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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 565850072
Report Date: 04/30/2025
Date Signed: 04/30/2025 01:06:18 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, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364

This is an official report of an unannounced visit/investigation of a complaint received in our office on **04/09/2024** and conducted by Evaluator Kelly Dulek

	COMPLAINT CONTROL NUMBER: 29-AS-20240409091302

FACILITY NAME:	SILVERADO THOUSAND OAKS, LLC			**FACILITY NUMBER:**	565850072
ADMINISTRATOR:	ROBLOE BABASANTA			**FACILITY TYPE:**	740
ADDRESS:	980 WARWICK AVE			**TELEPHONE:**	(805) 307-7300
CITY:	THOUSAND OAKS	**STATE:** CA		**ZIP CODE:**	91360
CAPACITY:	82	**CENSUS:** 40		**DATE:**	04/30/2025
		UNANNOUNCED		**TIME BEGAN:**	11:45 AM
MET WITH:	Robloe (Rob) Babasanta			**TIME COMPLETED:**	01:10 PM

ALLEGATION(S):

1	Resident was hospitalized due to a urinary tract infection resulting from staff neglect
2	Facility staff did not meet resident's incontinence care needs
3	Facility staff handled resident in a rough manner
4	Facility staff did not ensure resident had sufficient intake of food
5	Facility staff did not answer resident's calls for assistance
6	Facility staff yelled at resident
7	Facility staff did not provide records to resident's responsible person
8	
9	

INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Kelly Dulek conducted an unannounced subsequent complaint visit to
2	this facility to deliver findings. At 11:45AM, the LPA was greeted by front desk staff and LPA explained the
3	reason for the visit. At 11:57AM, the Administrator Rob Babasanta met with the LPA.
4	
5	On 04/09/2024, A referral was made to Community Care Licensing Division's (CCLD) Investigation
6	Branch (IB) and was accepted as an assignment to obtain medical records and home health records for
7	Resident #1 (R1). During the initial visit conducted on 4/10/2024 between 10:04 a.m. and 12:15 p.m.,
8	LPA Teresa Camara conducted a physical plant tour, interviewed the Administrator and obtained pertinent
9	documents. During a subsequent visit conducted on 03/25/2025, LPAs Peraldi, Dulek and Huynh
10	conducted a physical plant tour and conducted interviews with the Administrator, six (6) staff and four (4)
11	residents. The LPAs also requested and obtained copies of pertinent documents during the subsequent
12	visit.
13	
	Report Continued on LIC 9099-C

Unsubstantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Kristin Heffernan
NAME OF LICENSING PROGRAM ANALYST: Kelly Dulek
LICENSING PROGRAM ANALYST SIGNATURE:
DATE: 04/30/2025

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

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 04/30/2025

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

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COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: SILVERADO THOUSAND OAKS, LLC **FACILITY NUMBER:** 565850072
VISIT DATE: 04/30/2025

NARRATIVE

Regarding allegation: 1.) Resident was hospitalized due to a urinary tract infection resulting from staff neglect. It was alleged that Resident #1 (R1) had three (3) urinary tract infections (UTIs) while residing at the facility, one of which resulted in a hospital stay in November 2023. Medical records from Los Robles Regional Medical Center were obtained for R1 and the following was noted: R1 was first observed at the hospital on 10/25/2023. R1 was admitted to the hospital on 10/26/2023 and was discharged back to the facility on 11/02/2023. R1's condition throughout the hospitalization were listed in various medical documents as coffee ground emesis, shortness of breath, abdominal pain, chest pain and vomiting. During R1's hospitalizations, R1 had an upper GI endoscopy procedure done. A physical and multiple tests were performed prior to the procedure, and no immediate complications were listed on the Endoscopy Report. Additionally, R1's discharge records did not list UTI as a diagnosis. In R1's home health visit notes dated 03/04/2024, a urinalysis was sent out for a possible, continued UTI. However, a UTI was not listed as a diagnosis. R1 was again hospitalized at Los Robles Regional Medical Center on 03/30/2024 for acute GIB, Sepsis, Asp PNA and Complicated UTI. R1 was discharged on 04/11/2024; however, R1 was already moved out of the facility and moved into another facility. R1 moved out of the facility on 03/24/2024. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 2.) Facility staff did not meet resident's incontinence care needs. It was alleged R1 was found on multiple occasions sitting in feces and with feces around R1's scrotum. Per record review, R1 was admitted to the facility on 08/22/2023. Per R1's physician report dated 05/31/2023, R1 was not able to care for own toileting needs. LPA Peraldi reviewed R1's home health visit report notes from 07/10/2023 through 03/25/2024 and the following was noted: there was no mention of R1 being found with soiled diapers or sitting in feces. Interview with the Administrator stated that since R1 was in a wheelchair, staff would check on R1 at least every 2 hours or as needed. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 3.) Facility staff handled resident in a rough manner. It was alleged that facility staff handled R1 in a rough manner resulting in bruising. The complainant did not state where bruises were on

Report Continued on LIC 9099-C

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DATE: 04/30/2025

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

FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 04/30/2025

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R1's body or any other details. Interviews conducted with staff denied staff handing R1, or any resident, in a rough manner. R1's medical records from Los Robles Regional Medical Center for R1's hospitalizations on 10/25/2023 and 03/30/2024 did not note any bruising on R1's body. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 4.) Facility staff did not ensure resident had sufficient intake of food. It was alleged that R1 was not being fed and the food being served to R1, R1 would not eat. Per record review, R1 was admitted to the facility on 08/22/2023. Per R1's physician report dated 05/31/2023, R1 was to be on a diabetic diet. R1's Preplacement appraisal dated 08/17/2023, noted R1's special diet as diabetic. R1's service plan, dated 09/06/2023, listed raw onion as R1's allergy. LPA Peraldi reviewed R1's home health visit report notes from 07/10/2023 through 03/25/2024 and the following was noted: R1's home health notes mention R1's appetite depends on what is being served to R1. On 07/10/2023 and 03/04/2024, it was noted that R1 had difficulty complying with any medical instructions (for example medications, diets, exercise) within the past 3 months. On 03/04/2024, it was noted that R1 rarely eats a complete meal and generally eats only about half of any food offered. It was noted that R1 also drinks protein shakes and dietary supplements to increase calories. Throughout R1's home health notes R1 was also noted to have diminished cardiovascular capacity and generalized weakness which also attributed to R1's lack of appetite. During the initial complaint visit and subsequent visits, the LPAs observed a sufficient supply of perishable and non-perishable food. Four (4) out of four (4) residents interviewed revealed that the food is good, adequate, and well portioned. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 5.) Facility staff did not answer resident's calls for assistance. It was alleged that R1 would wait 30 minutes for facility staff to assist R1 when the call button was pressed. Interview with the Administrator revealed that R1 would press the call button but then a second later would press it again which turns off the call. The Administrator said that staff would remind R1 to only press the button once. The Administrator also explained that for residents who can't use the call buttons, there are bed pads that have

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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, 21731 VENTURA BLVD. #250
WOODLAND HILLS, CA 91364

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censors if a resident falls or has a sudden movement that alert staff. During the subsequent visit on 03/25/2025, at 11:08 a.m., the LPAs tested a call button and staff arrived within 2 minutes, thinking a resident pressed the button. Interviews with residents did not voice concerns regarding the wait time for assistance. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 6.) Facility staff yelled at resident. It was alleged that a facility staff that was described as a registered nurse (RN) was overheard yelling at R1. Interview with Administrator revealed that he has not heard or observed staff yelling at residents. Interviews with staff also denied staff yelling at residents, including R1. Interviews with residents did not voice any concerns regarding staff treatment. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

Regarding allegation: 7.) Facility staff did not provide records to resident's responsible person. It was alleged that facility staff refused to give R1's responsible party R1's medical records. Administrator stated that he did give R1's responsible party hard copies of R1's records. The Administrator explained that when records are requested, he puts in a written request to Silverado's home office. Once approved through the home office, the Administrator will then release the records. However, in the case of R1, the records were released to R1's family immediately upon request. The information obtained during the investigation did not include evidence sufficient to corroborate the above allegation. Although the allegation may have happened or is valid, there is not sufficient evidence to prove the alleged violation did or did not occur, therefore the allegation is deemed **Unsubstantiated** at this time.

No citations issued. Exit interview conducted. A copy of the report was provided.

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