

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 565850137
Report Date: 08/13/2026
Date Signed: 08/13/2026 05:12:02 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 **05/04/2026** and conducted by Evaluator Valeria Conway

	COMPLAINT CONTROL NUMBER: 29-AS-20260504093232
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FACILITY NAME:	BERNADETTE HOME CARE IV	FACILITY NUMBER:	565850137
ADMINISTRATOR:	VILLAPANDO, GERARDO	FACILITY TYPE:	740
ADDRESS:	2131 DUNNIGAN STREET	TELEPHONE:	(805) 419-6533
CITY:	CAMARILLO	ZIP CODE:	93010
CAPACITY:	6	DATE:	08/13/2026
	STATE: CA	UNANNOUNCED TIME BEGAN:	12:00 PM
	CENSUS: 5	TIME COMPLETED:	01:30 PM
MET WITH:	Janette Villapando		

ALLEGATION(S):

1	Staff leave resident in bed for an extended period of time
2	Staff do not administer medication as prescribed
3	Staff falsify medication administration records
4	Staff do not ensure that medication is stored in its originally received container
5	Insufficient staffing
6	Facility staff did not provide meals at appropriate time frames
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9	

INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Valeria Conway conducted a subsequent complaint visit to the facility
2	above to deliver final findings of the complaint allegations. At 12:00 P.M. LPA met with Janette Villapando,
3	Administrator and explained the purpose of the visit. Today, a brief tour was conducted.
4	
5	Entrance interview conducted.
6	
7	Throughout the course of the investigation, LPA reviewed all documents obtained and the following was
8	determined:
9	
10	Continued on LIC 9099-C
11	
12	
13	

Substantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Desaree Perera LICENSING EVALUATOR NAME: Valeria Conway LICENSING EVALUATOR SIGNATURE:		DATE: 08/13/2026
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.		
FACILITY REPRESENTATIVE SIGNATURE:		DATE: 08/13/2026

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 6
Control Number 29-AS-20260504093232

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: BERNADETTE HOME CARE IV **FACILITY NUMBER:** 565850137
VISIT DATE: 08/13/2026

NARRATIVE	
1	Continued from LIC 9099
2	
3	Regarding allegation of "Staff leave resident in bed for an extended period of time" and "Insufficient
4	staffing" it was alleged that on 4/29/2026 and 4/30/2026 residents were placed in bed as early as 4:30
5	P.M. due to what seems like short staffing. Interview with the licensee and staff indicated that some
6	residents become restless during the day due to their conditions and are placed in bed early. However,
7	three (3) out of five (5) residents interviewed stated that residents are often placed in bed earlier than
8	preferred due to short staffing and indicated that they would prefer to remain out of bed longer at times.
9	Adding that once placed in bed they are not assisted out of bed until approximately 7:00 A.M. to 8:00
10	A.M. the following morning.
11	When asked about the NOC shift, residents stated that the same staff members are regularly assigned
12	to provide care during all of the shifts, adding that they have not observed the owners working the NOC
13	shift. Two (2) residents could not be interviewed due to cognitive limitations that prevented effective
14	communication. LPA requested and reviewed staff timesheets, resident care plans, and other
15	documentation presented by the Licensee. The timesheets showed that on 4/29/2026, two staff were
16	scheduled. Staff #1 worked from 8:00 A.M. to 6:00P.M., with a lunch break from 12:00 to 1:00 P.M. Staff
17	2 worked from 3:00 P.M. to 1:00 A.M. with a lunch break from 7:00 to 8:00 P.M. The reviewed timesheets
18	reflected periods when no staff were scheduled to be on duty, including during staff meal breaks and
19	after 1:00 A.M. The Licensee stated that the residents sleep throughout the night and do not require
20	supervision or repositioning during those hours. The licensee further stated that they live very close to
21	the facility, and could respond within minutes in the event of an emergency and that staffing gaps could
22	be covered by NOC staff. Licensee did not provide NOC shift staff scheduled and stated that staff are
23	verbally assigned to the NOC shift. The licensee stated that any additional time worked would be
24	documented on a separate worksheet. LPA requested the additional worksheets; however, the Licensee
25	stated that no staff claimed additional hours for the month of April 2026. Review of the residents' care
26	plans revealed that three (3) residents are wheelchair-bound and require a 2-or-3-person assistance
27	when transferring. Based on observations, documentation, and interviews, the preponderance of
28	evidence standard has been met, therefore the above allegations, "Staff leave resident in bed for an
29	extended period of time" and "Insufficient staffing" is deemed Substantiated at this time.
30	Continued on LIC 9099-C
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SUPERVISORS NAME: Desaree Perera LICENSING EVALUATOR NAME: Valeria Conway LICENSING EVALUATOR SIGNATURE:		DATE: 08/13/2026
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FACILITY REPRESENTATIVE SIGNATURE:		DATE: 08/13/2026

LIC9099 (FAS) - (06/04) Page: 2 of 6
Control Number 29-AS-20260504093232

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: BERNADETTE HOME CARE IV

FACILITY NUMBER: 565850137
VISIT DATE: 08/13/2026

NARRATIVE	
1	Continued from LIC 9099-C
2	
3	Regarding allegation of "Facility staff did not provide meals at appropriate time frames" Interview with
4	the Licensee revealed that dinner is served at around 5 P.M. every evening and breakfast is served at 7
5	A.M the next morning, adding that snacks are always available. Interviews with staff revealed that they
6	follow a daily routine, however, they were not sure exactly when dinner is served daily as times varies.
7	Three (3) out of five (5) residents interviewed revealed that periods without food are long and
8	occasionally, dinner is served too early. Regarding snacks, residents stated that they are not often
9	offered. LPA was unable to interview the other two (2) residents as they were unable to effectively
10	communicate due to loss of cognitive abilities. Records reviewed including but not limited to the
11	admission agreement, incident reports and correspondence provided by the Licensee, ratified that
12	facility staff are putting residents to bed at around 4:30 P.M. and dinner is being served before 5:00 P.M.
13	Based on observations, documentation and interviews, the preponderance of evidence standard has
14	been met, therefore the above allegations, "Facility staff did not provide meals at appropriate time
15	frames" and "Staff falsify medication administration records" is deemed Substantiated at this time.
16	
17	Regarding "Staff do not administer medication as prescribed" and "Staff falsify medication administration
18	records", the RP expressed concern that Resident #1 (R1) was placed in bed at approximately 4:30
19	P.M., after dinner, although R1's prescribed medication was scheduled to be administered at bedtime
20	(around 7:00 or 8:00 P.M.), adding that the Medication Administration Record (MAR) reflected staff
21	initials indication that R1's medication was administered at 7:00 P.M. During an interview, the Licensee
22	confirmed that R1's medication was administered at approximately 4:30 P.M. rather than at the
23	prescribed administration time. Staff stated that the medication was administered early because R1
24	usually is difficult to wake when it is time for the bedtime medication. Interviews further revealed that
25	staff were not aware that R1's medication had an order allowing it to be crushed. Medical documentation
26	review confirmed R1 has an order dated 10/15/2025 stating that R1's medication "may be crushed" and
27	a text message, from the Licensee to the current staff, containing this information was sent on the same
28	date.
29	
30	Continued on LIC 9099-C
31	
32	

SUPERVISORS NAME: Desaree Perera

LICENSING EVALUATOR NAME: Valeria Conway

LICENSING EVALUATOR SIGNATURE:

DATE: 08/13/2026

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/13/2026

FACILITY NAME: BERNADETTE HOME CARE IV

FACILITY NUMBER: 565850137
VISIT DATE: 08/13/2026

NARRATIVE	
1	Continued from LIC 9099-C
2	
3	Additionally, an incident report submitted by the Licensee to CCL, ratified that staff assisted in the self-
4	administration of Quetiapine earlier than the prescribed time before being put to bed at 4:30 P.M.
5	Furthermore, based on the interviews and documentation reviewed, the MAR did not accurately reflect
6	the time R1's medication was administered. Per staff and licensee, medication was administered at
7	approximately 4:30 P.M., while the MAR indicated administration at 7:00 P.M. Licensee, explained that
8	due to these incidents, a written memo/warning was issued to staff. Based on observations,
9	documentation and interviews, the preponderance of evidence standard has been met, therefore the
10	

11 above allegations, "Staff do not administer medication as prescribed" and "Staff falsify medication
 12 administration records" is deemed **Substantiated** at this time.

13

14 Regarding the allegation of "Staff do not ensure that medication is stored in its originally received
 15 container" it was the RP's concern that staff pre-pours resident's medication in advance. During
 16 interviews, staff confirmed that medications are pre-poured, adding that medications are placed once a
 17 week in weekly organizers and in clear cups when the scheduled administration time arrives. LPA
 18 observed that prescribed medication has been removed from their original labeled container and pre-
 19 poured into pill organizers with resident names on them. Based on observations, documentation and
 20 interviews, the preponderance of evidence standard has been met, therefore the above allegation, "Staff
 21 do not ensure that medication is stored in its originally received container" is deemed **Substantiated** at
 22 this time.

23

24 Pursuant to Title 22, California Code of Regulations and/or CA Health and Safety Code, the following
 25 deficiencies were cited at this time (refer to LIC 9099-D) with civil penalty. Administrator was informed
 26 that failure to correct the deficiencies may result in civil penalties.

27

28 Exit interview conducted, appeal rights discussed, and a copy of this report, civil penalties and appeal
 29 rights were provided.

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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
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FACILITY NAME: BERNADETTE HOME CARE IV **FACILITY NUMBER:** 565850137
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 08/13/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 08/28/2026 Section Cited CCR 87411(a)	1 87411(a) Personnel Requirements. 2 Facility personnel shall at all times be 3 sufficient in numbers, and competent to 4 provide the services necessary to meet 5 resident needs. 6 This requirement is not met as 7 evidenced by:	1 Licensee agreed to provide a plan of 2 action explaining how staff will be 3 properly scheduled to assist with all 4 residents needs. Licensee will submit 5 action plan to LPA prior to POC due 6 date. 7
	8 Based on interviews and record 9 reviews, the licensee did not comply 10 with regulations as some residents 11 needs 2-3 person assistance and the 12 schedule/timesheets shows one on 13 duty which poses a potential health and 14 safety risk to residents in care.	8 9 10 11 12 13 14
Type B 08/28/2026 Section Cited CCR 87555(b)(1)	1 General Food Service Requirements 2 (b) The following food service 3 requirements shall apply: (1) Where all 4 food is provided by the facility 5 arrangements shall be made so that 6 each resident has available at least 7 three meals per day... Not more than fifteen (15) hours shall elapse between the third and first meal. This	1 Licensee will follow what's on their 2 admission agreement regarding 3 mealtimes for ALL residents. Write a 4 statement of understanding regarding 5 this regulation and submit it to LPA prior 6 to POC due date. 7

		requirement was not met as evidenced by:	
	8 9 10 11 12 13 14	Based on record review and interviews, Licensee did not ensure that meals were given as schedule and more than 15 hours passed between dinner and breakfast which poses a potential health and safety risk to residents in care.	8 9 10 11 12 13 14

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

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FACILITY NAME: BERNADETTE HOME CARE IV

FACILITY NUMBER: 565850137

DEFICIENCY INFORMATION FOR THIS PAGE:

VISIT DATE: 08/13/2026

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 08/14/2026 Section Cited CCR 87465(c)(2)	1 Incidental Medical and Dental Care (c) 2 Once ordered by the physician the 3 medication is given according to the 4 physician's directions. This requirement 5 was not met as evidenced by: 6 7	1 Licensee conducted medication training 2 with all current staff for R1. A copy of 3 the training was provided to the LPA. 4 POC cleared. 5 6 7
	8 Based on interviews and records 9 reviewed, Licensee did not comply with 10 the above regulation as medication was 11 not given as directed as R1's 12 medication was not being crushed nor 13 at the prescribed time which poses an 14 immediate health and safety risk to residents in care.	
Type A 08/21/2026 Section Cited CCR 87465(h)(5)	1 87465 (h) The following requirements 2 shall apply to medications which are 3 centrally stored: (5) Each resident's 4 medication shall be stored in its 5 originally received container. No 6 medications shall be transferred 7 between containers. This requirement is not met as evidenced by:	1 Licensee will write a statement of 2 understanding regarding this regulation. 3 As of today, all medication is being kept 4 in its original container. POC cleared. 5 6 7
	8 Observations revealed that Licensee 9 was pre-pouring medications and 10 removing them from its original 11 container which poses an immediate 12 health and 13 14	

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: Desaree Perera
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LICENSING EVALUATOR NAME: Valeria Conway

LICENSING EVALUATOR SIGNATURE:

DATE: 08/13/2026

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