

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 197608180
Report Date: 09/13/2025
Date Signed: 09/13/2025 11:38:05 AM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION GREATER LA AC/SC, 1000 CORPORATE CNTR DR. ST 500 MONTEREY PARK, CA 91754
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 Alberto Lopez

PUBLIC	COMPLAINT CONTROL NUMBER: 28-AS-20250515142610
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FACILITY NAME: SILVERADO SENIOR LIVING - THE HUNTINGTON FACILITY **FACILITY NUMBER:** 197608180

ADMINISTRATOR: ROCHELLE CARPIO **FACILITY TYPE:** 740

ADDRESS: 1118 N STONEMAN AVE **TELEPHONE:** (626) 308-9777

CITY: ALHAMBRA **STATE:** CA **ZIP CODE:** 91801

CAPACITY: 62 **CENSUS:** 57 **DATE:** 09/13/2025

MET WITH: Elizabeth Cruces, Business Manager, Vanessa, Rodriguez, Clinical Staff Manger. **UNANNOUNCED TIME BEGAN:** 10:48 AM

TIME COMPLETED: 11:39 AM

ALLEGATION(S):

1	Staff did not provide a resident access to a walking device
2	Staff authorized change in a resident's medical needs without proper consent
3	Staff did not prevent a resident from causing harm to another resident while in care
4	Staff left a resident unattended
5	Staff did not properly report an incident involving a resident
6	Staff did not safeguard a resident's personal belonging
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Alberto Lopez made a subsequent visit to the facility to deliver findings
2	of the above allegations. LPA met with Elizabeth Cruces, Business Manager, Vanessa, Rodriguez,
3	Clinical Staff Manger and discussed the purpose of the visit.
4	On 05/20/2025 Licensing Program Analysts (LPAs) Alberto Lopez and Elena Mallett conducted the initial
5	visit for the allegations listed above. LPAs arrived unannounced and met with Director of Health Services
6	Arienne Ghammangne. The purpose of the visit was explained.
7	During the visit today, LPA obtained copies of the staff and resident roster. Progress notes for R1,
8	Prescription for R1 dated 08/15/2024. R1 Clothing Assessment Forms (3). R1 MAR for time R1 was at
9	facility, R1 file, and Communication log for time R1 was at facility.
10	The investigation consisted of LPA reviewing and obtaining staff and resident rosters, interviewing six
11	(6) staff (S#1-S#6) and five (5) residents (R#2-R#6). R#1 has moved out of facility and is not available for
12	interview and cannot answer questions due to cognitive impairment. R#7 could not answer questions due
13	to cognitive impairment. LPA attempted to contact S#7 and S#8 several times but was unsuccessful.
	(cont)

Unsubstantiated

Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Lisa Hicks
NAME OF LICENSING PROGRAM ANALYST: Alberto Lopez
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 09/13/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 09/13/2025

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
GREATER LA AC/SC, 1000 CORPORATE CNTR
DR. ST 500
MONTEREY PARK, CA 91754

COMPLAINT INVESTIGATION REPORT (Cont)

FACILITY NAME: SILVERADO SENIOR LIVING - THE HUNTINGTON

FACILITY NUMBER: 197608180

VISIT DATE: 09/13/2025

NARRATIVE

1 (continued)
 2 The investigation revealed:
 3
 4 **1) Allegation Staff did not provide a resident access to a walking device.** It is alleged that the
 5 facility took away R1 cane and provided R1 with a walker and that the facility did not provide R1 with
 6 instructions for use. LPA interviewed six (6) staff and six (6) of (6) staff denied the allegation. S6 stated
 7 that the safety of the residents is the facility primary responsibility, and that R1 was combative and a
 8 strap on R1 cane was tearing R1 skin. R1 was provided with a walker to prevent R1 from striking other
 9 residents with the cane and to assist her in ambulating. The facility did not provide physical therapy to
 10 R1, on how to use the walker because it was not ordered by physician or required according to staff
 11 assessment completed by staff. One staff member stated that R1 was able to use walker just fine and
 12 that R1 was eventually given cane back when facility was sure R1 would not strike other residents. LPAs
 13 interviewed five (5) residents and five (5) of five (5) residents could not corroborate the allegation. Five
 14 (5) of (5) residents stated that the facility has never taken away their canes or walkers. There is
 15 insufficient evidence to support this allegation.
 16
 17 **2) Allegation: Staff authorized change in a resident's medical needs without proper consent.** It is
 18 alleged that facility pressured resident's family members into giving anti-psychotic to resident. LPA
 19 interviewed six (6) staff, and all six (6) staff denied the allegation. LPA interviewed five (5) residents, and
 20 all five (5) residents could not corroborate the allegations. R1 was admitted on 07/20/2024 and moved
 21 out on 08/18/2024. According to S3, R1 was prescribed an anti-psychotic for aggression and being
 22 combative on 08/15/2025. S3 stated S3 never personally administered the anti-psychotic due to her
 23 schedule. S1 stated physician is always consulted first and that the family/responsible party along with
 24 resident's physician make the final decision for any new medication(s). Record reviewed showed that
 25 R1 physician ordered the anti-psychotic, and family/responsible party agreed, for agitation with start
 26 date of 08/16/2024. There is no evidence that family was pressured into authorizing anti-psychotic for
 27 resident.
 28
 29 **3) Allegation: Facility staff do not intervene when resident's engage in physical altercations.** It is
 30 alleged that R1 had an altercation with another resident and the staff did not intervene. LPA interviewed
 31 six (6) staff, and all six (6) staff denied the allegation. No staff witness any altercation between residents.
 32 One staff stated resident was found on floor by staff on duty and SIR submitted to the department. LPA
 interviewed five (5) residents and five (5) of five (5) residents could not corroborate the allegation. All
 five (5) residents stated they have never witnessed resident on resident violence at facility. There is not
 enough evidence to show that staff allowed aggressive behavior between residents.

(continued)

NAME OF LICENSING PROGRAM MANAGER: Lisa Hicks
NAME OF LICENSING PROGRAM ANALYST: Alberto Lopez
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 09/13/2025

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

FACILITY REPRESENTATIVE SIGNATURE: DATE: 09/13/2025

LIC9099 (FAS) - (06/04)

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Control Number 28-AS-20250515142610

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
**COMPLAINT INVESTIGATION REPORT
(Cont)**

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
GREATER LA AC/SC, 1000 CORPORATE CNTR
DR. ST 500
MONTEREY PARK, CA 91754

FACILITY NAME: SILVERADO SENIOR LIVING - THE HUNTINGTON

FACILITY NUMBER: 197608180

VISIT DATE: 09/13/2025

NARRATIVE

1 (continued)

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4) Allegation: Staff left a resident unattended. It is alleged that resident was left unattended. LPA interviewed six (6) staff, and all six (6) staff denied the allegation. One staff member stated that the resident was not left unattended, that a staff member was present and assisting another resident when the staff found resident on the floor outside in the hallway. Five (5) of five (5) residents could not corroborate the allegation and one resident stated that staff are always "watching us" and provide us with good service. Staff stated that facility checks on residents every 2 hours. There is insufficient evidence to support this allegation.

5) Allegation: Staff did not properly report an incident involving a resident. It is alleged that facility did not report what happened involving resident incident to family on 08/17/2024. Facility reported that R1 was found on the floor in the hallway by staff on duty. Family member stated that contracted staff (S7) contacted the family and left voice mail on family member phone telling family member that resident was pushed to the ground by another resident and taken to hospital due to complaining of pain in left hip area. Also, S1 stated S1 contacted family the next day. One staff member stated that the facility reported the incident as reported by the staff (S8) who found R1 on the floor. S7 left the message, however S7 was contracted staff. Facility Administrator (S6) stated that S7 was authorized to provide information to the family but that S7 may have interpreted the facts differently since S7 did not witness the incident. LPA was unsuccessful in reaching S7 that left the message and the staff (S6) that found the resident on the floor after several attempts to do so. Neither staff are employed by the facility nor provide service to facility any longer. The evidence shows that facility staff (S7) contacted the family on the day of the incident and family acknowledged that fact, but family felt that it was not an official contact since "permanent" staff did not contact them right away. There is insufficient evidence to support this allegation.

6) Staff did not safeguard a resident's personal belongings. It is alleged that the facility never returned resident's phone charger after she left the facility. LPA interviewed six (6) staff, and all six (6) staff denied the allegation. LPA interviewed five (5) residents and five (5) of five (5) residents could not corroborate any lost or stolen items. One staff stated staff completes an inventory list when residents move in, and record review of resident personal property inventory form showed no phone charger on the list. Staff stated the facility does everything they can to safeguard residents personal property, but things do get separated from residents from time to time. S6 stated S6 personally handed the charger to R1 responsible party. There is insufficient evidence to support this allegation.

Although the allegations may have happened or are valid, there is not a preponderance of evidence to prove the alleged violations did or did not occur, therefore the allegations are UNSUBSTANTIATED.

An exit interview was conducted with Elizabeth Cruces, Business Manager, Vanessa, Rodriguez, Clinical Staff Manger A copy of this report along with the appeal rights were provided.

NAME OF LICENSING PROGRAM MANAGER: Lisa Hicks

NAME OF LICENSING PROGRAM ANALYST: Alberto Lopez

LICENSING PROGRAM ANALYST SIGNATURE: DATE: 09/13/2025

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 09/13/2025