

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 374604019
Report Date: 11/13/2023
Date Signed: 11/13/2023 11:00:34 AM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SO. CAL AC/SC, 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 **08/01/2022** and conducted by Evaluator Daniel Pena

	COMPLAINT CONTROL NUMBER: 08-AS-20220801100505
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FACILITY NAME: POINT LOMA ELDER CARE	FACILITY NUMBER: 374604019
ADMINISTRATOR: GAURAV RATHI	FACILITY TYPE: 740
ADDRESS: 3941 LIGGET DRIVE	TELEPHONE: (619) 255-6448
CITY: SAN DIEGO	ZIP CODE: 92106
CAPACITY: 6	DATE: 11/13/2023
MET WITH: Hugo Duran, Caregiver	UNANNOUNCED TIME BEGAN: 10:36 AM
	TIME COMPLETED: 11:25 PM

ALLEGATION(S):

1	Staff did not treat resident with dignity
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INVESTIGATION FINDINGS:

1	On 11/13/2023, at about 12:00 PM, Licensing Program Analyst (LPA) Daniel Pena conducted an
2	unannounced facility visit to conclude a complaint investigation regarding the above-mentioned
3	allegation. LPA identified himself and discussed the purpose of the visit and complaint conclusion with
4	Hugo Duran, Administrator.
5	
6	On 8/1/2022, CCLD received a complaint alleging a staff person did not treat a resident with dignity. The
7	Department's investigation consisted of LPA observation, document and video recording review, and
8	interviews with residents, staff, and outside sources.
9	
10	As a result of this investigation, LPA identified a former employee, later determined to be a person of
11	interest in this complaint. LPA interviewed the former employee. The former employee said they lived at
12	the facility but were off duty on 7/29/22. The former employee admitted to LPA they were involved in
13	some type of physical confrontation with Resident 1 (R1). LPA asked the former employee if they picked up and threw R1 on to a bed. The former employee said they picked R1 up and carried them from the sliding glass

Substantiated

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Simon Jacob
NAME OF LICENSING PROGRAM ANALYST: Daniel Pena
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 11/13/2023

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 11/13/2023

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 08-AS-20220801100505

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
SO. CAL AC/SC, 7575 METROPOLITAN DR. #109
SAN DIEGO, CA 92108

COMPLAINT INVESTIGATION REPORT (Cont)

FACILITY NAME: POINT LOMA ELDER CARE

FACILITY NUMBER: 374604019

VISIT DATE: 11/13/2023

NARRATIVE

1 (Continued: LIC9099)

2

3 door to their room. The former employee denied throwing R1 onto the bed and said they "set" R1 down.
4 The former employee said they did this because R1 tried to run their scooter through a sliding glass
5 door.

6

7 Interviews with independent outside sources divulged that the former employee was impatient, had no
8 people skills and lost their temper with residents. One outside source revealed that the former employee
9 told them that they (former employee) were fired for physically assaulting a resident. The former
10 employee said they lost their temper with a resident. In an interview with the former employee, they
11 stated they resigned from employment with the facility in February 2023. The employee denied being
12 terminated. Interviews revealed that facility management said the employee was "let go" but not due to
13 circumstances associated with this complaint or any type of abuse to any resident.

14

15 The Department has investigated the complaint alleging staff did not treat R1 with dignity. Based on
16 interviews, sufficient evidence was obtained that a former employee did not treat a resident with dignity.
17 The allegation that staff did not treat a resident with dignity is Substantiated. This finding means that the
18 preponderance of evidence standard has been met and the allegation is valid. Deficiencies have been
19 cited in accordance with California Code of Regulations, Title 22, Division 6, Chapter 8 and noted on the
20 attached LIC9099-D.

21

22 An exit interview was conducted with Mr. Duran, and a copy of this report and Licensee/Appeal Rights
23 (LIC 9058 01/16) were provided to Mr. Duran at the conclusion of the visit.

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NAME OF LICENSING PROGRAM MANAGER: Simon Jacob
NAME OF LICENSING PROGRAM ANALYST: Daniel Pena
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 11/13/2023

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 11/13/2023

LIC9099 (FAS) - (06/04)

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Control Number 08-AS-20220801100505

**COMPLAINT INVESTIGATION REPORT
 (Cont)**

FACILITY NAME: POINT LOMA ELDER CARE

FACILITY NUMBER: 374604019

DEFICIENCY INFORMATION FOR THIS PAGE:

VISIT DATE: 11/13/2023

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 11/15/2023 Section Cited CCR 80072(a)(3)	1 Personal Rights - ... (3) To be free from 2 corporal or unusual punishment, 3 infliction of pain, humiliation, 4 intimidation, ridicule, coercion, threat, 5 mental abuse, or other actions of a 6 punitive nature, including but not limited 7 to... This requirement is not met as evidenced by:	1 Subject employee was separated from 2 employment with the facility in February 3 2023, removing the immediate threat. 4 Licensee agreed to procure vendorized 5 training on personal rights. Licensee 6 will provide CCLD with the date for 7 training by POC date of 11/15/2023 and complete the employee training and provide written proof by email or fax by POC date of 12/13/2023.
	8 Based on interviews, the licensee did 9 not ensure a resident was free from 10 corporal or unusual punishment... This 11 posed an immediate safety risk to all 12 residents in care. 13 14	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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NAME OF LICENSING PROGRAM ANALYST: Daniel Pena
LICENSING PROGRAM ANALYST SIGNATURE: _____ **DATE:** 11/13/2023

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FACILITY TYPE: 740

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TELEPHONE: (619) 255-6448

CITY: SAN DIEGO

STATE: CA

ZIP CODE: 92106

CAPACITY: 6

CENSUS: 6

DATE: 11/13/2023

MET WITH: Hugo Duran, Caregiver

UNANNOUNCED TIME BEGAN: 10:36 AM

TIME COMPLETED: 11:25 PM

ALLEGATION(S):

1	Staff physically assaulted resident resulting in injuries
2	Staff destroyed resident's personal belongings
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INVESTIGATION FINDINGS:

1	It was also alleged; staff assaulted a resident which resulted in injuries and destroyed their personal
2	belongings. The Department's investigation consisted of LPA observation, document and video recording
3	review, and interviews with residents, staff, and outside sources.
4	
5	Per an incident report received at CCLD, on 7/29/2022, R1 was transported to a hospital emergency
6	department with skin tears on their arm and leg. On 8/5/2022, the facility submitted an incident report for
7	the incident. Per the report, R1 was observed by staff complaining of injuries to their right hand and left
8	thumb. Staff notified the facility administrator and cleaned R1's wounds. The administrator called
9	paramedics requesting them to transport R1 to the emergency room for treatment. R1's hand was x-
10	rayed but the incident report did not provide a diagnosis. The report indicated that R1 moved out of the
11	facility and into a private residence on 7/31/2022.
12	
13	During this investigation, LPA obtained and reviewed a video recording related to the incident on 7/29/23.
	In the video, R1, identified by an outside source, is seen sitting on their motorized scooter in the kitchen.

Unsubstantiated

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Simon Jacob

NAME OF LICENSING PROGRAM ANALYST: Daniel Pena

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 11/13/2023

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LIC9099 (FAS) - (06/04)

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COMPLAINT INVESTIGATION REPORT (Cont)

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VISIT DATE: 11/13/2023

NARRATIVE

1	(Continued: LIC9099-A)
2	
3	R1's right forearm/wrist appears to be bleeding. The depiction of the video does not show how R1's arm
4	and hand were injured but the injuries are consistent with the Incident Report sent to CCLD on 8/5/22.
5	
6	During this investigation, a former employee was interviewed regarding their involvement in a physical
7	conflict with R1 on 7/29/23. The former employee was in their bedroom on this day when they heard R1
8	and staff yelling. The former employee went to the kitchen to investigate the commotion. The former
9	employee observed R1 sitting on their scooter near the stove. The former struck R1's hand which then

10 struck a wall. The former employee said they struck the resident's hand because they thought R1 may
 11 burn themselves on the kitchen stove. The former employee denied injuring the resident.
 12
 13 Resident interviews did not produce corroboration for the allegation as no other residents were in the
 14 area. Residents advised LPA during interviews that R1 was difficult and disrespectful towards staff.
 15 None of the interviewed residents witnessed a staff person assault any resident or cause them injuries.
 16 The former employee later told an outside source that they admittedly lost their temper with a resident.
 17 The outside source did not say the former employee caused the injury to the resident. Per another
 18 outside source, R1 told them the former employee caused the injuries. However, the investigation
 19 produced no persons who witnessed any employee assault any resident.
 20
 21 It was also alleged that staff destroyed R1's personal belongings. An outside source reported that a
 22 former employee took R1's telephone from them to keep them from making calls outside of the facility. A
 23 former employee was interviewed but denied damaging or taking R1's personal property from them.
 24
 25 Facility records were reviewed and indicated that R1 moved out of the facility and into a private
 26 residence on 7/31/2022. R1's property was removed from the facility before the complaint was
 27 submitted. LPA reviewed R1's facility records which noted that R1 had an electric scooter, walker,
 28 wheelchair and television. Staff interviews reported consistent denials that they damaged R1's property.
 29
 30 The Department has investigated the complaint alleging staff assaulted R1 which resulted in injuries and
 31 destroyed R1's personal belongings. Based upon conflicting statements and inconclusive records,
 32 insufficient information was obtained to corroborate the allegations. The Preponderance of Evidence

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<p>STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY</p> <p>COMPLAINT INVESTIGATION REPORT (Cont)</p>	<p>CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SO. CAL AC/SC, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108</p>
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NARRATIVE

1 (Continued: LIC9099-C)
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 3 Standard was not met. Therefore, the allegations are Unsubstantiated.
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 5 An exit interview was conducted with Mr. Duran, to whom a copy of this report and the Licensee's Rights
 6 (LIC9058 01/16) were provided via hard copy.
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