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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 565800366
Report Date: 07/15/2026
Date Signed: 07/15/2026 04:19:34 PM

Document Has Been Signed on 07/15/2026 04:19 PM **- It Cannot Be Edited**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364

FACILITY NAME:	ATRIA HILLCREST		FACILITY NUMBER:	565800366
ADMINISTRATOR/ DIRECTOR:	REMON PAGELS		FACILITY TYPE:	740
ADDRESS:	405 HODENCAMP RD		TELEPHONE:	(805) 373-0606
CITY:	THOUSAND OAKS	STATE: CA	ZIP CODE:	91360
CAPACITY: 207		CENSUS: 145	DATE:	07/15/2026
TYPE OF VISIT:	Case Management - Incident	UNANNOUNCED	TIME VISIT/ INSPECTION BEGAN:	10:00 AM
MET WITH:	Ramon Pagels		TIME VISIT/ INSPECTION COMPLETED:	04:25 PM

NARRATIVE

Licensing Program Analyst (LPA) Erica Mosley conducted an unannounced subsequent Case Management – Incident visit at 10 a.m., The LPA met with Executive Director (ED), Remon Pagels and explained the reason for the visit. Entrance interview conducted.

Community Care Licensing Division (CCLD) received two (2) self-reported incident reports and a subsequent incident death report regarding Resident #1 (R1) on 12/12/2025, 12/14/2025 and 01/08/2026. Incident report indicated that on 12/12/2025, Resident #1 (R1) experienced an unwitnessed fall and activated their pendant. Staff #1 (S1) found R1 on the floor. 911 was called, but the R1 refused transport. R1's emergency contact (EC) and primary care physician (PCP) were notified. On 12/14/2025, the Department received a subsequent incident report stating the R1 continued to report pain in their left ribs and shortness of breath. Staff #2 (S2) called 911, and R1 was transported to the hospital. The EC and PCP were notified. On 01/07/2026, the EC informed the facility that the R1 passed away on 01/06/2026 at approximately 1:00 p.m. at a Skilled Nursing Facility (SNF) upon discharge from the hospital. On 01/08/2026, CCLD received the death report, and LPA Mosley requested the death certificate from the facility. On 02/03/2026, LPA received the death certificate and LPA Esther Cortez contacted the facility telephonically to request R1's care plan and physician report.

On 02/04/2026, LPA Mosley conducted the initial unannounced visit. During the visit LPA conducted a physical plant tour to ensure there were no immediate health and safety concerns, conducted an in-person interview with the ED, a file review for R1 along with obtained copies of pertinent documents relevant to the incident. CCLD's Investigations Branch continued the investigation. The Department requested Ventura County Fire Department (VCFD) for the emergency medical service (EMS) report / medical records, 911 audio recording and call logs related to R1 on 12/11/2025 and 12/15/2025.

Report continued on LIC 809-C PAGE 2...

NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez
NAME OF LICENSING PROGRAM ANALYST: Erica Mosley

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 07/15/2026

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 07/15/2026

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

FACILITY EVALUATION REPORT California law requires a public report of each licensing visit/inspection. This report is a record for the facility and the licensing agency. This report is available for public review; therefore, care is taken not to disclose personal or confidential information. Inquiries concerning the location, maintenance, and contents of these reports may be directed to the Licensing Program Analyst or Regional Office whose address and telephone number are listed on the front of this form.

DEFICIENCIES A deficiency is an instance of noncompliance with licensing requirements, including applicable statutes, regulations, interim licensing standards, operating standards, and written directives. Applicants/ licensees must be notified in writing of all licensing deficiencies. Deficiencies are listed on the left side of this form, and the applicable licensing requirement upon which the deficiency is identified. There are two types of deficiencies:

- Type A deficiencies are violations of licensing requirements that, if not corrected, have a direct and immediate risk to the health, safety, or personal rights of persons in care.

- Type B deficiencies are violations of licensing requirements that, without correction, could become a risk to the health, safety, or personal rights of persons in care, a recordkeeping violation that could impact the care of said persons and/or protection of their resources, or a violation that could impact those services required to meet the needs of persons in care.

PLANS OF CORRECTION (POCs) The licensing agency is required to establish a reasonable length of time to correct a deficiency. In order to set the time, the licensing agency must take into consideration the seriousness of the violation, the number of persons in care involved, and the availability of equipment and personnel necessary to correct the violation. Applicants/licensees are requested to provide a specific plan for each violation on the right side of the form across from each deficiency. The more specific the plan, the less chance exists for any misunderstanding in setting time limits and reviewing corrections. The applicant/licensee who encounters problems beyond their control in completing the corrections within the specified time frame may request and may be granted an extension of the correction due date by the licensing agency.

CORRECTION NOTIFICATION The applicant/licensee is responsible for completing all corrections and promptly notifying the licensing agency of corrections. Applicants/licensees are advised to keep a dated copy of any correspondence sent to the licensing agency concerning corrections, or if corrections are telephoned to the licensing agency, the date, person contacted, and information given.

CIVIL PENALTIES The licensing agency is required by law to issue a Penalty Notice, when applicable, to all facilities holding a license issued by the licensing agency, or subject to licensure, except Certified Family Homes, Resource Families, and Foster Family Homes, or any governmental entity.

PENALTY NOTICE GIVEN The statement concerning civil penalties serves as a penalty notice on this Licensing Report and failure to correct cited licensing deficiencies will result in civil penalties. Applicants/ licensees are required to pay civil penalties when administrative appeals have been exhausted and in accordance with any payment arrangements made with the licensing agency.

APPEAL RIGHTS The applicant/licensee has a right without prejudice to discuss any disagreement in this report with the licensing agency concerning the proper application of licensing requirements. The applicant/ licensee may request a formal review by the licensing agency to amend or dismiss the notice of deficiency and/ or civil penalty. Requests for review shall be made in writing within 15 business days of receipt of a deficiency notification or civil penalty assessment. Licensing deficiencies may be appealed pursuant to the procedures in the LIC 9058 Applicant/Licensee Rights.

AGENCY REVIEW The licensing agency review of an appeal may be conducted based upon information provided in writing by the applicant/licensee. The applicant/licensee may request an office meeting to provide additional information. The applicant/licensee will be notified in writing of the results of the agency review within 60 business days of the date when all necessary information has been provided to the licensing agency.

EMAIL REQUIREMENT Adult Community Care Facilities, Residential Care Facilities for the Chronically Ill, and Residential Care Facilities for the Elderly are required to provide and maintain an active email address of record with the licensing agency.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT (Cont)**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364

FACILITY NAME: ATRIA HILLCREST **FACILITY NUMBER:** 565800366
VISIT DATE: 07/15/2026

NARRATIVE

(PAGE 2) Report Continued from LIC 809...

The Department also requested records from Ventura County Sheriff's Office (VCSO) for the death, police and incident report related to R1 and hospital records. On 04/09/2026 the facility Executive Director (ED) was interviewed. On 04/15/2026 and 04/16/2026, attempts were made to contact R1's EC by telephone. On 04/17/2026 at 1:55 p.m., R1's EC was interviewed by telephone. On 04/20/2026 beginning at 1:13 p.m., two (2) staff members were interviewed at the facility.

Record review revealed that R1 had lived at the facility since 03/09/2014. R1 was on Level 2 level of care, with an assessment dated 02/06/2025. R1's comprehensive assessment indicated a need for routine monitoring of ambulatory status to ensure evacuation needs were identified and met, and interventions to decrease identified fall risk including encouraging R1 to always use their cane. R1 required assistance with showering/bathing, supervision with clothing selection, and occasional assistance with the mechanics of dressing. R1 received assistance with medication management and required assistance to and from the bathroom for toileting needs. R1 needed occasional assistance with assistive/adaptive devices. R1 received housekeeping services and required standard weekly laundry services. R1 was able to leave the facility unassisted and did not have a history of falls.

Hospital records revealed that R1 was admitted to the hospital on 12/14/2025 due to a fall. The primary diagnosis was listed as multiple fractures of the left ribs, with secondary diagnoses of a urinary tract infection (UTI) and sepsis. It was noted that R1 was brought to the hospital after a fall at home with worsening left-sided chest pain. Imaging revealed that R1 sustained "minimally displaced left posterior 6th and 7th rib fractures and a nondisplaced left posterior 8th rib fracture." R1 was discharged on 12/22/2025 to a SNF.

Death report revealed that on 01/06/2026, VCSO deputies responded to the SNF as fire department staff were conducting chest compressions on R1. R1 was pronounced deceased at 2:10 p.m. According to the medical examiner, R1's death was due to accidental injury.

Interviews with the ED revealed that R1 was described as very social and enjoyed living in the community. R1 was considered an advocate for the community and loved being part of the facility environment. It was noted that R1 was frequently out of their apartment and would ambulate around the community using either a cane or a walker. R1 was very active, out and about often, and attended all community activities. R1 was described as very independent and on minimal care.

Report continued on LIC 809-C PAGE 3...

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DATE: 07/15/2026

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NARRATIVE

(PAGE 3) Report Continued from LIC 809-C PAGE 2...

R1 changed their own briefs and required only reminder-level supervision regarding restroom use. It was also noted that facility staff conducted additional checks in R1's apartment to ensure support was available if needed. Furthermore, it was reported that facility staff followed proper protocol when responding to R1's fall.

Staff interviews revealed that R1 was very social and often seen throughout the community. R1 frequently attended community activities and did not have a history of falls. R1 commonly ambulated with a cane or walker, and staff stated that R1's mobility "had no limits." It was noted that during the initial fall, staff encouraged R1 to go to the hospital when EMS arrived; however, R1 stated, "I'm fine," and refused treatment against medical advice.

Interview with the EC revealed that R1 "loved that place" and had no complaints regarding the care and supervision received while residing in the community. R1 had lived there for 12 years and had no difficulty voicing concerns. It was noted that R1 was "very stubborn." The EC reported that R1 had "lost their balance" and fallen and added that R1 "suffered from vertigo." The EC stated that the facility did a good job responding to R1's fall and attempting to contact appropriate emergency services; however, they tried, but you can't force somebody to go to the hospital. The EC confirmed R1 was in charge of their own decision making.

No deficiencies are being cited at this time pertaining to this self-reported incident and death report. Exit interview conducted and a copy of report was provided.

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