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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 198320514
Report Date: 07/08/2026
Date Signed: 07/08/2026 01:21:29 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 **04/22/2026** and conducted by Evaluator Wendy Gibbs

	COMPLAINT CONTROL NUMBER: 11-AS-20260422095123

FACILITY NAME:	SILVERADO ROLLING HILLS			**FACILITY NUMBER:**	198320514
ADMINISTRATOR:	GIUNTO, TAYLOR			**FACILITY TYPE:**	740
ADDRESS:	2455 PACIFIC COAST HWY			**TELEPHONE:**	(949) 240-7200
CITY:	TORRANCE	**STATE:** CA		**ZIP CODE:**	90505
CAPACITY:	68	**CENSUS:** 66		**DATE:**	07/08/2026
		UNANNOUNCED		**TIME BEGAN:**	08:14 AM
MET WITH:	Christina Hale			**TIME COMPLETED:**	01:30 PM

ALLEGATION(S):

1	Staff handled resident in a rough manner, resulting in bruising
2	Staff did not properly report incident
3	Staff do not have the required training
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INVESTIGATION FINDINGS:

1	On 07/08/2026, Licensing Program Analyst (LPA), Wendy Gibbs, conducted a subsequent unannounced
2	Complaint Visit to the facility listed above. LPA met with Christina Hale, Executive Director, and the
3	purpose of 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 04/29/2026, LPA inspected the facility, interviewed Staff S1-S9, and
6	received documents pertinent to the investigation. LPA received and reviewed the following documents,
7	Staff Roster, Resident Roster, Admission Agreement (dated 10/14/2025) , Progress Notes (dated
8	11/04/2025 to 02/20/2026), Resident Incident Logs, electronic Medication Administration Record (eMAR),
9	Routine Wellness Observation Results (dated 01/29/2026), Nursing Admission Evaluation Results (dated
10	10/16/2025 and 02/12/2026), Health and Service Evaluation Results (dated 10/21/2025), Physician's
11	Report (dated 10/08/2025), Unusual Incident/Injury Report (dated 02/25/2026 & 02/12/2026), and eight
12	(8) staff Relias Transcripts.
13	During today's visit, LPA interviewed Residents R2-R8 and Residents Responsible Party W2-W4.

Unsubstantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Eva M Alvarez

LICENSING EVALUATOR NAME: Wendy Gibbs
LICENSING EVALUATOR SIGNATURE:
DATE: 07/08/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 07/08/2026

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

Control Number 11-AS-20260422095123

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
EL SEGUNDO ASC, 1000 CORPORATE DR #100
MONTEREY PARK, CA 91754

FACILITY NAME: SILVERADO ROLLING HILLS **FACILITY NUMBER:** 198320514
VISIT DATE: 07/08/2026

NARRATIVE

The investigation revealed the following:

Allegation: Staff handled resident in a rough manner, resulting in bruising

The allegation alleges that a resident had unexplained bruising, and the family thinks the resident was handled in a rough manner.

During the facility visit, LPA observed residents being assisted with transferring and ambulating. LPA observed staff's hands were properly placed while assisting to ensure safe ambulation and a safe transfer.

During record review, LPA received and reviewed eight (8) staff's Relias Transcripts and observed eight (8) out of eight (8) staff have received training in Performing Safe Transfers. In reviewing the Service Plan, LPA observed R1 "requires frequent "hands on assistance with transfers and/or change in position.

During interviews with Staff S1-S9, were asked if they have or have observed staff handle a resident in a rough manner, nine (9) out of nine (9) stated no, they have not observed staff handling a resident in a rough manner. Additionally, Staff S1-S9, were asked what they would do if they observed staff handling a resident, nine (9) out of nine (9) stated they would step in to take over assistance and would report it.

During interviews with Residents R2-R8, were asked if they have been handled by staff in a rough manner, seven (7) out of seven (7) stated no, staff have not handled them in a rough manner.

During interviews with resident's Responsible Party W2-W4, were asked if they have any concerns regarding their resident being handled in a rough manner, three (3) out of three (3) stated no, they have no concerns regarding their resident being handled in a rough manner.

Allegation: Staff did not properly report an incident

The allegation alleges that when the family was notified of a resident's fall, they were not informed the resident sustained an injury.

During record review, LPA received and reviewed resident R1's Admission Agreement that on page 6, under F. Notification of Resident Representative Upon Significant Change of Condition states that states "In the event that you experience a significant change in condition or require emergency medical attention, Silverado will attempt to contact your designated resident representative by telephone within twelve (12) hours. LPA received and reviewed the Progress Notes and observed on 02/02/2026 R1 experienced a fall and it was noted that R1's the Responsible Party was notified in person. Additionally, on 02/05/2026, R1 was placed on Alert Charting, and the Progress Notes indicate R1's Responsible Party was Made aware of this and was on their way to the facility. LPA received and reviewed three Unusual Incident/Injury Report's faxed to Community Care Licensing (CCL), regarding R1. The first fax was received on 02/03/2026 at 5:00pm, regarding R1 experiencing a fall resulting in an injury 02/05/2026 at 4:21pm, regarding R1 experiencing abdominal pain and being transferred to the Emergency Room. The third fax was received on 02/13/2026 at 12:55pm regarding R1 experiencing a change of condition on 02/12/2026.

SUPERVISORS NAME: Eva M Alvarez
LICENSING EVALUATOR NAME: Wendy Gibbs
LICENSING EVALUATOR SIGNATURE:
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FACILITY REPRESENTATIVE SIGNATURE:
DATE: 07/08/2026

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
EL SEGUNDO ASC, 1000 CORPORATE DR #100
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VISIT DATE: 07/08/2026

NARRATIVE

During interviews with Staff S1-S9, were asked if residents' families are notified of all incidents, nine (9) out of nine (9) stated yes, families are notified of any incidents regarding their resident. Additionally, Staff S1-S9, were asked if incidents were reported to Community Care Licensing, nine (9) out of nine (9) stated yes, incidents are reported to Community Care Licensing.
During interviews with Residents R2-R8, were asked if their family is notified of any incidents, seven (7) out of seven (7) stated to their knowledge their responsible parties are notified of any incidents.
During interviews with resident's Responsible Party W2-W4, were asked if they have any concerns regarding incidents being reported to them, three (3) out of three (3) stated they are informed by staff of all incidents.

Allegation: Staff do not have the required training

The allegation alleges that staff lack the required training to know how to respond to incidents.
During the facility visit, emergency personnel (911) were called to evaluate a resident and transfer the resident to the emergency room. LPA observed staff were trained on when to call emergency personnel, how to support the resident while awaiting emergency personnel, and the documents prepared and ready to go when emergency personnel arrived.
During record review, LPA received and reviewed staff Relias Transcripts for eight (8) staff. LPA observed eight (8) out of eight (8) staff have received between 25.25 hours and 51.97 hours for training since 04/01/2025.
During interviews with Staff S1-S9, were asked if they received training regarding assisting resident, nine (9) out of nine (9) stated yes, they have received training regarding assisting residents.
During interviews with Residents R2-R8, were asked if they feel staff are trained to assist residents, seven (7) out of seven (7) stated yes, they believe staff are properly trained.
During interviews with residents' Responsible Party W2-W4, were asked if they have any concerns regarding staff training, three (3) out of three (3) stated no, they have no concerns regarding staff training.

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(s) is/are **unsubstantiated**.

LPA did not observe or cite any deficiencies.

An exit interviews was conducted with Christian Hale, Executive Director, and a copy of this report was provided.

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LICENSING EVALUATOR NAME: Wendy Gibbs
LICENSING EVALUATOR SIGNATURE:
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