

Department of SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 565802433

Report Date: 03/12/2026

Date Signed: 03/12/2026 03:45:07 PM

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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
FACILITY EVALUATION REPORT	

FACILITY NAME:	BELMONT VILLAGE THOUSAND OAKS	FACILITY NUMBER:	565802433
ADMINISTRATOR/MARK RANNO		FACILITY TYPE:	740
DIRECTOR:		TELEPHONE:	(805) 496-9301
ADDRESS:	3680 N MOORPARK RD	STATE:	CA
CITY:	THOUSAND OAKS	ZIP CODE:	91360
CAPACITY:	158	CENSUS:	114
TYPE OF VISIT:	Case Management - Incident	DATE:	03/12/2026
		UNANNOUNCED TIME VISIT/INSPECTION	10:00 AM
		BEGAN:	
MET WITH:	Mark Ranno, Executive Director (ED)	TIME VISIT/INSPECTION	04:00 PM
	Karen Pasten, Director of Resident Care Services	COMPLETED:	

NARRATIVE

1 Licensing Program Analyst (LPA) Erica Mosley conducted a Case Management - Incident visit to follow
2 up on two (2) self-reported incidents which took place on 02/23/2026 and 02/28/2026. Upon arrival at 10
3 a.m. LPA was greeted by the front desk receptionist and explained the reason for the visit. LPA met with
4 Executive Director (ED) Mark Ranno and Director of Resident Care Services Karen Pasten and the
5 reason for the visit was explained. Entrance interview conducted.
6
7 Incident #1: On 02/23/2026, it was alleged that Staff #1 (S1) called Resident #1 (R1) "stupid" and
8 repeatedly questioned why they were confused. Once the facility became aware of the allegation, staff
9 followed protocol and initiated an internal investigation. The appropriate agencies, including Licensing
10 and Ombudsman, were notified. R1 was interviewed, and S1 was immediately suspended pending the
11 outcome of the investigation. S1 was interviewed and provided in-service training regarding professional
12 interactions with residents with memory impairment.
13
14 Incident #2 On 02/28/2026 it was alleged that Resident #2 (R2) disclosed to their Power of attorney
15 (POA) that "A man took me downstairs and molested me". Once the facility became aware of the
16 allegation staff followed protocol and initiated an internal investigation. The appropriate agencies,
17 including Licensing and Ombudsman, were notified. R2 was evaluated by the facility LVN, POA refused
18 transport to the emergency room for further evaluation, however agreed to a virtual telemedicine
19 physician visit. Primary care physician was contacted and provided a copy of the report, and the police
20 were notified #26-26-884.
21
22 During today's visit, LPA and staff toured the physical plant area inside and out to ensure there were no
23 immediate health and safety concerns. **Report Continued on LIC 809C...**
24
25

NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez

NAME OF LICENSING PROGRAM ANALYST: Erica Mosley

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 03/12/2026

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 03/12/2026

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 III, 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
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FACILITY NAME: BELMONT VILLAGE THOUSAND OAKS

FACILITY NUMBER: 565802433

VISIT DATE: 03/12/2026

NARRATIVE	
1	(PAGE 2) Report Continued from LIC 809...
2	Starting at 10:34 a.m. and throughout the visit LPA conducted four (4) in person staff interviews, resident
3	interviews, at 2:15 p.m. attempted to conduct a telephonic interview with POA of R2, file and record
4	review for S1, R1 and R2, facility records review and obtained copies of pertinent documents relevant to
5	the incidents.
6	
7	Incident #1: Documentation revealed that Resident #1's (R1) Physician's Report dated 11/25/2024 lists
8	dementia as the primary diagnosis. The assessment and service plan dated 11/18/2025 indicate that R1
9	receives assistance with medication management, housekeeping, laundry, and hands-on assistance
10	with bathing, dressing, grooming, continence care, toileting, transferring, and fall-prevention
11	interventions. The MDS-COGS assessment dated 08/26/2025 scored 6, indicating low-to-moderate
12	impairment. The Montreal Cognitive Assessment (MoCA) dated 09/25/2025 scored 11/30, indicating
13	significant cognitive impairment. S1 has no history of disciplinary action. On 03/02/2026, S1 conducted
14	an in-service training regarding expectations for professional communication with residents, including
15	appropriate approaches when working with individuals living with dementia. The facility's internal
16	investigation was completed, and S1 returned to work on 03/03/2026.
17	
18	Interview with the Director of Resident Care Services (DRCS) revealed that A third-party companion
19	reported that R2 stated a staff member had called them "stupid" and repeatedly questioned why they
20	were confused. The facility immediately notified the Executive Director, suspended the staff member,
21	and initiated an investigation. During interviews, the resident stated they did not recall being called
22	"stupid," though they remembered disliking the staff member's tone and were unable to identify or
23	describe the individual. A full body assessment on R2 confirmed the resident was safe with no concerns
24	noted. Following interviews with all involved parties, S1 denied the allegation, has no history of
25	misconduct and was reinstated. The resident requested that the S1 not be assigned to them moving
26	forward.
27	
28	Interview with R1 revealed that they did not recall the incident or being called "stupid." R1 stated they
29	previously disliked the tone of a staff member but could not recall who the staff member was or what
30	they looked like. Resident interviews indicated that residents feel safe within the community and
31	reported that staff treat and speak to them with respect. Residents reported no concerns regarding the
32	quality of care or staff conduct.
	Staff interviews indicated that they have never witnessed nor engaged in disrespectful behavior toward residents, including calling a resident "stupid." Report Continued on LIC 809C PAGE 3...

NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez
NAME OF LICENSING PROGRAM ANALYST: Erica Mosley
LICENSING PROGRAM ANALYST SIGNATURE: _____
DATE: 03/12/2026

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

FACILITY REPRESENTATIVE SIGNATURE: _____
DATE: 03/12/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION
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FACILITY EVALUATION REPORT (Cont)WOODLAND HILLS N.ASC, 21731 VENTURA
BLVD. #250
WOODLAND HILLS, CA 91364**FACILITY NAME:** BELMONT VILLAGE THOUSAND OAKS**FACILITY NUMBER:** 565802433**VISIT DATE:** 03/12/2026**NARRATIVE**

1 **(PAGE 3) Report Continued from LIC 809-C PAGE 2...**
2 Staff stated they treat residents with dignity and respect. It was noted that during the facility's internal
3 investigation, S1 denied the allegation, stating that they "would never make derogatory statements
4 toward residents."
5
6 Incident #2: Documentation shows that R2's Physician's Report dated 10/30/2025 lists dementia as the
7 primary diagnosis. The assessment and service plan dated 10/29/2025 indicate that R2 requires
8 assistance with medication management, housekeeping, and hands-on assistance with bathing,
9 dressing, and grooming. R2 also requires reminders and cues for continence and toileting, reminders to
10 use assistive devices, and occasional redirection and guidance. A Montreal Cognitive Assessment
11 (MoCA) dated 10/29/2025 scored 17/30, indicating moderate cognitive impairment. Telemedicine
12 documentation dated 02/28/2026 shows that R2 was seen for an urgent care visit and presented with
13 dementia accompanied by delusions. The physical exam noted R2 to be healthy, well-nourished, and
14 well-developed, with no acute distress. The assessment included delusions and dementia with psychotic
15 disturbance, with dementia severity and type listed as unspecified. An in-service training was conducted
16 on 03/02/2026 regarding appropriate responses to resident allegations of abuse, neglect, or
17 inappropriate conduct.
18
19 Interview with the DRCS revealed that R2 reported to their POA that a man had entered thier room at
20 night and attempted to "make out" with them, later describing the event as an attempted sexual
21 encounter but stating they did not believe they were touched, harmed, or assaulted. R2 was unable to
22 describe the individual and provided inconsistent details, at one point saying multiple men were involved
23 and later stating it was one person. A nursing assessment found no injuries, no pain, and no signs of
24 trauma, and the Sheriff's Department responded and obtained statements from the resident and staff.
25 The resident's primary care provider, who is familiar with R2 history of dementia with delusions, advised
26 that an ER visit was not necessary and adjusted their medication. The facility completed an in-service
27 training with staff on responding to allegations of abuse, and the POA expressed that they believe the
28 report was related to the resident's dementia but wanted it documented. During the visit R2 refused to
29 be interviewed. Resident interviews indicated that residents feel safe within the community and reported
30 that staff treat and speak to them with respect. Residents reported no concerns regarding the quality of
31 care or staff conduct. Staff interviews indicated that no residents have ever disclosed abuse to them.
32 Staff stated that if a disclosure were to occur, they are required to report it immediately per facility
protocol.

No deficiencies were cited at this time. A supplementary report or visit will be conducted if warranted Exit
interview conducted. Report was reviewed and a copy was provided.

NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez
NAME OF LICENSING PROGRAM ANALYST: Erica Mosley
LICENSING PROGRAM ANALYST SIGNATURE: **DATE:** 03/12/2026

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FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 03/12/2026