

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 565802425
Report Date: 05/18/2026
Date Signed: 05/18/2026 04:21:37 PM

Substantiated

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on **04/27/2026** and conducted by Evaluator Esther Cortez

	COMPLAINT CONTROL NUMBER: 29-AS-20260427145037
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FACILITY NAME: VISTAS AT OXNARD SENIOR LIVING,THE		FACILITY NUMBER: 565802425
ADMINISTRATOR:FRANCESCA WEST		FACILITY TYPE: 740
ADDRESS: 2211 E GONZALES RD		TELEPHONE: (805) 819-2518
CITY: OXNARD	STATE: CA	ZIP CODE: 93036
CAPACITY: 100	CENSUS: 54	DATE: 05/18/2026
	UNANNOUNCED	TIME BEGAN: 01:10 PM
MET WITH: Francesca West		TIME COMPLETED: 04:30 PM

ALLEGATION(S):

1	Staff do not ensure that residents are administered their medications as prescribed.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA), Esther Cortez conducted an unannounced subsequent complaint visit
2	for the above allegation. Upon arrival, LPA met with Executive Director Francesca West and explained
3	the reason for the visit.
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5	On 05/05/2026, between 03:45 p.m. and 5:00 p.m., the LPA interviewed the Executive Director, the
6	Health and Wellness Director, one (1) staff, and obtained copies of resident records and other pertinent
7	documents relevant to the investigation. During today's visit the LPA conducted file review for three (3)
8	residents and interviewed the ED.
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10	Report will continue on LIC9099-C, 2nd page.
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Substantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Kasandra Lopez	
LICENSING EVALUATOR NAME: Esther Cortez	
LICENSING EVALUATOR SIGNATURE:	DATE: 05/18/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 05/18/2026

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 4
Control Number 29-AS-20260427145037

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

FACILITY NAME: VISTAS AT OXNARD SENIOR LIVING,THE **FACILITY NUMBER:** 565802425
VISIT DATE: 05/18/2026

NARRATIVE	
1	Regarding the allegation, "Staff do not ensure that residents are administered their medications as
2	prescribed," it is the concern of the Reporting Party (RP) that Resident 1 (R1) did not receive their
3	medication from 04/01/2026 – 04/09/2026, or on 1/8, 1/10, 1/13, 1/17, and 1/21/2026. If R1 does not
4	receive their medication, it causes them to decompensate quickly and suffer side effects. It was further
5	reported that Resident 2 (R2) continued to receive medication from September 18, 2025, through March
6	25, 2026, despite the prescription being discontinued. Lastly, Resident 3 (R3) did not receive their
7	medication sometime in April 2026. To investigate, the LPA conducted interviews and a file review.
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9	During an interview, Executive Director (ED) Francesca West confirmed the allegation. The ED stated
10	that there had been issues obtaining medications for R1 from the pharmacy in April. This was due to the
11	pharmacy rejecting a medication order because it was signed by a nurse practitioner at R1's primary
12	care provider's office rather than their psychiatrist's office. Regarding the missed doses in January, the
13	ED stated that the refill order was pending; however, the medication was documented as administered
14	on the days in between. The ED was unsure why the medication was given on some days and not
15	others, noting that "pending refill" was written on the Medication Administration Record (MAR). The ED
16	also stated that R3 did not receive medication in April due to a pending refill.
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18	Furthermore, the ED confirmed that R2 was receiving medication that had been discontinued in
19	September 2025 until mid-March 2026. The ED stated this was an oversight by the previous Wellness
20	Director, Giovanni Guirra. The ED revealed that facility staff did not bring any of these issues to her
21	attention; instead, she was made aware by the residents' case manager and states they should of never
22	happened. Once notified of the discrepancies, the ED implemented the following corrective actions:
23	Conducted a Medication Technician in-service training, initiated a new training platform on Relias, met
24	with the pharmacy to troubleshoot the issues and subsequently switched pharmacies for the three
25	residents, implemented a new policy requiring two staff members to review discharge notes and verify
26	that the pharmacy has received all medication orders.
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28	Report will continue on LIC9099-C, 3rd page.
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SUPERVISORS NAME: Kasandra Lopez	
LICENSING EVALUATOR NAME: Esther Cortez	
LICENSING EVALUATOR SIGNATURE:	DATE: 05/18/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 05/18/2026

LIC9099 (FAS) - (06/04) Page: 2 of 4
Control Number 29-AS-20260427145037

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA
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FACILITY NAME: VISTAS AT OXNARD SENIOR LIVING,THE

FACILITY NUMBER: 565802425
VISIT DATE: 05/18/2026

NARRATIVE	
1	A review of the MARs for all three residents confirmed that R1 did not receive Clozapine 100 mg on
2	1/8/26, 1/10/26, 1/13/26, 1/17/26, 1/21/26, and from 4/1/26 to 4/09/26. The MAR review also confirmed
3	that R3 did not receive Clozapine 100 mg on 04/01/26. The LPA observed R2's After Visit Summary
4	from Community Memorial Brent Neurology on file, dated 9/18/25, which instructed to stop Carbidopa-
5	Levodopa due to drug induced Parkinsonism. The LPA was unable to review R2's MARs for September
6	and October due to resident was admitted to the facility on 10/08/2025; however, the LPA observed that
7	the MARs from November 2025 to March 2026 reflected that R2 was administered Carbidopa-Levodopa
8	from January 24, 2026 until March 24, 2026. According to the ED, the medication was finally stopped in
9	March when the resident's case manager informed them it had been discontinued in September 2025.
10	Based on the interviews and record reviews, the statements from the ED and the residents' MARs
11	confirmed the allegation. Therefore, the allegation, "Staff do not ensure that residents are administered
12	their medications as prescribed," is deemed Substantiated at this time.
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14	Per the California Code of Regulations, Title 22, Division 6, Chapter 8, the following deficiency was cited
15	during the visit (See 9099-D). Civil Penalty issued for the amount of \$250. The ED was informed that
16	failure to correct deficiency may result in additional civil penalties.
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18	Exit interview conducted. A copy of the report and appeal rights were provided.
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SUPERVISORS NAME: Kasandra Lopez

LICENSING EVALUATOR NAME: Esther Cortez

LICENSING EVALUATOR SIGNATURE:

DATE: 05/18/2026

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/18/2026

FACILITY NAME: VISTAS AT OXNARD SENIOR LIVING,THE

FACILITY NUMBER: 565802425
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DEFICIENCY INFORMATION FOR THIS PAGE:

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 05/19/2026 Section Cited CCR 87465(a)(4)	1 87465(a)(4) Incidental Medical&Dental 2 Care. (a) A plan for incidental medical 3 and dental care shall be developed by 4 each facility...(4) The licensee shall 5 assist residents with self-administered medications as needed. This	1 The ED stated that all MT's have 2 received corrective action plans, 3 conducted a in service training, 4 switched all three resident pharmacies, 5 and will submit proof of all this to LPA by 05/19/2026.

	6 7	requirement is not met as evidenced by:	6 7	
	8 9 10 11 12 13 14	Based on interviews and record review, the licensee did not comply with the section cited above, by allowing R1 and R3 missed one or multiple prescribed medications and continuing to administer a discontinued medication to R2 which poses an immediate health and safety 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	
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Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISORS NAME: Kasandra Lopez LICENSING EVALUATOR NAME: Esther Cortez LICENSING EVALUATOR SIGNATURE:		DATE: 05/18/2026
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FACILITY REPRESENTATIVE SIGNATURE:		DATE: 05/18/2026