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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 496803339
Report Date: 06/04/2026
Date Signed: 06/04/2026 02:50:06 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1450 NEOTOMAS AVENUE, STE. 100 SANTA ROSA, CA 95405

This is an official report of an unannounced visit/investigation of a complaint received in our office on **04/08/2026** and conducted by Evaluator Marisol Cuadra

PUBLIC	COMPLAINT CONTROL NUMBER: 21-AS-20260408132257

FACILITY NAME:	BROOKDALE PAULIN CREEK			**FACILITY NUMBER:**	496803339
ADMINISTRATOR:	BRENNER, JEFFREY			**FACILITY TYPE:**	740
ADDRESS:	2375 RANGE AVE			**TELEPHONE:**	(707) 575-3722
CITY:	SANTA ROSA	**STATE:** CA		**ZIP CODE:**	95403
CAPACITY:	100	**CENSUS:** 68		**DATE:**	06/04/2026
		UNANNOUNCED		**TIME BEGAN:**	02:13 PM
MET WITH:	Wendy Trigueros (Financial Services Director)			**TIME COMPLETED:**	03:04 PM

ALLEGATION(S):

1	-Facility did not centrally store medications.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Cuadra arrived unannounced to conduct a complaint investigation and
2	delivered findings regarding the allegation listed above and met with Wendy Trigueros, Financial
3	Services Director.
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5	Regarding allegations about facility did not centrally store medications. Per Reporting party, on 3/28/2026
6	the facility was unable to locate 72 vials of morphine and facility staff (S1) contacted resident's (R1)
7	responsible party to request a call to be made to hospice and order more morphine, but later S1 called
8	and said to cancel the morphine order, they found the vials at the medication room refrigerator. Also,
9	there were concerns about medication management after they learned that antibiotics prescribed to R1
10	were lost for three days due to an issue with the pharmacy involving R1's name resulting in R1 missing
11	their prescribed medication to treat an infected wound leading to R1's hospitalization.
12	Continued on LIC9099C...
13	

Substantiated	Estimated Days of Completion:

SUPERVISORS NAME: Bethany Moellers
LICENSING EVALUATOR NAME: Marisol Cuadra
LICENSING EVALUATOR SIGNATURE:
DATE: 06/04/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 06/04/2026

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

Control Number 21-AS-20260408132257

FACILITY NAME: BROOKDALE PAULIN CREEK **FACILITY NUMBER:** 496803339
VISIT DATE: 06/04/2026

NARRATIVE

Continued from LIC9099...

Based on records review of R1's medical records provided by the facility, on 3/18/26 R1 was hospitalized and referred to hospice care. According to S1 confirmed that R1 was admitted to hospice on 3/18/26, there were medication changes due to R1's health condition, on 3/19/26 S1 requested hospice to change the medication to something that R1 could take orally or have hospice to come and administer injections prescribed. On 3/20/26 S1 checked all changes and noticed that the cream had not been changed or addressed, S1 asked RN form hospice case manager if they could change the medication or schedule someone from hospice to come and apply the cream. On 3/21/26 R1's order was sent into pharmacy for oral medication for infection. Regarding prescribed antibiotics "on hold" for three days, it was determined the issue was due to the pharmacy having wrong R1's name and waiting on name confirmation from prescribing doctor, but the facility was in constant communication with R1's responsible parties and R1's physician attempting to clarify issue with R1's name error. Regarding morphine medication, on 3/25/26 S1 received a call from their medication technician (Med Tech) stating that the morphine had not come in yet; Med tech told S1 that they called hospice, and they said that refill syringes were sent out. On 3/26/26 S1 spoke to hospice RN – case manager who informed S1 that 79 refilled syringes were sent the night before, which they had been checked in by the front desk. After S1 researched, it was found out that they were logged in and because they needed to be refrigerated the front desk put them in office fridge until someone came to pick up clinical, but clinical was not aware of the medication being dropped off, but all 79 syringes we accounted for and returned to narcotic storage in medication room. S1 ensures that after learning of this incident, the facility has changed the process of how they allow pharmacy to drop off medication, the new process instructs that the medication must be handed to a nurse or medication manager and signed for. The preponderance of evidence standard has been met; therefore, the above allegation is found to be SUBSTANTIATED. California Code of Regulations, (Title 22, Division 6, Chapter 8), is cited on the attached LIC 9099D. Appeal Rights Given.

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT (Cont)**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1450 NEOTOMAS AVENUE, STE. 100 SANTA ROSA, CA 95405

FACILITY NAME: BROOKDALE PAULIN CREEK **FACILITY NUMBER:** 496803339
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 06/04/2026

Deficiency Type POC Due Date / Section Number		DEFICIENCIES		PLAN OF CORRECTIONS(POCs)
Type A 06/05/2026 **Section Cited** CCR 87465(h)(2)	1 2 3 4 5 6 7	Type A 87465 Incidental Medical and Dental Care (h) The following requirements shall apply to medications which are centrally stored: (2) Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for the supervision of the centrally stored medication. This requirement has not been met as evidence by:	1 2 3 4 5 6 7	Administrator to conduct staff training to ensure that staff know how to properly store centrally stored medication per regulation 87465(h)(2). Administrator to submit date of training to LPA by POC due date of 6/5/26.
	8 9 10 11 12 13 14	Based on records review and interviews with facility staff, licensee failed to kept refrigerated narcotics received from the pharmacy in a locked place that is not accessible to residents in care which poses an immediate risk to the health & safety of residents.	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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LICENSING EVALUATOR SIGNATURE: **DATE:** 06/04/2026

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		TIME BEGAN:	02:13 PM
MET WITH:	Wendy Trigueros (Financial Services Director)	**TIME COMPLETED:**	03:04 PM

ALLEGATION(S):

- Facility did not notify responsible party of resident change in condition.

INVESTIGATION FINDINGS:

Licensing Program Analyst (LPA) Cuadra arrived unannounced to conduct a complaint investigation and delivered findings regarding the allegation listed above and met with Wendy Trigueros, Financial Services Director.

The Department received an allegation of facility did not notify responsible party of resident change in condition. Per Reporting party, resident (R1) had a change of condition, but the facility failed to notify their responsible party. Based on records review of R1's medical records provided by the facility. On 3/18/26 while R1 was at the hospital, R1 was diagnosed with UTI and discharged back to the facility on antibiotics for one week and hospice referral, then on 3/21/26 R1's responsible party was contacted by R1's physician via telephone to notify them about R1's change of condition. However, LPA conducted interviews with facility staff (S1) confirmed that R1 had an infection, which was a yeast infection diagnosed, but they were unaware that R1's responsible party didn't know about it, since
Continued on LIC9099C...

Unsubstantiated	**Estimated Days of Completion:**

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NARRATIVE

Continued from LIC9099A...

since they were with R1 at the hospital and they were aware of other hospitalization of R1 within that month, R1's responsible party spent the time when they returned from hospital on getting R1's admitted to hospice and waiting on medication changes until 3/20/26 when they informed R1's responsible party that day of medication changes needed. Based on records review and interviews conducted by LPA with pertinent parties, LPA received conflicting information and is unable to determine that R1's responsible party was not notified by the facility about R1's change of condition because the facility learned via fax about R1's change of

condition at the same time as the responsible party via telephone of urine culture results from R1's physician. A finding that the complaint allegation facility did not notify responsible party of resident change in condition is unsubstantiated means that although the allegation may have happened or is valid, there is not a preponderance of evidence to prove the alleged violation(s) did or did not occur, therefore the allegation is UNSUBSTANTIATED.

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