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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 306005652
Report Date: 01/06/2026
Date Signed: 01/06/2026 11:29:54 AM

Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION ORANGE COUNTY RO, 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 **07/06/2023** and conducted by Evaluator Hanna Gough

	COMPLAINT CONTROL NUMBER: 22-AS-20230706102447

FACILITY NAME:	SILVERADO BREA LLC		**FACILITY NUMBER:**	306005652
ADMINISTRATOR:	VALENCIA, VANESSA		**FACILITY TYPE:**	740
ADDRESS:	149 W LAMBERT RD		**TELEPHONE:**	(714) 598-2052
CITY:	BREA	**STATE:** CA	**ZIP CODE:**	92821
CAPACITY:	70	**CENSUS:** 45	**DATE:**	01/06/2026
		UNANNOUNCED	**TIME BEGAN:**	08:00 AM
MET WITH:	Ashiman Gill		**TIME COMPLETED:**	11:45 AM

ALLEGATION(S):

1	Resident sustained unexplained injuries while in care.
2	Medications are accessible to residents in care.
3	Residents hygiene needs are not being met.
4	Facility staff did not provide adequate supervision resulting in a resident consuming another resident's
5	medication.
6	Residents bedding is left soiled for a long period of time.
7	Facility is falsifying medication log.
8	Resident was left in the same clothing for a long period of time.
9	

INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Hanna Gough arrived at the facility to investigate the above mentioned
2	complaint allegations. LPA was greeted and granted entry by staff. LPA met with Administrator (AD)
3	Ashiman Gill And discussed the purpose of the visit.
4	
5	The investigation into the allegation of resident sustained unexplained injuries while in care revealed the
6	following: LPA observed a physicians report for Resident #1(R1) dated August 18, 2021, stating that R1
7	was ambulatory, was able to feed, bathe, dress and groom self with minimal assistance and did not have
8	a history of a skin condition or breakdown. LPA observed facility progress notes for R1 from January 16,
9	2023 to June 14, 2023, stating that on May 9, 2023 a large bruise was noticed on their right thigh with no
10	falls reported. LPA observed routine wellness observations and observed that on March 20, 2023 R1 had
11	a bruise on both elbows due to a fall. LPA observed that on July 20, 2023, R1 had a bruise noted on their
12	inner left shoulder with no reason noted. Three of four staff interviews revealed that R1 bruised easily
13	and they could not recall a specific time when a bruise was notated.
	Continue on 9099C

Unsubstantiated	**Estimated Days of Completion:**

SUPERVISORS NAME: Armando J Lucero
LICENSING EVALUATOR NAME: Hanna Gough
LICENSING EVALUATOR SIGNATURE:
DATE: 01/06/2026

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 01/06/2026

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

COMPLAINT INVESTIGATION REPORT (Cont)

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

FACILITY NAME: SILVERADO BREA LLC
FACILITY NUMBER: 306005652
VISIT DATE: 01/06/2026

NARRATIVE

LPA was unable to interview R1 due to not residing at the facility. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed an in service of updated staff training dated September 16, 2025, that covered topics of preventing bruising/pressure injuries.

Regarding the facility allegation of medications are accessible to residents in care and facility is falsifying medication log revealed the following: It was alleged that staff are leaving medications in a room unattended making the medication accessible to residents in care and that facility staff threw away medication after a resident refused to take it, but told staff that it had been administered. Interviews with three of three staff revealed that the facility nurse is the only one that passes medications and marks off the medication log and that they stand there and ensure the resident takes their medications before moving on. Three of three staff could not recall a time where medications were ever accessible to residents in care or when the medication log had been falsified. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed a medication security policy that was reviewed and signed by facility staff on March 27, 2025 and April 1, 2025. LPA reviewed resident medication and observed it to be administered according to physicians orders at the time of the investigation using the facility electronic medication administration record.

Regarding the facility allegation of residents hygiene needs are not being met revealed the following: It was alleged that residents were not given showers for three weeks. Two of three staff informed LPA that when a resident refuses to take a shower, they will try again later. If the resident keeps refusing, they will try again on the next shift. Two of three staff informed LPA that they will keep asking the resident, but will not force them to take a shower. LPA did not observe shower logs for residents in care. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed staff training covering bathing a person with dementia last done in the year 2024 for three of three staff.

Regarding the facility allegation of residents bedding is left soiled for a long period of time revealed the following: It was alleged that facility staff left Resident #2(R2) in their soiled bed for three weeks. LPA reviewed a physicians report dated January 1, 2023, stating that R2 was diagnosed with dementia, does not require continuous bed care, did not have bladder or bowel impairment, was unable to communicate their needs, was able to care for their own toileting needs and was considered non ambulatory. Two of three staff informed LPA that residents are checked for brief changes every two hours unless needing a changing sooner. Two of three staff informed LPA that caregivers are able to change residents sheets even if they are still in the bed. Two of three staff informed LPA that R2 was difficult to change, but the staff never left them soiled for an extended period of time. Continue on 9099C

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NARRATIVE

The Department attempted to interview R2, but they could not confirm or deny the allegation. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed a staff in-service training that was conducted on September 16, and September 29, 2025, covering topics such as bed making, perineal care, and bowel movement protocol. LPA observed residents to be out of their rooms and appeared to be cleaned. LPA did not observe a smell throughout the facility due to residents hygiene needs not being met or residents being left soiled for a long period of time.

Regarding the allegation of facility staff did not provide adequate supervision resulting in a resident consuming another resident's medication revealed the following: It was alleged that Resident #3 (R3) drank Resident #4(R4) medication that was crushed and put in their drink. LPA reviewed a physicians report dated November 4, 2021, stating that R3 was diagnosed with dementia and was able to feed themselves. LPA did not observe an updated physicians report for R3. LPA reviewed a physicians report dated November 21, 2022 for R4 stating that R4 was diagnosed with dementia and is able to feed themselves. LPA did not observe an updated physicians report for R4. Three of three staff informed LPA that they do not walk away from the resident until all the medication has been consumed to ensure that another resident does not pick up their cup. One of three staff informed LPA that R2 is unable to drink unassisted, so staff would help them drink the juice with their medication. The Department attempted to interview R3 and R4 and they could not confirm or deny the allegation. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed updated staff medication training dated June 8, 2025, and October 29, 2025, for two of three staff. One of three staff does not do medication distribution in the facility. LPA did not observe medications accessible to residents at the time of the investigation. LPA observed the medication room and the medication cart to be locked on both of the facility floors.

Regarding the facility allegation of resident was left in the same clothing for a long period of time revealed the following: It was alleged that Resident #5(R5) was left in the same clothing over an entire weekend without being changed. LPA reviewed a physicians report dated April 27, 2022, for R5 stating R5 was diagnosed with dementia and was able to dress/groom themselves. LPA did not observe an updated physicians report for R5. Two of three staff informed LPA that R5 wore similar clothing everyday which included a tshirt and levi jeans. Two of three staff informed LPA that R5 looked the same everyday due to their clothing being so similar. LPA was unable to interview R5 due to them not residing at the facility. Although the complaint allegation was deemed UNSUBSTANTIATED, LPA observed three of three staff have resident personal rights training completed in 2024.

Continue on 9099C

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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
ORANGE COUNTY RO, 770 THE CITY DR., SUITE 7100
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FACILITY NAME: SILVERADO BREA LLC **FACILITY NUMBER:** 306005652
VISIT DATE: 01/06/2026

NARRATIVE

Based on information gathered, interviews and record review, the Department is unable to ascertain if the above allegations occurred as reported. Although the allegations may have happened or is valid, there is not a preponderance of evidence to prove or refute the alleged violation occurred; therefore, the allegations are deemed UNSUBSTANTIATED.

6	An exit interview was conducted and a copy of this report was provided at the time of the investigation.
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