

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 374603279
Report Date: 08/21/2026
Date Signed: 08/21/2026 02:09:10 PM

Unsubstantiated

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 02/12/2026 and conducted by Evaluator Nacole Patterson

		COMPLAINT CONTROL NUMBER: 08-AS-20260212105806	
FACILITY NAME: BELMONT VILLAGE SABRE SPRINGS		FACILITY NUMBER:	374603279
ADMINISTRATOR: TRACY KNEPPLE		FACILITY TYPE:	740
ADDRESS: 13075 EVENING CREEK DR S		TELEPHONE:	(858) 486-5020
CITY: SAN DIEGO		ZIP CODE:	92128
CAPACITY: 184		DATE:	08/21/2026
		UNANNOUNCED TIME BEGAN:	10:05 AM
MET WITH: Executive Director Mark Ranno		TIME COMPLETED:	11:30 AM

ALLEGATION(S):

1	Lack of supervision resulted in resident elopements.
2	Licensee did not ensure staff were adequately trained.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Nacole Patterson conducted an unannounced visit to deliver findings
2	regarding the above complaint allegations. LPA introduced themselves and disclosed the purpose of the
3	visit to Executive Director Mark Ranno.
4	
5	On 02/12/2026 it was alleged that lack of supervision resulted in three (3) resident elopements, and
6	Licensee did not ensure staff were adequately trained to care for residents with Parkinson's Disease. The
7	Department's investigation consisted of unannounced facility visits, interviews with facility staff, residents,
8	outside sources, and records review. Staff informed that the specific incidents in question were not
9	considered to be elopements due to the residents in question being able to leave the facility unassisted
10	during the timeframe of the incidents. Resident two (R2) walked down a stairwell and exited to the
11	sidewalk, and staff redirected them back to the facility. Staff informed that R2 utilized a Wander Guard
12	bracelet which alerted caregivers when they approached a doorway. Staff stated that R2's needs were
13	complex and the facility was in regular contact with R2's doctor and family to help them live safely in the facility.
(Continued on LIC9099 p.2)	

Unsubstantiated	Estimated Days of Completion: 0
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SUPERVISORS NAME: Sabel Martinez	
LICENSING EVALUATOR NAME: Nacole Patterson	
LICENSING EVALUATOR SIGNATURE:	DATE: 08/21/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 08/21/2026

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 3
Control Number 08-AS-20260212105806

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: BELMONT VILLAGE SABRE SPRINGS	FACILITY NUMBER: 374603279
	VISIT DATE: 08/21/2026

NARRATIVE	
1	(Continued from LIC9099 p.1)
2	Due to R2's increase in behavior episodes and agitation, the facility paid for a 1-1 private caregiver for
3	additional supervision of R2. Staff informed that the second concern of a potential elopement occurred
4	with Residents 3 (R3) and Resident 4 (R4), who had just moved into the facility at the time of incident.
5	Upon admission, both residents were assessed by their primary care physicians to be able to leave the
6	facility unassisted. The residents were married and R4 maintained high functioning. Subsequent
7	observations after the residents were admitted showed that both residents required moderate
8	supervision checks with reminders. The facility upgraded their care plans accordingly and both residents
9	consented to utilize Wander Guards for safety. Regarding staff competency in caring for Parkinson's
10	residents, staff informed that the annual training that caregivers were required to take provided
11	knowledge for how to meet the basic care needs for any type of resident. The facility additionally
12	provided a specific Parkinson's Disease in-service training to staff on 12/15/2025 with a geriatric
13	specialist.
14	
15	R4 was interviewed during an unannounced facility visit. R4 denied that the facility did not provide
16	adequate supervision for residents and informed that the incident they and R3 were involved in was a
17	miscommunication, as it had not been established that they were unable to leave the facility without staff
18	supervision. R4 informed that staff cared for them well and that they felt safe at the facility. R3 was
19	unable to be interviewed due to passing away. R1 and R2 were unable to be interviewed due to no
20	longer living at the facility.
21	
22	Two Outside Sources (OS1, OS2) were interviewed regarding the allegation. OS1, a prominent Geriatric
23	Specialist in the county, provided training to facility caregivers on 12/15/2025 regarding caring for
24	residents with Parkinson's Disease. OS1 informed that they provided a 40-minute training with a 20-
25	minute Q&A session at the facility and the staff were engaged and asked good questions. OS1 stated
26	that the facility's training to staff for residents with Parkinson's Disease was better than most in the
27	county, and OS1 regularly recommended the facility to people with some of the highest care needs
28	among this population. OS1 additionally stated that depending on the level of severity of the condition,
29	the RCFE training regulations for Dementia care covered similar care needs for residents with
30	Parkinson's. OS1 stated that the facility's care model went above the requirements, as they provided a
31	licensed medical professional on staff 24-hours per day and the facility's caregiver training was more
32	extensive than other facilities. OS1 did not have concerns about staff training for Parkinson's residents
	or supervision at the facility. OS1 noted that care for this population was nuanced, and an additional
	aspect was helping families to have realistic expectations of RCFE care. LPA interviewed OS2, a
	representative from an outside advocacy agency familiar with the facility. OS2 did not express concerns
	regarding supervision at the facility or how the facility cared for residents with Parkinson's Disease.
	(Continued on LIC9099 p.3)

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: BELMONT VILLAGE SABRE SPRINGS	FACILITY NUMBER: 374603279
	VISIT DATE: 08/21/2026

NARRATIVE	
1	(Continued from LIC9099 p.2)
2	OS1 was familiar with a possible elopement that occurred years ago, but did not know the supervision
3	level required for the resident in question, and was unable to confirm if it was a true elopement. OS2
4	was aware that the facility had been accused of an elopement, but did not have further information or
5	specifics regarding the situation.
6	
7	Relevant records were reviewed regarding the allegation. In-service training records corroborated that
8	the facility provided specific training to caregivers for Parkinson's residents with OS1 on 12/15/2025.
9	Additional core training and onboarding training records for all caregiving staff included Dementia care,
10	ADLs, community safety, elopement procedures/prevention, first aid, identifying risk, evacuation chairs,
11	resident rights, pendant call system, skin management, stages of Alzheimer's Disease, incontinence
12	care, transfer assistance, and lift devices.
13	
14	LPA reviewed relevant records for the residents in question, including medical assessments, facility
15	assessments, Needs and Services Plans, and care notes. The records corroborated staff statements
16	regarding the situations that were presumed to be elopements. The records showed that each resident's
17	initial assessment, upon admission, was aligned with the respective resident's assessment from their
18	primary care physicians. The records additionally showed that the facility monitored each residents'
19	condition and updated their plans of care according to their changing needs. Records showed that R2's
20	responsible person was resistant to increasing the recommended services for R2's care plan, which
21	increased R2's incidents of falling and attempts to exit the facility unassisted. Records showed that the
22	facility updated R2's physician report regarding changes in behavior and requested a reassessment
23	when R2 left the facility unsafely during an episode of agitation/disorientation. The facility paid for a
24	personal 1-1 caregiver to provide increased supervision for R2. Staffing records showed that the facility
25	scheduled 4-5 caregivers for each night shift in the Assisted Living section of the facility, in addition to a
26	24-hour nurse and Med Tech. The records showed that the staffing levels matched the acuity levels of
27	the residents for that time of day.
28	
29	During an unannounced facility visit, LPA directly observed 3 staff walking with Circle of Friends
30	residents, the program that provides higher supervision for residents with mild cognitive impairments
31	who do not yet meet the level of need for the memory care unit. One staff was facilitating the group and
32	two other staff were on the periphery monitoring the group of residents. One male resident became
	agitated/disoriented and began arguing with the facilitator and was assisted back to their room by one of
	the caregivers. Facility census during this time showed that there 16 residents in the Circle of Friends
	program.
	Based on interviews, direct LPA observations and records review, a preponderance of evidence does
	not exist to prove that the alleged violation occurred, therefore the allegation is UNSUBSTANTIATED.
	An exit interview was conducted with Executive Director Mark Ranno, to whom a copy of this report and
	the Licensee/Appeal Rights (LIC9058 03/22) were provided.

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