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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 565850112
Report Date: 08/17/2026
Date Signed: 08/17/2026 03:53:48 PM

Substantiated

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

This is an official report of an unannounced visit/investigation of a complaint received in our office on **03/03/2026** and conducted by Evaluator Garrett Haner-Tomasko

	COMPLAINT CONTROL NUMBER: 29-AS-20260303093047

FACILITY NAME:	REGENCY PALMS OXNARD		**FACILITY NUMBER:**	565850112
ADMINISTRATOR:	KENNETH MAHLER		**FACILITY TYPE:**	740
ADDRESS:	1020 BISMARK WAY		**TELEPHONE:**	(805) 247-0227
CITY:	OXNARD	**STATE:** CA	**ZIP CODE:**	93033
CAPACITY:	127	**CENSUS:** 93	**DATE:**	08/17/2026
		UNANNOUNCED	**TIME BEGAN:**	12:00 PM
MET WITH:	Sales Director - Ty Hanson		**TIME COMPLETED:**	04:15 PM

ALLEGATION(S):

1	Facility staff did not properly maintain resident’s records/logs.
2	Facility staff did not ensure to provide adequate food service, resulting in resident weight loss.
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INVESTIGATION FINDINGS:

1	At 2:00pm, on 8/17/2026, Licensing Program Analyst (LPA) Haner-Tomasko arrived at the facility
2	unannounced to deliver final findings to the allegations above. LPA met with Sales Director Ty Hanson,
3	announced who he was and the reason for the visit.
4	
5	During visits conducted on 3/4/2026, 3/11/2026, and 3/18/2026 LPAs Peraldi, Dulek, Huynh, and
6	Barutyan conducted interviews, collected relevant documentation and toured the facility. During today's
7	visit LPA toured the facility, checked the wellbeing of select residents and conducted interviews.
8	
9	On the allegation, facility staff did not properly maintain resident’s records/logs; it was alleged that the
10	facility does not keep records of daily care provided to the residents, including Resident #1 (R1). It was
11	also alleged that the facility does not keep records of when residents are sick or when staff provide them
12	assistance with adult brief changes/incontinence care.
13	(Continued on LIC9099-C)

Substantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Garrett Haner-Tomasko
LICENSING EVALUATOR SIGNATURE:
DATE: 08/17/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 08/17/2026

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

Control Number 29-AS-20260303093047

FACILITY NAME: REGENCY PALMS OXNARD **FACILITY NUMBER:** 565850112
VISIT DATE: 08/17/2026

NARRATIVE

Review of R1's preadmission assessment, medical assessment, and service plan reveal R1 is independent regarding their toileting, but does require stand-by assistance from staff with bathing and dressing.

The facilities Standard Operating Procedures states, "Staff are required to document all assistance provided with Activities of Daily Living (ADLs) using either the paper or electronic system, depending on the Community's current documentation method." Staff interviews revealed that just recently within the last couple of months they are required to document resident bowel movements, but they do not document when assistance is provided with all ADL's.

Additionally, during this investigation record review revealed that on 2/5/2026 R1 fell and cut one of their hands on a broken dish they dropped and first aid was applied. The facility's Standard Operating Procedures states, "All falls and near-falls shall be documented in the Community's eHR and Incident Report. The resident's care plan shall be reviewed and updated following a fall." It also states that after a fall a review will be conducted to identify contributing factors, evaluate effectiveness of current interventions, and implement additional preventative measures. Additionally, staff will receive training on fall risk identification, safe transfer and mobility assistance, and fall response procedures; this training will be documented in employee training records." Review of R1's records indicate R1's care plan was not updated following the fall on 2/5/2026, and staff stated that they do receive fall prevention training but do not recall receiving any additional training after resident falls, including R1's fall on 2/5/2026.

Based on all interviews conducted and documents obtained, at this time the above allegation was found to be **substantiated**, the facility is not operating in accordance with the plan of operation.

On the allegation, facility staff did not ensure to provide adequate food service, resulting in resident weight loss; it was alleged that R1 lost approximately ten (10) pounds in about twenty-two days and was not eating, staff did provide R1 full plates of food but they went untouched and staff made no note of this. Additionally, it was alleged that staff were not recording, monitoring or addressing the weight loss. According to allegations the Administrator at the time, Kenneth Mahler, stated to R1's responsible party that they should look at the menu to identify foods R1 would like and that the facility does not document if residents eat their meals.

(Continued on LIC9099-C)

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Control Number 29-AS-20260303093047

NARRATIVE

Review of R1's medical assessment dated 1/21/2026 states R1 is not on a special diet and can feed themself. The preplacement assessment dated 1/30/2026 states R1 is able to independently eat but needs to be offered specific items to choose from and the food must be placed in front of them. It also notes R1 is on a regular diet and does not have any food allergies. R1's Service Plan dated 2/3/2026 states regarding meals and nutrition that R1 is independent, requires no assistance with meal reminders or feeding support; the care team will monitor for changes in condition and conduct a reappraisal as appropriate.

The facilities Standard Operating Procedures dated states, "the Wellness Director (or designee) is responsible for ensuring resident's weight and vital signs are taken monthly, recorded, tracked and reported to the Medical Provider if abnormal. The Executive Director will ensure the Weights & Vital Signs Monitoring policy is in effect and consistently followed." It also states, "Upon admission, the Wellness Director or designated staff will obtain resident's baseline weight and baseline vital signs. Baseline data will be recorded in the resident's chart and used for comparison in ongoing monitoring." According to the procedures, a significant change in weight is defined as weight loss or gain of 5% or more within a month or 10% within six months.

Interviews and record review reveal the facility did not take R1's weight upon admission. Staff also stated that resident weights are not obtained upon admission and are not taken monthly.

Based on all interviews conducted and documents obtained, at this time the above allegation was found to be **substantiated**, since the facility did not follow their plan of operation by obtaining R1's weight and is unable to monitor R1's weight each month.

Exit interview conducted, deficiency cited on LIC809-D page, report signed, appeal rights and report provided to the Sales Director.

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DATE: 08/17/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION 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: REGENCY PALMS OXNARD **FACILITY NUMBER:** 565850112
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 08/17/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 08/31/2026 **Section Cited** CCR 87208(a)	Plan of Operation (a) The licensee shall have and maintain a current, written definitive plan of operation for the facility. The licensee shall operate the facility in accordance with the terms specified in the plan of operation and	The Sales Director states the Executive Director and Wellness Director will review the facilities Standard Operating Procedures, create a written plan of implementation including staff training on any new procedures. The plan will

	6 7	may be cited for not doing so pursuant to Health and Safety Code section 1569.49…	6 7	be emailed to the LPA on or before 8/31/2026.
	8 9 10 11 12 13 14	This requirement was not met as evidenced by: Based on interviews and record review, the licensee did not ensure the facility is operating in accordance with the plan of operation which poses a potential health, safety, and personal rights risk to persons in care.	8 9 10 11 12 13 14	
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Kelly Burley
LICENSING EVALUATOR NAME: Garrett Haner-Tomasko
LICENSING EVALUATOR SIGNATURE: **DATE:** 08/17/2026

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FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 08/17/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT

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ADMINISTRATOR: KENNETH MAHLER
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ADDRESS: 1020 BISMARK WAY
TELEPHONE: (805) 247-0227
CITY: OXNARD **STATE:** CA **ZIP CODE:** 93033
CAPACITY: 127 **CENSUS:** 93 **DATE:** 08/17/2026
UNANNOUNCED **TIME BEGAN:** 12:00 PM
MET WITH: Sales Director - Ty Hanson **TIME COMPLETED:** 04:15 PM

ALLEGATION(S):

1 2 3 4 5 6 7 8 9	Facility staff did not properly supervise resident resulting in multiple falls. Facility staff did not communicate with authorized representative in a timely manner. Facility is not ensuring that the facility is staffed effectively.

INVESTIGATION FINDINGS:

At 2:00pm, on 8/17/2026, Licensing Program Analyst (LPA) Haner-Tomasko arrived at the facility unannounced to deliver final findings to the allegations above. LPA met with Sales Director Ty Hanson, announced who he was and the reason for the visit.

During visits conducted on 3/4/2026, 3/11/2026, and 3/18/2026 LPAs Peraldi, Dulek, Huynh, and Barutyan conducted interviews, collected relevant documentation and toured the facility. During today's visit LPA toured the facility, checked the wellbeing of select residents and conducted interviews.

On the allegation, facility staff did not properly supervise resident resulting in multiple falls; it was alleged that Resident #1 (R1) fell four times in February 2026; on 2/3/2026, 2/4/2026, 2/5/2026, and 2/11/2026.

(Continued on LIC9099-C)

Unsubstantiated | **Estimated Days of Completion:**

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VISIT DATE: 08/17/2026

NARRATIVE

LPA review of R1's records reveal a medical assessment conducted on 1/21/2026 states R1 does not have motor impairment/paralysis; does not require assistance with repositioning and transferring; and R1 is not able to leave the facility unsupervised due to being a high fall risk and having cognitive difficulties. A preplacement assessment dated 1/30/2026 states R1 is able to move around a room without help from another person; has mild mobility impairment; is a fall risk due to recently starting to use a walker; they become dizzy when they stand; and they have a diagnosis of multiple systems atrophy. R1's Service Plan conducted on 3/3/2026 states regarding R1's mobility that they require verbal reminders and queuing from staff and staff are to support R1 with safe ambulation, mobility, and repositioning. It also states R1 requires assistance with observation, fall management, and uses a cane, walker, or wheelchair.

Review of incident reports submitted by the facility to Community Care Licensing (CCL) revealed no incident reports were submitted for R1 during February 2026. Internal facility accident/injury reports noted; on 2/3/2026 R1 had a change in condition, 911 was called, R1's responsible person spoke with emergency responders and the decision was made to not transport R1 to the local ER, no indication that R1 sustained a fall during this incident; and on 2/5/2026 R1 fell and cut their hand on a broken dish they dropped and first aid was applied. Records maintained by the facility for R1 document the fall occurring on 2/5/2026, as noted above, but no additional falls are noted. LPA attempted to interview the staff scheduled to provide care for R1 on 2/3/2026, 2/4/2026, 2/5/2026, and 2/11/2026; however, some of those staff are no longer employed at the facility. Staff who were interviewed stated that they do not recall R1 falling since they arrived at the facility. They stated that they do receive fall prevention training but do not recall receiving any additional training after residents fall.

The facilities Standard Operating Procedures states, "All falls and near-falls shall be documented in the Community's eHR and Incident Report. The resident's care plan shall be reviewed and updated following a fall." It also states that after a fall a review will be conducted to identify contributing factors, evaluate effectiveness of current interventions, and implement additional preventative measures. Additionally, staff will receive training on fall risk identification, safe transfer and mobility assistance, and fall response procedures; this training will be documented in employee training records.

(Continued on LIC9099-C)

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NARRATIVE

Based on all interviews conducted and documents obtained, at this time the above allegation was found to be **unsubstantiated**, meaning that the allegation may have happened or is valid, but there is not a preponderance of the evidence to prove that the alleged violation occurred. During this same visit, LPA addressed the facility's failure to follow its Plan of Operation, specifically its lack of updating R1's care plan following the fall on 2/5/2026 and its failure to provide additional staff training after the incident, despite this allegation being unsubstantiated.

On the allegation, facility staff did not communicate with authorized representative in a timely manner; it was alleged that on 2/24/2026, R1's responsible party requested documents kept by the facility regarding R1, and the facility provided the documents that day. The responsible party arranged to meet on 2/25/2026 with a medication technician (med-tech) to discuss questions they had regarding the documents. On 2/25/2026 the med-tech canceled the meeting due to an emergency. On 2/26/2026, R1's responsible party text the med-tech seeking clarification on the documents the facility provided and six hours after initially texting the med-tech, the med-tech replied.

Based on the information obtained through interviews and record review, the investigation confirmed that the facility provided requested documents on the same day they were requested, follow-up communication from the med-tech was delayed. Although incidents did cause a delay in communication, the evidence did not establish a pattern of intentional withholding of information or repeated failure to notify. Therefore, the allegation that facility staff did not communicate with R1's authorized representative in a timely manner is **unsubstantiated**.

On the allegation, facility is not ensuring that the facility is staffed effectively; it was alleged that the facility is dangerously understaffed and that residents are unsupervised. Additionally, it is alleged that mid-February 2026 a med-tech left and there was no Memory Care Director or Wellness Director.

LPA reviewed staffing schedules, time sheets, and invoices for agency staff for the month of February 2026. Documents indicated a minimum of three (3) care staff in the Assisted Living unit and three (3) care staff in the Memory Care unit during both the am and pm shift. Additionally, there was one (1) medication technician scheduled in Assisted Living and one (1) scheduled in Memory care on both shifts. The overnight shift consisted of one (1) shared medication technician and between two (2) to three (3) caregivers.
(Continued on LIC9099-C)

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NARRATIVE

Interviews revealed the Memory Care Director position is now called the Wellness Lead, they are one in the same. Records reveal the facility had a Wellness Lead all of February 2026 who left in March 2026 and in April 2026 a new employee was hired to take the position. The Wellness Director position opened in September 2025, consultants and the corporate nurse were brought in to support the empty position until it was filled in March 2026.

Based on all interviews conducted and documents obtained, at this time the above allegation was found to be **unsubstantiated**, meaning that the allegation may have happened or is valid, but there is not a preponderance of the evidence to prove that the alleged violation occurred.

Exit interview conducted, report signed, and report provided to Sales Director.

SUPERVISORS NAME: Kelly Burley
LICENSING EVALUATOR NAME: Garrett Haner-Tomasko
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