

Department of  
**SOCIAL SERVICES**

*Community Care Licensing*

# COMPLAINT INVESTIGATION REPORT

Facility Number: 374602369  
Report Date: 10/01/2025  
Date Signed: 10/01/2025 03:28:36 PM

## Unsubstantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION SAN DIEGO RO, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108
<b>COMPLAINT INVESTIGATION REPORT</b>	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/11/2025** and conducted by Evaluator Natasha Persaud

	<b>COMPLAINT CONTROL NUMBER: 08-AS-20250611162354</b>
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<b>FACILITY NAME:</b> GOLDEN LIVING HEALTH MANAGEMENT, INC.	<b>FACILITY NUMBER:</b> 374602369
<b>ADMINISTRATOR:</b> ROCIO GRANDA	<b>FACILITY TYPE:</b> 740
<b>ADDRESS:</b> 3223 DUKE STREET	<b>TELEPHONE:</b> (619) 222-1109
<b>CITY:</b> SAN DIEGO	<b>ZIP CODE:</b> 92110
<b>CAPACITY:</b> 113	<b>DATE:</b> 10/01/2025
<b>MET WITH:</b> Administrator, Rocio Granda	<b>UNANNOUNCED TIME BEGAN:</b> 03:10 PM
	<b>TIME COMPLETED:</b> 03:20 PM

**ALLEGATION(S):**

1	Staff did not accord resident dignity in their relationship with staff or residents
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**INVESTIGATION FINDINGS:**

1	Licensing Program Analyst (LPA), Natasha Persaud conducted a telephone visit to conclude complaint investigation regarding the above-mentioned allegation. LPA spoke with Administrator, Rocio Granda.
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4	During the investigation, a brief tour of the facility was conducted, record review, and interviews
5	conducted with staff, residents, and outside sources. It was alleged that staff did not accord resident
6	dignity in their relationship with staff or residents. It was reported Resident #1 (R1) and Resident #2 (R2)
7	had a quarrel about the bedroom door being opened. R1 wanted the door open due to an odor caused by
8	R1's medical condition. R2 preferred to keep the door closed at all times. On 06/19/25, LPA observed a
9	sign on R1 & R2's door that stated to keep the door closed. Resident interviews revealed on 06/06/25,
10	R1 and R2 were yelling at one another, and R2 was in their wheelchair and kicked R1's hand. R1 did not
11	sustain any injuries and the altercation was unwitnessed. Continued on LIC 9099C.
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<b>Unsubstantiated</b>	<b>Estimated Days of Completion:</b>
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**NAME OF LICENSING PROGRAM MANAGER:** Lizzette Tellez  
**NAME OF LICENSING PROGRAM ANALYST:** Natasha Persaud  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_  
**DATE:** 10/01/2025

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

**FACILITY REPRESENTATIVE SIGNATURE:** \_\_\_\_\_  
**DATE:** 10/01/2025

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 2  
**Control Number** 08-AS-20250611162354

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  
**COMPLAINT INVESTIGATION REPORT  
(Cont)**

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES  
COMMUNITY CARE LICENSING DIVISION  
SAN DIEGO RO, 7575 METROPOLITAN DR. #109  
SAN DIEGO, CA 92108

**FACILITY NAME:** GOLDEN LIVING HEALTH MANAGEMENT, INC. **FACILITY NUMBER:** 374602369  
**VISIT DATE:** 10/01/2025

**NARRATIVE**

1 R2 is paralyzed on one side of their body, R2 admitted they were flailing their one operational hand and  
2 leg at R1 but uncertain if they made contact. Staff stated they entered the room and R1 and R2 were  
3 having a disagreement about the door being opened or closed. R2 has a history of wanting the door to  
4 remain closed all day. Staff confirmed they did not witness R2 hit or kick R1. Staff explained they would  
5 have intervened if there was any physical altercation. The facility does not provide one on one  
6 supervision. Staff addressed the ongoing concern between the two residents not agreeing with the  
7 status of the door. Therefore, the facility took action by relocating R1 to a private room to avoid further  
8 conflict.  
9  
10 During the course of the investigation, interviews were conducted, and records were reviewed.  
11 Investigation revealed inconsistent statements and information obtained did not present a  
12 preponderance of evidence to support or corroborate the allegation. The allegation was deemed  
13 unsubstantiated. An exit interview was conducted via telephone and a copy of this report along with  
14 Licensee Rights (LIC 9058 03/22) were emailed to Administrator, Rocio Granda. [See LIC 811  
15 Confidential Names List to identify Resident #1 and Resident #2]  
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**NAME OF LICENSING PROGRAM MANAGER:** Lizzette Tellez  
**NAME OF LICENSING PROGRAM ANALYST:** Natasha Persaud  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_  
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**DATE:** 10/01/2025