

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 374604747
Report Date: 03/27/2025
Date Signed: 03/27/2025 04:33:54 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 **07/02/2024** and conducted by Evaluator Nacole Patterson

	COMPLAINT CONTROL NUMBER: 08-AS-20240702125951
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FACILITY NAME: IVY PARK AT SABRE SPRINGS	FACILITY NUMBER: 374604747
ADMINISTRATOR: DAYNES, ROBERT	FACILITY TYPE: 740
ADDRESS: 12515 SPRINGHURST DRIVE	TELEPHONE: (858) 391-9160
CITY: SAN DIEGO	ZIP CODE: 92128
CAPACITY: 100	DATE: 03/27/2025
MET WITH: Executive Director Rob Daynes	UNANNOUNCED TIME BEGAN: 01:00 PM
	TIME COMPLETED: 01:30 PM

ALLEGATION(S):

1	Resident fall due to neglect.
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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 allegation. LPA introduced themselves and disclosed the purpose of the
3	visit to Executive Director Rob Daynes.
4	
5	On 07/02/2024 it was alleged that staff neglect led to Resident 1 (R1)'s fall, resulting in R1 lying on the
6	floor throughout the night. The Department's investigation consisted of unannounced facility visits,
7	interviews with facility staff, residents, outside sources, and records review. Staff interviews did not
8	corroborate the allegation, as staff consistently denied that Resident 1 (R1) suffered a fall that resulted in
9	them being unattended for hours without staff help. Staff informed that R1 lived in the Assisted Living
10	section of the building and was mostly independent, not requiring assistance with Activities of Daily Living
11	(ADLs) or checks throughout the night. Staff interviews revealed that R1 began to experience a change
12	in cognition during the timeframe of complaint, experiencing disorientation to time and place, and
13	misremembering events. (Continued on LIC9099 p.2)

Unsubstantiated	Estimated Days of Completion: 0
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NAME OF LICENSING PROGRAM MANAGER: Jennifer Lott
NAME OF LICENSING PROGRAM ANALYST: Nacole Patterson
LICENSING PROGRAM ANALYST SIGNATURE: _____
DATE: 03/27/2025

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

FACILITY REPRESENTATIVE SIGNATURE: _____
DATE: 03/27/2025

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 2

Control Number 08-AS-20240702125951

<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 SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108</p>
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FACILITY NAME: IVY PARK AT SABRE SPRINGS **FACILITY NUMBER:** 374604747
VISIT DATE: 03/27/2025

NARRATIVE

1 (Continued from LIC9099 p.1)
2
3 Staff interviews further revealed that R1 slipped from their bed the evening of 06/28/2024 with no
4 injuries, and staff responded to assist them during the event.
5
6 An outside advocacy agency familiar with the facility and R1's care was contacted and stated they had
7 no concerns regarding the facility's supervision and care to residents. The outside source remarked that
8 R1 may have been experiencing confusion when they made the statement about lying on the ground. A
9 second outside source informed that R1 presented as independent.
10
11 Records review revealed facility pendant and Narrative Charting logs during the timeframe of complaint.
12 The documents showed that R1 pressed their pendant twice during the early morning on 06/28/24, and
13 was responded to within 7 minutes, and then 2 minutes. The 2-minute response time was noted to be
14 when R1 was found sitting on their bedroom floor after slipping from their bed; R1 informed staff that
15 they did not suffer an injury during this incident. Additional facility and outside source records showed
16 that R1 was evaluated to be independent upon moving into the facility and was able to perform all
17 Activities of Daily Living (ADLs) without assistance, including going for walks outside of the facility
18 unassisted. No records were found to establish that R1 required routine nighttime checks, or that staff
19 delayed in responding to R1's pendant call when they requested help.
20
21 During an unannounced facility visit LPA interviewed R1. LPA noted that R1 had moved from the
22 Assisted Living section of the building to the Memory Care unit. R1 stated that they did not recall falling
23 and lying on the ground all night without assistance. R1 stated that staff came right away when they
24 pushed their call button and provided great care. R1 informed they loved living at the facility and had no
25 issues with the care provided.
26
27 Based on interviews, direct LPA observations and records review, a preponderance of evidence does
28 not exist to prove that the alleged violation occurred, therefore the allegation is UNSUBSTANTIATED.
29 An exit interview was conducted with Executive Director Rob Daynes, to whom a copy of this report and
30 the Licensee/Appeal Rights (LIC9058 03/22) were provided.
31
32

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LICENSING PROGRAM ANALYST SIGNATURE: _____
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