

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 547209004
Report Date: 01/15/2026
Date Signed: 01/15/2026 02:02:13 PM

Unfounded

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION FRESNO ASC, 1314 E SHAW AVE FRESNO, CA 93710
COMPLAINT INVESTIGATION REPORT	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **10/25/2025** and conducted by Evaluator Sarah Hurt

	COMPLAINT CONTROL NUMBER: 24-AS-20251025043019
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FACILITY NAME: QUAIL PARK AT SHANNON RANCH	FACILITY NUMBER: 547209004
ADMINISTRATOR: MOYER, JEFF	FACILITY TYPE: 740
ADDRESS: 3330 & 3440 W FLAGSTAFF AVE	TELEPHONE: (559) 527-8245
CITY: VISALIA	STATE: CA
CAPACITY: 150	ZIP CODE: 93291
	CENSUS: 93
	DATE: 01/15/2026
MET WITH: Facility Administrator, Kim Santos	UNANNOUNCED TIME BEGAN: 10:00 AM
	TIME COMPLETED: 12:15 PM

ALLEGATION(S):

1	Staff did not meet resident's oral hygiene needs while in care.
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INVESTIGATION FINDINGS:

1	On 01/15/2025, Licensing Program Analyst's (LPA) Sarah Hurt and Shawna Doucette arrived to the
2	facility unannounced to deliver findings on the above allegation. LPA met with Facility Administrator, Kim
3	Santos, and stated the purpose of the visit.
4	
5	Regarding the allegation Staff did not meet resident's oral hygiene needs while in care. Reporting Party
6	stated upon further review Resident 1 lived at a different facility location. Resident 1 was not a resident at
7	this facility. Based on the information received, we have found that the complaint is Unfounded, meaning
8	that the allegation is false, could not have happened, and/or is without reasonable basis, therefore, we
9	have dismissed the complaint.
10	
11	No deficiencies cited. Exit interview conducted with facility Administrator Kim Santos. A copy of this report
12	was provided at the time of visit
13	

Unfounded	Estimated Days of Completion:
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SUPERVISORS NAME: Brenda Chan

LICENSING EVALUATOR NAME: Sarah Hurt

LICENSING EVALUATOR SIGNATURE:

DATE: 01/15/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 01/15/2026

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