

Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 565802462
Report Date: 06/15/2026
Date Signed: 06/15/2026 03:27:42 PM

Document Has Been Signed on 06/15/2026 03:27 PM - It Cannot Be Edited

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: SAGE MOUNTAIN SENIOR LIVING		FACILITY NUMBER:	565802462
ADMINISTRATOR/BETSY MCCOY		FACILITY TYPE:	740
DIRECTOR:			
ADDRESS:	3499 GRANDE VISTA DR	TELEPHONE:	(805) 375-0695
CITY:	THOUSAND OAKS	STATE: CA	ZIP CODE: 91320
CAPACITY:	145	CENSUS: 108	DATE: 06/15/2026
TYPE OF VISIT:	Case Management - Incident	UNANNOUNCED TIME VISIT/INSPECTION	03:00 PM
MET WITH:	Christian Castillo	BEGAN: TIME VISIT/INSPECTION	03:30 PM
		COMPLETED:	

NARRATIVE	
1	Licensing Program Analyst (LPA) Esther Cortez conducted a subsequent case management visit to
2	deliver findings for an investigation initiated on 01/09/2025. LPA met with Executive Director Christian
3	Castillo and explained the reason for the visit.
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5	On 11/05/2024, the Department received a self-reported death report from the facility. The death report
6	stated that on 11/02/2024, Resident #1 (R1) was found unresponsive in the common area of the
7	memory care unit. The caregiver began life-saving efforts and assessed R1 for possible choking.
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9	On 01/09/2025, from 10:55pm to 4:30pm, Licensing Program Analyst (LPA) Esther Cortez conducted an
10	unannounced Case Management – Incident visit to the above facility. LPA Cortez met with the Executive
11	Director Christian Castillo and explained the reason for the visit was to follow up on the self-reported
12	death report received on 11/05/2024. The report pertained to the 11/02/2024 death of Resident #1 (R1).
13	During the visit, the LPA conducted an interview with the ED, conducted a brief tour of the facility and
14	obtained copies of pertinent documents. Community was experiencing a power outage; any necessary
15	pertinent documents were to be sent to the LPA. The LPA informed the administrator that the incident
16	was referred to the Community Care Licensing (CCL) Investigations Branch (IB) for review and further
17	investigation was required prior to issuing findings.
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19	On 01/17/2025, the Department contacted the facility ED, Christian Castillo, via email and requested
20	additional documents regarding R1 pertinent to the investigation and on 01/20/2025, Castillo provided
21	the requested documents. Report will continue on LIC809-C, 2nd page.
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NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez	
NAME OF LICENSING PROGRAM ANALYST: Esther Cortez	

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 06/15/2026

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 06/15/2026

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.

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FACILITY EVALUATION REPORT (Cont)	

FACILITY NAME: SAGE MOUNTAIN SENIOR LIVING FACILITY NUMBER: 565802462
VISIT DATE: 06/15/2026

NARRATIVE	
1	On 01/24/2025, from approximately 11:00am to 04:00pm, the Investigator conducted interviews with the Executive Director, staff, residents, and one resident's family member; on 01/28/2025, at approximately 12:30pm with staff. On 04/15/2025 and 04/17/2025, the Investigator conducted telephone interviews with staff. In addition, the Investigator requested and reviewed medical records from Los Robles Medical Center, R1's facility records, facility Death Report, Ventura County Autopsy Report, and Death Certificate. On 10/27/2025, from 09:45am to 04:15pm Licensing Program Analyst (LPA) Esther Cortez conducted an unannounced Case Management – Incident visit to the above facility. The LPA interviewed the Executive Director, attempted to interview two (2) residents, conducted a file review and collected pertinent documents relevant to the investigation A review of R1's facility file documents indicate that R1 was admitted to the facility on 05/18/2021. R1's Physician Report, dated 05/13/2021, lists diagnosis as CADASIL and Vascular Dementia. The report also lists Mild Cognitive Impairment (MCI), does not need assistance with self-care, is able to feed self, disoriented, confused, and able to follow instructions and able to communicate needs. The investigation revealed that on 11/02/2024, at approximately 08:40am, R1 finished their breakfast and proceeded to the common area. While in the common area, Staff 1 (S1) saw that R1 needed assistance. S1 began life-saving efforts and assessed R1 for possible choking. S1 conducted a finger sweep and found no obstruction. S1 began abdominal thrust. The facility staff's Memory Care Unit responded to the area and called 911. CPR was initiated and continued until local paramedics arrived and continued life-saving efforts. R1 was pronounced dead at 09:15am. A review of the documents obtained noted that R1 was not identified as having a choking alert diagnosis. R1 was able to self-feed independently. Staff interviews revealed that R1 was a fast eater and staff would direct R1 to slow down. Medical records reviewed by the Investigator noted no history of choking. The autopsy stated that the cause of death is asphyxia due to airway obstruction (choking) and the manner of death was accidental. Vascular dementia and CADASIL was also noted as contributing factor to R1's death. There were no apparent signs of acute trauma or neglect associated to the death. Report will continue on LIC809-C, 3rd page.

NAME OF LICENSING PROGRAM MANAGER: Kasandra Lopez	
NAME OF LICENSING PROGRAM ANALYST: Esther Cortez	
LICENSING PROGRAM ANALYST SIGNATURE:	DATE: 06/15/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	DATE: 06/15/2026

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FACILITY EVALUATION REPORT (Cont)	

NARRATIVE	
1	On 11/02/2024, staff revealed that R1 was not seen or heard coughing or reaching for their neck and
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6	No deficiencies are being cited at this time pertaining to this self-reported death report. Exit interview
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