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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 425802118
Report Date: 11/19/2025
Date Signed: 11/20/2025 11:04:25 AM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364

This is an official report of an unannounced visit/investigation of a complaint received in our office on **09/04/2024** and conducted by Evaluator Kristin Kontilis

	COMPLAINT CONTROL NUMBER: 29-AS-20240904153809

FACILITY NAME:	OAK COTTAGE OF SANTA BARBARA MEMORY CARE		**FACILITY NUMBER:**	425802118
ADMINISTRATOR:	TYLER BARNES		**FACILITY TYPE:**	740
ADDRESS:	1820 DE LA VINA STREET		**TELEPHONE:**	(805) 456-7270
CITY:	SANTA BARBARA	**STATE:** CA	**ZIP CODE:**	93101
CAPACITY:	50	**CENSUS:** 32	**DATE:**	11/19/2025
		UNANNOUNCED	**TIME BEGAN:**	01:15 PM
MET WITH:	Tyler Barnes, Administrator		**TIME COMPLETED:**	03:00 PM

ALLEGATION(S):

1	Staff violated resident's personal rights.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Kristin Kontilis conducted a subsequent complaint visit to issue final
2	findings on this investigation. LPA met with Administrator Tyler Barnes and explained the purpose of the
3	visit. During the investigation, LPA conducted an initial visit on 9/10/2024 from 1:45 pm to 5:00 pm, where
4	LPA interviewed staff and residents and requested documents. Additional interviews were conducted on
5	9/5/2024 and 5/27/2025. LPA conducted additional staff interviews on 11/18/2025 from 11:40 am to 4:00
6	pm and 11/19/2025 from 1:45 pm to 2:00 pm.
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8	On the allegation: Staff violated resident's personal rights. It was alleged Resident 2 (R2), who verbally
9	expresses themselves with limited and few words and is wheelchair-bound, is placed in a corner away
10	from other residents with their brakes locked so they cannot leave. It was alleged that this is a form of
11	restraint, and R2's wheelchair has caused damage to the surrounding walls, suggesting this is a common
12	practice.
13	
	Please continue to 9099-C, Pg 2.

Substantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Kristin Kontilis
LICENSING EVALUATOR SIGNATURE:
DATE: 11/19/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 11/19/2025

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 21731 VENTURA BLVD. #250
WOODLAND HILLS, CA 91364

FACILITY NAME: OAK COTTAGE OF SANTA BARBARA MEMORY CARE
FACILITY NUMBER: 425802118
VISIT DATE: 11/19/2025

NARRATIVE

1	Staff interviewed stated staff often sit next to R2 to calm them down and redirect them. Staff also stated
2	R2 sits at different tables in the facility, but do not put anything near the chair to prevent them from
3	leaving. Staff stated if they see R2 getting agitated and trying to get out of the chair, they know they
4	want to be moved.
5	On 11/18/2025 at approximately 1:38 pm–1:41 pm, LPA observed R2 and R3 in their wheelchairs at a
6	table, with an empty chair next to each of them, obstructing an exit path from the table. LPA observed
7	R2 attempting to stand up from the table. LPA observed two staff standing against the wall away from
8	the table. One staff interviewed indicated the empty chair next to residents with no caregiver does
9	appear like the chair is blocking the residents in. The staff also stated there is typically a staff in the chair
10	next to the residents. Administrator confirmed the residents are not physically able to get up from the
11	table on their own if the chairs are blocking them in. On 11/18/2025, LPA observed R2 and R3 three
12	separate times during the visit sitting in their wheelchairs at the table with the empty chairs next to them,
13	and at no time were the chairs occupied by staff. Administrator stated the chairs are not supposed to be
14	next to the residents when they are empty and when staff are not sitting in them next to the residents
15	during activities.
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17	Pursuant to Title 22, California Code of Regulations, the following deficiency is cited (refer to LIC 9099-
18	D).
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20	Exit interview conducted. Copy of report and Appeal Rights issued at the time of the visit.
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SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Kristin Kontilis
LICENSING EVALUATOR SIGNATURE:
DATE: 11/19/2025

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 11/19/2025

Control Number 29-AS-20240904153809

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 21731 VENTURA BLVD.

FACILITY NAME: OAK COTTAGE OF SANTA BARBARA MEMORY CARE
FACILITY NUMBER: 425802118
DEFICIENCY INFORMATION FOR THIS PAGE:
VISIT DATE: 11/19/2025

Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Type A 11/21/2025 **Section Cited** CCR 87705(f)(5)	1 2 3 4 5 6 7	87705(f)(5) Care of Persons with Dementia: Interior and exterior space shall be available on the facility premises to permit residents with dementia to wander freely and safely. This requirement is not met as evidenced by:	1 2 3 4 5 6 7	The chairs were immediately removed from blocking the residents in. Administrator conducted an all-care staff meeting instructing staff to immediately put the chair back in its original place when called away from resident(s).
	8 9 10 11 12 13 14	Based on observation and interview, the licensee did not comply with the section cited when they restricted two residents from freely moving about the facility, which posed an immediate health, safety, and personal rights risk to residents in care.	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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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 21731 VENTURA BLVD. #250
WOODLAND HILLS, CA 91364

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CITY:	SANTA BARBARA **STATE:** CA	**ZIP CODE:**	93101

CAPACITY: 50	**CENSUS:** 32 UNANNOUNCED	**DATE:**	11/19/2025
		TIME BEGAN:	01:15 PM
MET WITH: Tyler Barnes, Administrator		**TIME COMPLETED:**	03:00 PM

ALLEGATION(S):

1	Staff failed to meet resident's needs.
2	Staff failed to safeguard residents' personal belongings.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Kristin Kontilis conducted a subsequent complaint visit to issue final
2	findings on this investigation. LPA met with Administrator Tyler Barnes and explained the purpose of the
3	visit. During the investigation, LPA conducted an initial visit on 9/10/2024 from 1:45 pm to 5:00 pm, where
4	LPA interviewed staff and residents and requested documents. Additional interviews were conducted on
5	9/5/2024 and 5/27/2025. LPA conducted additional staff interviews on 11/18/2025 from 11:40 am to 4:00
6	pm and 11/19/2025 at 1:45 pm to 2:15 pm.
7	On the allegation: Staff failed to meet resident's needs. It was alleged R1's bathing and grooming needs
8	were not met. It was alleged R1's hair was "usually greasy," their teeth were not brushed and staff
9	claimed they inadvertently missed R1's showers.
10	Staff stated there are fewer showers to give in the evening shift and they get done, unless residents
11	refuse. If residents refuse, they try another caregiver. Interviews indicated there are four caregivers on
12	each shift, and each caregiver assists about eight residents. Staff stated caregivers are told to bring
13	Please continue to 9099-C, Pg 2.

Unsubstantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Kristin Kontilis
LICENSING EVALUATOR SIGNATURE:
DATE: 11/19/2025

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 11/19/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT (Cont)**	**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES** **COMMUNITY CARE LICENSING DIVISION** **CCLD Regional Office, 21731 VENTURA BLVD. #250** **WOODLAND HILLS, CA 91364**

FACILITY NAME: OAK COTTAGE OF SANTA BARBARA MEMORY CARE **FACILITY NUMBER:** 425802118

VISIT DATE: 11/19/2025

NARRATIVE

1	resident to the dining area presentable, with care provided for hair, teeth, clean clothes, with socks and
2	shoes. If a resident refuses, they try again at a another time and let their physician know if the behavior
3	is
4	not normal. Caregivers document if a care task did not get done. One staff noted that although R1 was
5	showered, their hair appeared greasy the next day. Staff interviewed did not recall R1 refusing showers
6	often or not being showered.
7	R1's visitor was interviewed, who indicated they observed R1's toiletries including toothpaste, deodorant
8	and face lotion, at the back of a cabinet inaccessible and appearing to not be used. R1's visitor stated
9	their toothbrush and toothpaste were new and unused for a month, showing R1's teeth had not been
10	brushed. Staff stated residents' care needs are indicated in their care plan, and teeth should be brushed
11	twice a day. Staff stated some residents use mouth swabs with mouthwash, which are a sponge on the
12	end of a stick. Staff stated some residents do not like their teeth brushed, but they have a right to refuse
13	and are not forced. Most staff interviewed did not recall R1 refusing care often. One staff stated R1 did
14	not like having their teeth brushed, and on one occasion did not spit out the water for 30 minutes during
15	teeth brushing, despite staff asking them to.
16	R1's visitor indicated they have found R1 "unkempt" with feces under their fingernails and sitting in wet

17	briefs. Staff interviewed were consistent and stated no residents are in wet briefs for an extended period
18	of time, as the care plan indicates what residents need assistance with and they are regularly checked
19	and changed, or assisted to the toilet. A witness stated on 05/13/2025 at around 3:50 pm, they
20	witnessed a resident in the common area calling for staff multiple times, stating they needed to use the
21	restroom. The witness observed two caregivers engaged in a conversation instead of helping the
22	resident. The witness informed a staff member about the situation, but stated they felt the staff were
23	dismissive. During visits to the facility for the investigation, LPA did not observe any malodors and
24	observed caregivers present around residents in the common areas, attending to residents. One staff
25	stated about a year ago there was one resident who had a behavior of sticking their hand in their brief,
26	and their family member cleaned their nails. There was no other evidence found to suggest residents
27	were sitting in wet briefs or had dirty hands.
28	R1's visitor also noted they have observed R1 not properly dressed, as they were not wearing a bra or
29	socks, and had their roommate's pants on that were too small and tight. Staff stated some residents
30	don't like to wear bras, and med techs are informed if the clothing is too small so that can be
31	communicated to the responsible party. Care staff stated the caregivers know each resident's clothes
32	and most items are labeled, but occasionally there are mix ups with residents' laundry put into the wrong
	room that are corrected. Staff
	Please continue to 9099-C, Pg 3.

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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 11/19/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT (Cont)**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364

FACILITY NAME: OAK COTTAGE OF SANTA BARBARA MEMORY CARE **FACILITY NUMBER:** 425802118

VISIT DATE: 11/19/2025

NARRATIVE

1	interviews did not indicate a resident was dressed in another resident's clothing. Staff interviewed more
2	recently indicated clothing items are labeled and do not get mixed up, although sometimes residents
3	leave their jackets in the common area and staff return them.
4	R1's visitor stated R1 was not assisted properly with feeding, such as being fed pieces that were too
5	large or were not finger foods, even though R1 was supposed to receive assistance with feeding. Staff
6	stated if a resident has a special diet, the kitchen is informed and the food prepared accordingly. If there
7	are issues with a resident eating, that information is communicated to the doctor for a change diet order
8	or for additional evaluation. Staff also stated they try to accommodate residents' preferences. Staff
9	stated they must provide the care services listed on the resident's care plan. Staff indicated some
10	residents eat with their hands. The investigation did not reveal any evidence that staff did not assist R1
11	with meals.
12	Although the allegation may have happened or is valid, there is not a preponderance of evidence to
13	prove the alleged violation did or did not occur, therefore the allegation is Unsubstantiated at this time.
14	The facility is reminded of their responsibility to provide adequate care and supervision to meet
15	residents' needs.
16	
17	On the allegation: Staff failed to safeguard residents' personal belongings. It was alleged a resident's
18	glasses were missing, and staff brought a visitor four different pairs that did not belong to the resident. It
19	was alleged residents may be without their glasses, dentures and hearing aids. It was also alleged
20	another resident takes R1's personal items such as stuffed animals and toys.
21	R1's visitor stated staff do not put R1's glasses on them unless instructed to do so. Staff interviewed
22	indicated they are supposed to make sure hearing aids are turned on during the shift. Staff interviewed
23	stated they did not remember R1 or any other resident losing their glasses or hearing aid. Staff
24	interviewed indicated they have all glasses and hearing aids labeled, and the items are collected at
25	bedtime and kept in the med tech station overnight, unless the family requests to keep the items in the
26	room.
27	R1's visitor stated staff indicated R1's roommate likes to put things away, and this accounts for why
28	items go missing. Most staff interviewed did not remember R1's stuffed animal, but stated there were
29	common area activity items and stuffed animals. One staff stated they remembered R1's stuffed animal

30	dog was missing at one time but was found after a short amount of time, but they could not recall more
31	details.
32	Although the allegation may have happened or is valid, there is not a preponderance of evidence to prove the alleged violation did or did not occur, therefore the allegation is Unsubstantiated at this time. The facility is reminded of their responsibility to safeguard residents' personal belongings and ensure access to them, and provide adequate supervision to residents. Exit interview conducted and a copy of this report issued at the time of the visit.

SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Kristin Kontilis
LICENSING EVALUATOR SIGNATURE:

DATE: 11/19/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 11/19/2025