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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 198320197
Report Date: 08/29/2025
Date Signed: 08/29/2025 04:20:02 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION EL SEGUNDO ASC, 1000 CORPORATE DR #100 MONTEREY PARK, CA 91754

This is an official report of an unannounced visit/investigation of a complaint received in our office on **08/21/2025** and conducted by Evaluator Wendy Gibbs

	COMPLAINT CONTROL NUMBER: 11-AS-20250821121316

FACILITY NAME:	PLAZA AT WESTWOOD, THE			**FACILITY NUMBER:**	198320197
ADMINISTRATOR:	LUZ EMMA ROSE			**FACILITY TYPE:**	740
ADDRESS:	2228 WESTWOOD BLVD			**TELEPHONE:**	(310) 475-8861
CITY:	LOS ANGELES	**STATE:** CA		**ZIP CODE:**	90064
CAPACITY:	136	**CENSUS:** 64		**DATE:**	08/29/2025
		UNANNOUNCED		**TIME BEGAN:**	09:07 AM
MET WITH:	Selena Cruz			**TIME COMPLETED:**	04:25 PM

ALLEGATION(S):

1	Staff do not accord dignity to resident in care.
2	Staff are not preventing resident in care from harassing other resident in care.
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INVESTIGATION FINDINGS:

1	On 08/29/2025, Licensing Program Analyst (LPA), Wendy Gibbs, conducted an unannounced Complaint
2	Visit to the facility listed above. LPA met with Administrator Assistant, Selena Cruz, and the purpose of
3	today's visit was explained. LPA was granted entry into the facility.
4	The investigation consisted of the following:
5	During the initial visit conducted on 08/28/2025, LPA inspected the facility, interviewed Staff S1,
6	interviewed Residents R1-R7, and received and reviewed documents pertinent to the investigation. The
7	following documents were received and reviewed Staff Roster, Resident Roster, resident's Admission
8	Agreement, resident's Personal Rights of Residents in Privately Operated Residential Care Facilities for
9	the Elderly, the Plaza at Westwood General Facility Information and House Rules, Identification and
10	Emergency Information, Appraisal/Needs and Services Plan, resident's Physician's Report, staff Training
11	Logs (dated 03/18/2025, and Unusual Incident/Injury Report (dated 08/09/2025 and 08/15/2025).
12	During today's visit LPA interviewed Staff S2-S7 and received and reviewed additional documents. The
13	document received and reviewed was an Internal Incident Report (dated 08/09/2025), and meeting notes
	between S1 and R1 (dated 08/11/2025).

Unsubstantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Eva M Alvarez
NAME OF LICENSING PROGRAM ANALYST: Wendy Gibbs
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 08/29/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 08/29/2025

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

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: PLAZA AT WESTWOOD, THE **FACILITY NUMBER:** 198320197
VISIT DATE: 08/29/2025

NARRATIVE

The investigation revealed the following:
Allegation: Staff do not accord dignity to resident in care
The allegation alleges that a resident tried to see the administrator and the door was closed and locked by staff and the administrator has not spoken to the resident about the incidents that have occurred at the facility.
LPA received and reviewed staff In-Service Training Logs, regarding the Personal Rights of Residents signed and dated 03/18/2025. During the facility tour, LPA observed the Personal Rights of Residents posted in the hallway. LPA received and reviewed R1's Personal Rights of Residents in Privately Operated Residential Care Facilities for the Elderly signed and dated on 08/20/22, that states on page 2, they have the right "to be accorded dignity in their personal relationships with staff, residents, and other persons." LPA received and reviewed documentation of S1 and R1 discussing the incidents that occurred that are signed and dated 08/19/2025.
During interviews with Staff S1-S7, were asked if residents are treated with dignity, seven (7) out of seven (7) stated residents are treated with dignity.
During interviews with Residents R1-R7 were asked if they are treated with dignity by staff, seven (7) out of seven (7) stated yes, they are treated with dignity by staff. Additionally, two (2) out of the seven (7) stated some of the staff can be rude.
During the course of the investigation, LPA was unable to find evidence to support the allegation(s). Although the allegation(s) may have happened or is valid, there is no preponderance of evidence to prove the alleged violation(s) did or did not occur, therefore the allegation is **unsubstantiated**.

Allegation: Staff are not preventing resident in care from harassing other resident in care.

The allegation alleges that a resident is being harassed by other residents who are making false allegations about them.
During record review, LPA received and reviewed residents General Facility Information and House Rules provided to residents upon move-in, that states in number 3. "Disruptive or violent resident behavior: Disruptive or violent behavior whether it is verbal or physical abuse towards staff or other residents is unacceptable. The facility administrator will arrange a meeting with the resident and their responsible party to discuss any incident to ensure that such actions do not happen again. A second incident may result in a written warning that any continued disruptive or violent behavior can result in a notice of eviction." Additionally, LPA received and reviewed incident reports dated 08/09/2025 and 08/15/2025, regarding police officers responding to the facility due to interactions between R1-R3. On 08/09/25, staff S8 heard R1 and R2 yelling at each other in R2's room. According to R1 and R2, they were arguing about money, towels, and a walker. S8 separated the residents and escorted R1 to their room. At 10:50PM S3 reported police

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VISIT DATE: 08/29/2025

NARRATIVE

had arrived. Police spoke with residents and staff. The police officers determined it was a civil matter and recommended staff to keep the residents separated. On 08/15/2025 at 8:45PM, R3 spoke with S4. R3 told S4 they wanted to call the police because they were afraid of R1. S4 told R3 that it's their right to call and make a report. During an interview with S4, stated R3 told them they were afraid R1 was going to hit them. Police officers came to the facility and spoke with residents involved in the incident. During interviews with Staff S1, stated Residents R1-R3 have been advised not to interact with one another, and that staff are present in common areas and during activities to ensure residents do not have a confrontation.

During interviews with Staff S1-S7, were asked how they ensure a resident does not harass another resident, seven (7) out of seven (7) stated they provide supervision to residents while in common area, and if residents have an issue with another resident staff speak with them to resolve the issue or to ensure it does not escalate.

During interviews with Residents R1-R7, were asked if they have been harassed by another resident, five (5) out of seven (7) stated no, they have not been harassed by a resident. Additionally, Residents R1-R7, were asked if staff prevent residents from harassing other residents, six (6) out of seven (7) stated yes, staff are there to prevent incidents and ensure there is no harassment.

During the course of the investigation, LPA was unable to find evidence to support the allegation(s). Although the allegation(s) may have happened or is valid, there is no preponderance of evidence to prove the alleged violation(s) did or did not occur, therefore the allegation is **unsubstantiated**.

No deficiencies were observed or cited during today's visit.

An exit interview was conducted with Administrator Assistant, Selena Cruz, and a copy of this report was provided.

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