

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 374604455

Report Date: 02/24/2026

Date Signed: 02/24/2026 01:17:39 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 **04/10/2025** and conducted by Evaluator Ramon Serrano

	COMPLAINT CONTROL NUMBER: 08-AS-20250410161651
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FACILITY NAME: IVY PARK AT OTAY RANCH	FACILITY NUMBER: 374604455
ADMINISTRATOR: CALAIS ANGUIANO	FACILITY TYPE: 740
ADDRESS: 1290 SANTA ROSE DRIVE	TELEPHONE: (619) 779-7400
CITY: CHULA VISTA	STATE: CA ZIP CODE: 91913
CAPACITY: 137	CENSUS: 118 DATE: 02/24/2026
MET WITH: Diana Weinstein	UNANNOUNCED TIME BEGAN: 09:15 AM
	TIME COMPLETED: 12:30 PM

ALLEGATION(S):

1	Staff did not administer medications as prescribed
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Ramon Serrano conducted an unannounced complaint visit to deliver
2	complaint findings. LPA introduced himself and disclosed the purpose of the visit with Executive Director
3	Diana Weinstein.
4	
5	Community Care Licensing (CCL) has investigated the above allegation. The investigation consisted of
6	LPA observations, records review, interviews with staff, residents and outside sources.
7	
8	LPA Serrano investigated allegations that facility staff failed to administer medications to Resident 1 (R1)
9	and Resident 2 (R2) as prescribed. LPA reviewed both residents' records, including physician reports,
10	hospice documentation, Medication Administration Records (MARs), charting notes, and incident reports.
11	The Department also interviewed staff regarding medication administration procedures, PRN protocols,
12	and coordination with hospice nurses. For R1, the physician report dated 4/3/25 indicated that R1 had
13	COPD, anxiety, and ongoing pain from pelvic and rib fractures requiring full care and hospice-level management.

Unsubstantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Robyn Clark
LICENSING EVALUATOR NAME: Ramon Serrano
LICENSING EVALUATOR SIGNATURE:

DATE: 02/24/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/24/2026

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-20250410161651

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: IVY PARK AT OTAY RANCH

FACILITY NUMBER: 374604455

VISIT DATE: 02/24/2026

NARRATIVE

- 1 Hospice notes described R1 as medically fragile with ongoing pain, shortness of breath, increased
2 anxiety, and agitation. Charting notes from January through April 2025 showed R1 regularly received
3 morphine and Ativan as ordered, while staff documented that R1 often expressed severe pain shortly
4 after receiving their PRN medication. R1 frequently stated that they believed staff were withholding their
5 medication, even when charting showed the medication had just been administered. Staff consistently
6 documented attempts to redirect R1, explain hospice medication orders, and reassure them about their
7 care.
8
9 Review of R1's MARs showed that R1 was out of the facility for extended periods: from January 31,
10 2025 through March 22, 2025; again from March 23, 2025 through April 3, 2025; and again from April 6,
11 2025 through April 30, 2025. MARs and charting showed that on the limited days R1 was present in the
12 facility, they received their medications as ordered. Facility records described several incidents where
13 R1 became distressed, attempted to use their wheelchair as a walker, refused redirection, grabbed staff
14 clothing, and verbally escalated to the point that 911 was contacted. R1 also called 911 independently,
15 attempting to reach hospice and request changes to their medication orders. Incident reports and
16 hospice notes both indicated that R1 frequently reported feeling unheard or unsupported, though
17 documentation showed medications were given as prescribed.
18
19 For R2, LPA reviewed MARs dated August through September 2025, physician orders, and charting
20 notes from January through September 2025. R2 had COPD and acute kidney failure and was
21 prescribed one medication daily at noon. MARs showed that the noon medication was withheld from
22 August 1 through September 10, 2025 following orders from a physician or registered nurse. Staff had
23 initialed and documented each date accordingly. Charting notes indicated that R2 sometimes became
24 upset, thinking their medication was late when it was not, and also showed confusion about how many
25 times per day they should receive medication. Staff documented multiple instances where R2 forgot that
26 they had already taken their medication. No evidence was found indicating staff failed to administer
27 medication as ordered.
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30 Record review, interviews, MARs, and hospice documentation did not support the allegation that staff
31 failed to administer medications to R1 or R2. The documentation consistently showed that both
32 residents received medication in accordance with physician and hospice directives. R1's concerns
appeared related to ongoing pain, anxiety, and behavioral symptoms, while R2's concerns were related
to confusion about medication schedules.

SUPERVISORS NAME: Robyn Clark
LICENSING EVALUATOR NAME: Ramon Serrano
LICENSING EVALUATOR SIGNATURE:

DATE: 02/24/2026

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 02/24/2026

LIC9099 (FAS) - (06/04)

Page: 2 of 3

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COMPLAINT INVESTIGATION REPORT (Cont)

FACILITY NAME: IVY PARK AT OTAY RANCH

FACILITY NUMBER: 374604455

VISIT DATE: 02/24/2026

NARRATIVE

1 The allegation that staff did not administer medications as prescribed is unsubstantiated. This means
 2 there is not enough evidence to prove the allegation occurred. An exit interview was conducted with
 3 Diana Weinstein A copy of this report along with licensee rights (LIC 9058, 3/22) was provided to Diana
 4 Weinstein whose signature below verifies receipt of these rights.
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