

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 198603504
Report Date: 08/13/2026
Date Signed: 08/13/2026 02:38:06 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 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 **07/13/2026** and conducted by Evaluator Noemi Galarza

PUBLIC	COMPLAINT CONTROL NUMBER: 28-AS-20260713153031
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FACILITY NAME:	LA POSADA	FACILITY NUMBER:	198603504
ADMINISTRATOR:	COLLEEN ROZATTI	FACILITY TYPE:	740
ADDRESS:	8120 PAINTER AVE	TELEPHONE:	(562) 945-2651
CITY:	WHITTIER	ZIP CODE:	90602
CAPACITY:	114	DATE:	08/13/2026
		UNANNOUNCED TIME BEGAN:	08:57 AM
MET WITH:	Colleen Rozatti, Executive Director	TIME COMPLETED:	02:40 PM

ALLEGATION(S):

1	Staff neglect resulted in resident's death.
2	Staff did not report a change in condition to resident's representative.
3	Staff did not follow isolation procedures for illness.
4	Facility did not provide records to resident's representative.
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Galarza conducted a subsequent complaint investigation visit regarding the above allegations. The purpose of the visit was explained to Executive Director Colleen Rozatti.
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3	
4	The investigation consisted of the following: On 7/15/2026, record review was completed, resident (R1's)
5	file documents and infection control plan were obtained, and staff (S1-S4) were interviewed. During
6	today's visit, the physical plant was toured, additional record review was completed and staff (S5-S7) and
7	residents (R2- R9) were interviewed.
8	
9	Report continuation- see LIC 9099C
10	
11	
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Unsubstantiated	Estimated Days of Completion:
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SUPERVISORS NAME: Lisa Hicks	
LICENSING EVALUATOR NAME: Noemi Galarza	
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 3
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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: LA POSADA	FACILITY NUMBER: 198603504
	VISIT DATE: 08/13/2026

NARRATIVE	
1	Allegation: Staff did not follow isolation procedures for illness. It is alleged that the Memory Care
2	Unit did not have infection control isolation procedures in place because on January 31, 2026, during a
3	visit no staff or residents were observed wearing masks, and no PPE containers were observed in the
4	unit. According to information obtained, only a suction canister was observed inside deceased resident
5	(R1's) room. Based on interviews conducted, the findings indicate that once Memory Care Unit staff
6	learned that R1's roommate had RSV, infection control practices were put in place. R1's roommate was
7	isolated in a different room, and when R1 returned from the hospital the resident was isolated by
8	themselves in their room. Records indicate that R1's roommate returned to the facility on 1/7/2026, and
9	was isolated and quarantined for 5 days. Per interviews, doctors determine the number of isolation days,
10	and if the facility is unable to accommodate the resident(s) the hospital transfers residents to a skilled
11	nursing facility. Staff denied the allegation and stated they follow orders. There is insufficient supporting
12	information to confirm the allegation.
13	
14	Allegation: Facility did not provide records to resident's representative. It is alleged that on March
15	12, 2026, resident (R1's) representatives met with Resident Care Coordinator, new Wellness Director,
16	and hospice nurse to discuss the reason R1's was sent out to the emergency room on January 26, 2026
17	despite being enrolled in hospice care. The complaint alleges that R1's representative was informed that
18	R1 and their roommate were not fully isolated due to capacity constraints. According to information
19	obtained, R1's records were requested on March 9, 2026 and no response was received. Based on staff
20	interviews, a meeting was held because R1's representative requested documents. Staff stated that the
21	resident's Medical Assessment, hospice documents, and medication list was provided to the
22	representative. According to staff, facility provides a summary email to representatives regarding
23	incident report details, but no internal documents. Administration staff stated families/authorized
24	representatives have access to resident file documents via August Health electronic health records, and
25	are able to print the documents. The facility requires all document requests be emailed, unless it is a
26	request from a law firm. There is insufficient evidence to support the allegation.
27	
28	Although the allegations may have happened or are valid, there is not a preponderance of evidence to
29	prove the alleged violation(s) did or did not occur, therefore the allegations are Unsubstantiated .
30	
31	An exit interview was conducted with Executive Director Colleen Rozatti. A copy of the report was
32	issued.

SUPERVISORS NAME: Lisa Hicks	
LICENSING EVALUATOR NAME: Noemi Galarza	
LICENSING EVALUATOR SIGNATURE:	DATE: 08/13/2026
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FACILITY REPRESENTATIVE SIGNATURE:	DATE: 08/13/2026

LIC9099 (FAS) - (06/04) Page: 3 of 3
Control Number 28-AS-20260713153031

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COMPLAINT INVESTIGATION REPORT
(Cont)

DR. ST 500
MONTEREY PARK, CA 91754

FACILITY NAME: LA POSADA

FACILITY NUMBER: 198603504

VISIT DATE: 08/13/2026

NARRATIVE

1 **Allegation: Staff neglect resulted in resident's death.** The complaint alleges that on January 26,
2 2026 resident (R1) was sent to the emergency room with a fever and unresponsive, but earlier that day
3 the resident was alert, communicative, and in stable health. A total of 7 staff were interviewed. Six out of
4 seven staff denied the allegation. Staff interviews revealed that resident (R1's) roommate had
5 Respiratory Syncytial Virus (RSV) without symptoms, but changes to their baseline were noted.
6 According to staff interviews, a few days later resident (R1) began displaying changes to their baseline
7 and was sent out to the hospital for an evaluation because a change in condition was noted. Record
8 review was completed. The findings indicate resident (R1) was enrolled in hospice at the time of death.
9 According to facility records, on January 12, 2026, care staff noted changes in R1 i.e., lethargy and
10 change in appetite. Resident (R1's) roommate was diagnosed with RSV on January 2,/2026, and
11 returned to the facility on January 7, 2026. Upon return R1's roommate was isolated in a different room
12 and quarantined for 5 days. Resident (R1) was sent out to the hospital on January 26, 2026 at
13 approximately 11:56 PM and returned to the facility on January 27, 2026 at approximately 2:40 AM with
14 oxygen. Hospice was notified. Resident (R1) showed signs of decline. Care staff notified hospice
15 accordingly. On January 29, 2026, hospice sent out a bed side nurse for the night. Resident (R1)
16 passed away on January 30, 2026 at 6:15 AM. The Death Certificate lists the cause of death as acute
17 cardiopulmonary arrest and Senile Dementia. There is insufficient evidence to support the allegation.
18
19
20 **Allegation: Staff did not report a change in condition to resident's representative.** It is alleged
21 facility staff did not communicate or was honest with the resident's representative that resident (R1) was
22 experiencing changes and decline, until before transporting R1 to the hospital because the resident had
23 a fever. It is also alleged that facility staff did not inform R1's representative that the resident was
24 exposed to RSV. Based on staff interviews, former Executive Director did not immediately notify Memory
25 Care Unit staff that R1's roommate had confirmed RSV. According to staff, once they received
26 information, they started isolating resident (R1). Staff stated that resident's responsible parties are
27 immediately notified of any change in condition. Records indicate that R1's representative was
28 contacted telephonically by facility staff whenever there was a change in condition. Residents
29 interviewed did not agree with the allegation. They stated that staff promptly notify their responsible
30 parties when there are changes in condition. The findings indicate their is insufficient information to
31 support the allegation.
32

SUPERVISORS NAME: Lisa Hicks
LICENSING EVALUATOR NAME: Noemi Galarza
LICENSING EVALUATOR SIGNATURE:

DATE: 08/13/2026

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FACILITY REPRESENTATIVE SIGNATURE:

DATE: 08/13/2026