

Department of SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 195850240
Report Date: 05/21/2025
Date Signed: 05/21/2025 04:48:52 PM

Unsubstantiated

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 **05/15/2025** and conducted by Evaluator Angela Barutyan

	COMPLAINT CONTROL NUMBER: 29-AS-20250515120119
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FACILITY NAME: VARIEL OF WOODLAND HILLS, THE	FACILITY NUMBER: 195850240
ADMINISTRATOR: LOURDES BUSTAMANTE	FACILITY TYPE: 740
ADDRESS: 6233 VARIEL AVE	TELEPHONE: (818) 651-6018
CITY: WOODLAND HILLS	STATE: CA ZIP CODE: 91367
CAPACITY: 436	CENSUS: 363 DATE: 05/21/2025
MET WITH: Allison Marty	UNANNOUNCED TIME BEGAN: 10:25 AM
	TIME COMPLETED: 05:00 PM

ALLEGATION(S):

1	Resident eloped without supervision while in care.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Angela Barutyan arrived at the facility unannounced to conduct an
2	initial complaint investigation for the allegation listed above at 10:25AM. LPA met with
3	Administrator/Director of Hospitality Lourdes Bustamante and Executive Director (ED) Allison Marty and
4	explained the reason for the visit.
5	
6	During today's visit, LPA interviewed three (3) staff between 10:32AM-12:36PM, reviewed and obtained
7	copies of pertinent documents between 11:56AM-12:15PM, conducted a brief physical plant tour with
8	Director of Nursing (DON) Jessica Saks at 12:17PM, interviewed two (2) responsible parties/visitors of
9	residents between 12:23PM-01:49PM, and discussed the allegation with ED at 04:07PM.
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11	Report Continued on LIC9099-C.
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Unsubstantiated

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Kristin Heffernan
NAME OF LICENSING PROGRAM ANALYST: Angela Barutyan
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 05/21/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/21/2025

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

LIC9099 (FAS) - (06/04)

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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

**COMPLAINT INVESTIGATION REPORT
(Cont)**

FACILITY NAME: VARIEL OF WOODLAND HILLS, THE

FACILITY NUMBER: 195850240

VISIT DATE: 05/21/2025

NARRATIVE

1 It was alleged that Resident #1 (R1) who resides in the memory care (MC) unit on the seventh floor of
2 Building B eloped two (2) times. On 04/24/2025, R1 and Resident #2 (R2) went to the second-floor
3 dining room unsupervised and on 05/01/2025, R1 took the elevator outside of the MC unit to the first-
4 floor lobby and walked outside of Building B towards Building C. In both incidents, R1 did not leave
5 facility grounds, was found by staff immediately, and was unharmed, but R1 was unsupervised in the
6 elevator both times that R1 left the MC floor. Staff confirmed that MC can only be entered and exited
7 with a key fob. MC residents do not get their own key fobs, their responsible parties do upon request.
8 MC has two (2) exits, one (1) to the Assisted Living (AL) lobby and one (1) to the parking garage. LPA
9 observed MC with three (3) delayed egress doors and at 12:20PM, LPA confirmed that the MC exit
10 doors to the elevators automatically lock immediately upon closing. Staff stated that the elevators on the
11 seventh floor outside of MC can only go to the first floor without a key fob and not to floors 2-6 which
12 include the main dining room and AL units. LPA interviewed two (2) responsible parties and three (3)
13 staff who stated that R1 and R2 have left the MC floor on multiple occasions but have not left the facility.
14 R1's physician's report signed and dated 04/29/2025 documents R1 with a dementia diagnosis and
15 unable to leave the facility unassisted. However, R1 did not leave the facility. At this time, the California
16 Code of Regulations, Title 22 Section 87101(e)(3) Definitions states that "elopement" occurs when a
17 resident who is at risk of harm due to their cognitive condition leaves the facility unsupervised, or while
18 in the licensee's care, leaves another safe location unsupervised." As R1 and R2 did not leave the
19 facility unsupervised and were not missing for an extended period of time, the incidents do not fall under
20 the definition of "elopement" at this time. However, on a separate case management report, the facility
21 was cited for lack of care and supervision (see LIC 809). Based on interviews, observation, and record
22 review, the information obtained during the investigation does not have sufficient evidence to
23 corroborate the allegation. Although the allegation may have happened or is valid, there is not a
24 preponderance of evidence to prove the alleged violation did or did not occur, therefore the above
25 allegation "Resident eloped without supervision while in care" is deemed **UNSUBSTANTIATED** at this
26 time.

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28 No deficiencies cited at this time. Exit interview conducted. A copy of the report was provided.
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NAME OF LICENSING PROGRAM MANAGER: Kristin Heffernan
NAME OF LICENSING PROGRAM ANALYST: Angela Barutyan
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 05/21/2025

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/21/2025