LPA observed residents in care and interviewed staff.
7	
8	The Department's investigation consisted of interviews with residents, staff, and outside sources, records
9	review, and a tour of the facility. It was alleged that staff did not treat residents with dignity.
10	
11	Continued on LIC9099-C page...
12	
13	

Substantiated	Estimated Days of Completion: 0
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SUPERVISORS NAME: Sabel Martinez

LICENSING EVALUATOR NAME: Rebecca A Borunda
LICENSING EVALUATOR SIGNATURE:

DATE: 02/27/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/27/2026

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

LIC9099 (FAS) - (06/04)

Page: 1 of 6

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

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MET WITH: Care Director Ron Puno	CENSUS: 66
	DATE: 02/27/2026
	UNANNOUNCED TIME BEGAN: 09:10 AM
	TIME COMPLETED: 12:50 PM

ALLEGATION(S):

- 1 Staff handled resident in a rough manner, resulting in bruising
- 2 Staff did not meet residents' incontinence needs
- 3 Staff restrained residents
- 4 Licensee did not protect residents in care
- 5 Licensee did not submit incident reports
- 6 Licensee did not ensure staff completed required training
- 7 Staffing levels did not meet residents needs
- 8 Facility was not kept free from pests
- 9

INVESTIGATION FINDINGS:

- 1 Licensing Program Analyst (LPA) Rebecca Borunda conducted an unannounced complaint visit to
- 2 conduct follow up and deliver findings regarding the above-mentioned allegations. LPA identified herself
- 3 to, was greeted by, and explained the purpose of the visit to Care Director Ron Puno. General Manager
- 4 Charles Bloom arrived during the visit.
- 5
- 6 During today's visit, LPA observed residents in care and interviewed staff.
- 7
- 8 The Department's investigation consisted of interviews with residents, staff, and outside sources, records
- 9 review, and a tour of the facility. It was alleged that staff handled resident in a rough manner, resulting in
- 10 bruising, staff did not meet resident's incontinence needs, staff restrained residents, Licensee did not
- 11 protect residents in care, Licensee did not submit incident reports, Licensee did not ensure staff
- 12 completed required training, and facility was not kept free from pests.
- 13 Continued on LIC9099-C page...

Unsubstantiated Estimated Days of Completion: 0

SUPERVISORS NAME: Sabel Martinez
LICENSING EVALUATOR NAME: Rebecca A Borunda
LICENSING EVALUATOR SIGNATURE: **DATE:** 02/27/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/27/2026

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LIC9099 (FAS) - (06/04)

Page: 2 of 6

Control Number 08-AS-20230526124450

**COMPLAINT INVESTIGATION REPORT
(Cont)****FACILITY NAME:** AEGIS ASSISTED LIVING AT
SHADOWRIDGE**FACILITY NUMBER:** 374602653**VISIT DATE:** 02/27/2026**NARRATIVE**

1 Interviews with management revealed that there was a previous employee who was making multiple
2 allegations regarding staff treatment of residents, restraining residents in wheelchairs with tables and
3 walls, and not providing frequent incontinence care. Interviews with staff denied that the allegations
4 occurred, stating that residents were frequently checked for any bruising, marks, or other injuries, and
5 they would be reported right away if a resident sustained an injury. Staff denied that residents were
6 handled in a rough manner or were rushed during care. Staff stated that residents were frequently
7 checked for toileting and incontinence care and denied any issues with skin breakdown or other
8 complications from soiled briefs. Interviews with staff denied the use of tables or walls as restraints for
9 residents who used wheelchairs, and management stated that tables in the memory care are light
10 enough to be pushed by residents if they wanted to get up from their wheelchair. Additionally, any
11 residents who were deemed to be fall risks were kept in common areas where staff could monitor them.
12

13 Interviews with residents and outside sources did not reveal any concerns regarding the quality of care
14 provided by staff and denied any concerns regarding rough treatment, restraints, and protecting
15 residents. Outside sources did state that there was occasionally an incontinence smell in the memory
16 care, however, they also clarified it was due to residents having just soiled their briefs and not being left
17 in soiled briefs for a very long time. The outside sources also stated that staff were very quick to respond
18 to resident care needs.
19

20 It was alleged that the facility did not submit an incident report regarding an altercation between two staff
21 members while in the presence of residents. Review of employee discipline documents described the
22 incident as a staff member used profanity towards another staff member while in the presence of
23 residents. Interviews and review of the report did not provide any evidence that the profanity was
24 directed towards residents. Interviews with facility management and review of incident reports submitted
25 to the Department in 2023 revealed that the facility submitted incident reports for incidents regarding
26 resident changes in conditions, falls, injuries, and hospitalizations. Review of regulatory requirements on
27 incident reports revealed that incidents that threaten the safety, welfare, or health of residents are
28 required. Review of the discipline document while paired with information collected during interviews did
29 not reveal a regulatory requirement for the facility to submit an incident report to the Department.
30

31 Continued on LIC9099-C page...
32

SUPERVISORS NAME: Sabel Martinez**LICENSING EVALUATOR NAME:** Rebecca A Borunda**LICENSING EVALUATOR SIGNATURE:****DATE:** 02/27/2026**I acknowledge receipt of this form and understand my licensing appeal rights as explained and
received.****FACILITY REPRESENTATIVE SIGNATURE:****DATE:** 02/27/2026

LIC9099 (FAS) - (06/04)

Page: 3 of 6

Control Number 08-AS-20230526124450**COMPLAINT INVESTIGATION REPORT
(Cont)****FACILITY NAME:** AEGIS ASSISTED LIVING AT
SHADOWRIDGE**FACILITY NUMBER:** 374602653**VISIT DATE:** 02/27/2026**NARRATIVE**

1 Interviews with staff and management revealed that staff used a combination of online training, in
2 person shadowing, and in-service training sessions. Interviews with staff revealed that staff completed
3 online training and then shadowed during the first few weeks of employment. Interviews with staff
4 revealed that ongoing online training classes were scheduled monthly and staff attended monthly staff
5 meetings which covered multiple training topics. Management estimated that staff underwent between

6 30 and 40 hours of online training before supervision for at least 24 hours before being released to
 7 provide resident care independently. Interviews with residents and outside sources did not reveal any
 8 concerns regarding the staff's level and quality of training.
 9
 10 Interviews with staff and facility management and review of staffing schedules in 2023 revealed that the
 11 facility scheduled an average of three caregivers and one medtech to cover the assisted living portion of
 12 the building and scheduled four caregivers to split the facility's two memory care sections, with a
 13 medtech covering both sections during the AM and PM shifts. Staff stated that overnight supervision
 14 consisted of three caregivers covering assisted living, and each memory care section, and one medtech
 15 to cover any overnight medication needs. Interviews with staff, residents, and outside sources did not
 16 disclose any issues with residents receiving assistance with care. Additionally, some residents were
 17 brought out of memory care during the day to participate in an activity program and were overseen by
 18 separate staff. Memory care staff provided toileting for those residents when necessary and generally
 19 remained in the memory care to provide supervision for the remaining residents.
 20
 21 Interviews with staff did reveal that the facility had some minor issues with ants and roaches, however
 22 those staff stated that management addressed the insect issues in a timely manner once staff reported
 23 the pest issue. Review of pest control invoices from 2022 and 2023 revealed that a pest control
 24 company serviced the facility twice a month and those services rotated between servicing the facility's
 25 kitchen and the overall facility. Interviews with outside sources did not reveal any concerns or evidence
 26 of issues with pests in the facility.
 27
 28 The Department has investigated the above-mentioned allegations and based on interview and record
 29 review, the preponderance of the evidence has not been met, therefore, these allegations are deemed
 30 unsubstantiated.
 31
 32 An exit interview was conducted with General Manager Charles Bloom, whose signature below confirms
 receipt of a copy of this report and the Licensee Appeal Rights (LIC9058 03/22).

SUPERVISORS NAME: Sabel Martinez
LICENSING EVALUATOR NAME: Rebecca A Borunda
LICENSING EVALUATOR SIGNATURE: _____
DATE: 02/27/2026

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FACILITY REPRESENTATIVE SIGNATURE: _____
DATE: 02/27/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY COMPLAINT INVESTIGATION REPORT (Cont)	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108
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FACILITY NAME: AEGIS ASSISTED LIVING AT SHADOWRIDGE **FACILITY NUMBER:** 374602653
VISIT DATE: 02/27/2026

NARRATIVE

1 Facility management stated that staff disciplinary action ranged from immediate individual in-service
 2 training, verbal and written warnings, and termination, dependent on the severity of the alleged behavior.
 3 Additionally, any staff who were accused of misconduct were subject to an internal investigation and a
 4 meeting with facility management to discuss the allegation. Interviews with staff and outside sources
 5 revealed that in 2023, there was a staff member, Staff 1 (S1) who did not get along with other staff and
 6 was using profanity while in common areas of the facility and while in the presence of residents.
 7 Interviews confirmed that while S1 did not direct profanity towards residents, residents were present and
 8 could overhear S1's comments. Additionally, there was at least one occasion where S1 and another staff
 9 member, Staff 2 (S2) got into an altercation that almost became physical while in the presence of
 10 residents. Interviews with staff and review of disciplinary documents revealed that S2 started the
 11 altercation and received a written warning. Due to S1's difficulty to work alongside and ongoing profanity
 12 use in front of residents, S1 was terminated from employment. Additionally, interviews with staff and
 13 facility management revealed that a different staff member, Staff 3 (S3) was reported to have been
 14 yelling and screaming at a resident in memory care who was agitated during an overnight shift.
 15 Interviews revealed that S3 had prior disciplinary action and S3 resigned following the incident. Staff and
 16 facility management stated that the inappropriate behaviors were isolated to those specific staff
 17 members, which residents and outside sources supported during interviews. Interviews with
 18 management and review of staff roster revealed that none of the above staff currently work at the facility
 19 and were either terminated or voluntarily resigned.

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The Department has investigated the above-mentioned allegation and based on interviews and records review, the preponderance of the evidence has been met, therefore, this allegation is deemed substantiated. The following deficiency is cited per CA Code of Regulations Title 22 and noted on the attached LIC9099-D page.

An exit interview was conducted with General Manager Charles Bloom, whose signature below confirms receipt of a copy of this report and the Licensee Appeal Rights (LIC9058 03/22).

SUPERVISORS NAME: Sabel Martinez
LICENSING EVALUATOR NAME: Rebecca A Borunda
LICENSING EVALUATOR SIGNATURE: _____
DATE: 02/27/2026

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

FACILITY REPRESENTATIVE SIGNATURE: _____
DATE: 02/27/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY <h2 style="margin: 0;">COMPLAINT INVESTIGATION REPORT (Cont)</h2>	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108
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FACILITY NAME: AEGIS ASSISTED LIVING AT SHADOWRIDGE **FACILITY NUMBER:** 374602653
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 02/27/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 02/27/2026 Section Cited CCR 87468.1(a)(1)	1 87468.1 (a) Residents in all residential 2 care facilities for the elderly shall have 3 all of the following personal rights: (1) 4 To be accorded dignity in their personal 5 relationships with staff, residents, and 6 other persons. 7 This requirement has not been met as evidenced by:	1 All three staff members are no longer 2 working at the facility. General Manager 3 provided LPA with a copy of most 4 recent inservice training regarding 5 resident dignity during the visit. 6 7 DEFICIENCY CLEARED.
	8 Based on interview and record review, 9 the Licensee did not comply with the 10 section cited above in that 3 staff acted 11 inappropriately towards or in the 12 presence of residents. This posed a 13 potential personal rights risk to 66 of 66 14 residents.	

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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LICENSING EVALUATOR NAME: Rebecca A Borunda

LICENSING EVALUATOR SIGNATURE:

DATE: 02/27/2026

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