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Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306000831
Report Date: 01/26/2026
Date Signed: 01/26/2026 04:45:25 PM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 770 THE CITY DR., SUITE 7100 ORANGE, CA 92868

This is an official report of an unannounced visit/investigation of a complaint received in our office on **08/06/2021** and conducted by Evaluator Sean Haddad

PUBLIC	COMPLAINT CONTROL NUMBER: 22-AS-20210806122628

FACILITY NAME:	BROOKDALE GARDEN GROVE			**FACILITY NUMBER:**	306000831
ADMINISTRATOR:	PAMELA BRADLEY			**FACILITY TYPE:**	740
ADDRESS:	10200 CHAPMAN AVE			**TELEPHONE:**	(714) 636-6453
CITY:	GARDEN GROVE	**STATE:** CA		**ZIP CODE:**	92840
CAPACITY:	140	**CENSUS:** 118		**DATE:**	01/26/2026
		UNANNOUNCED		**TIME BEGAN:**	02:40 PM
MET WITH:	Brisseth Arrellano			**TIME COMPLETED:**	05:00 PM

ALLEGATION(S):

1	Resident sustained unexplained injury while in care.
2	Resident's room has bed bugs.
3	Resident's room has pests.
4	Toiletries not provided to resident.
5	Staff not maintaining residents hygiene.
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7	
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INVESTIGATION FINDINGS:

1	This unannounced inspection is being conducted by Licensing Program Analyst (LPA) Sean Haddad for
2	the purpose of delivering findings for the investigation into the above identified complaint allegations. LPA
3	met with Administrator (AD) Brisseth Arrellano and explained the reason for today's inspection.
4	
5	The investigation into the allegations that a resident sustained unexplained injury while in care, resident's
6	room has bed bugs, resident's room has pests, toiletries not provided to resident, and staff not
7	maintaining resident's hygiene revealed the following: During the course of the investigation, LPA
8	inspected the facility, interviewed AD, staff. witnesses, and residents, and obtained and reviewed copies
9	of the resident roster, staff roster, Resident #1's (R1) service plan dated August 12, 2021, R1's facility
10	progress notes, pest control invoices, and the facility's shower schedule.
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12	
13	

Unsubstantiated	Estimated Days of Completion:

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Sean Haddad
LICENSING EVALUATOR SIGNATURE:
DATE: 01/26/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 01/26/2026

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

Control Number 22-AS-20210806122628

FACILITY NAME: BROOKDALE GARDEN GROVE **FACILITY NUMBER:** 306000831
VISIT DATE: 01/26/2026

NARRATIVE

Regarding the allegation that resident sustained unexplained injury while in care: it was alleged that on May 11, 2021, R1 had a fall, was taken to the hospital with unknown injuries, stayed at a skilled nursing facility for three days, and then returned to the facility. It was also alleged that on July 27, 2021, blood was observed on the back of R1's head, R1 was unable to recall what happened, and staff were unable to explain what happened. LPA interviewed the facility's wellness director at the time who stated that R1 did have many falls, including one in May 2021 where R1's head started bleeding, and R1 was sent to the hospital due to this fall. LPA attempted to interview R1, but R1 is no longer a resident of the facility. LPA interviewed four residents who reported no issues with the care they receive at the facility. LPA reviewed R1's service plan dated August 12, 2021, which indicates R1 is on fall precautions. LPA reviewed R1's facility progress notes which document that R1 had multiple falls, none of which resulted in fractures. Per R1's facility progress notes, on May 10, 2021, R1 was found on the floor bleeding from their head and was taken to the hospital. R1's facility progress notes do not contain an entry for the reported July 27, 2021, injury. LPA interviewed AD who stated that R1 did not have any fractures from these recent falls and, although R1 was sent to the hospital in relation to some falls, R1 was not hospitalized and was instead returned to the facility each time. LPA interviewed R1's responsible party who stated that the facility took proper measures to address R1's falls and that the most recent fall occurred around May 11, 2021, and resulted in a head laceration that was being treated by R1's doctor. Although R1 had recent falls, the information obtained did not corroborate that R1 sustained any serious injuries or that the facility did not obtain timely medical care for R1.

Regarding the allegation that resident's room has bed bugs: it was alleged that R1's room and mattress are infested with bed bugs and that on May 11, 2021, R1 was found on the floor by a caregiver due to bed bugs feeding on R1. LPA interviewed the administrator at the time who stated that the facility did have an issue with bed bugs which began in R1's room and spread to nearby rooms, the facility immediately relocated R1 to another room with bed bug precautions, the facility then called a pest control company that treated the affected rooms for bed bugs, called in a second pest control company that treated the entire floor, and had a bed bug sniffing dog check for bed bugs. LPA interviewed the facility's wellness director at the time who stated that there were bed bugs in R1's room, but they were addressed. LPA attempted to interview R1, but R1 is no longer a resident of the facility. LPA interviewed four residents who reported no issues with bed bugs in their room, and two of the residents were aware that the facility had a bed bug issue that was addressed by the facility and one resident confirmed that a bed bug sniffing dog was used as reported by the administrator at the time.

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Control Number 22-AS-20210806122628

NARRATIVE

LPA and the administrator at the time used an ultraviolet flashlight to inspect six rooms in the area affected by bed bugs, including R1's original room, and observed no evidence of continued bed bug infestation. LPA reviewed pest control invoices corroborating that two pest control companies provided bed bug treatments, a bed bug sniffing dog was also used, and one of the pest control companies cleared the facility of bed bugs on August 6, 2021. LPA interviewed R1's responsible party who was concerned that the bed bugs were discovered in R1's room, but provided no information corroborating that the facility did not handle the bed bug situation properly. Although bed bugs were found in R1's room, the information obtained showed that the facility addressed the situation properly.

Regarding the allegation that resident's room has pests: it was alleged that R1's room and bed have ants. LPA interviewed the administrator at the time who denied there are issues with pests or other ants, stating that the facility's pest control company monitors the entire building for pests regularly. LPA attempted to interview R1, but R1 is no longer a resident of the facility. LPA interviewed four residents who reported no issues with pests in their rooms. LPA and the administrator at the time used an ultraviolet flashlight to inspect six rooms in the area around R1's room and observed no evidence of pests of any kind. LPA reviewed pest control invoices corroborating that two pest control companies provided pest control services to the facility. LPA interviewed R1's responsible party who stated that the ants were addressed as soon as they reported it to the facility.

Regarding the allegation that toiletries not provided to resident: it was alleged that on May 25, 2021, R1's room had no toiletries. LPA interviewed the facility's wellness director at the time who stated that R1 was moved to a new room due to bed bugs in their old room, nothing was transferred from their old room to their new room due to bed bug precautions, so facility staff gave R1 toiletries that they had on hand as R1's toiletries were left in their old room. LPA attempted to interview R1, but R1 is no longer a resident of the facility. LPA interviewed four residents who reported no issues with toiletries, with one resident confirming that the facility provides toiletries to residents. LPA interviewed R1's responsible party who stated that when R1 was relocated to a new room, their toiletries and other belongings were not relocated with them, but stated this did not have a significant impact on R1. Although R1's toiletries were not relocated to R1's new room due to bed bug precautions, the investigation did not reveal that R1 went a long period without access to toiletries or that the facility did not provide toiletries to R1 when they were requested.

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 770 THE CITY DR., SUITE 7100
ORANGE, CA 92868

FACILITY NAME: BROOKDALE GARDEN GROVE **FACILITY NUMBER:** 306000831
VISIT DATE: 01/26/2026

NARRATIVE

Regarding the allegation that staff not maintaining residents' hygiene: it was alleged that R1 went a week and a half without bathing. LPA interviewed the facility's wellness director at the time who stated they were unaware of any issues with R1's showers. LPA attempted to interview R1, but R1 is no longer a resident of the facility. LPA interviewed four residents who reported no issues with showers, with one resident confirming they get all the showers they need. LPA reviewed R1's service plan dated August 12, 2021, which confirms R1 needed assistance with showers and they were scheduled for two showers a week. LPA reviewed the facility's shower schedule which shows R1 was scheduled for two showers a week. LPA interviewed R1's responsible party who stated that on one occasion they noticed that R1 had body odor and their hair was oily, they raised this concern to the facility, and R1's showers were increased which addressed the problem. Per AD, the facility does not have shower logs from that period.

Based on the information gathered during the investigation and review of all documents obtained, the Department is unable to ascertain if the above allegations occurred as reported. Although the allegations may have happened or are valid, there is not a preponderance of evidence to prove or refute the alleged violations occurred; therefore, these allegations are deemed Unsubstantiated. An exit interview was conducted and a copy of this report was discussed with and provided to facility representative.

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