

Department of
SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 079200355
Report Date: 06/13/2025
Date Signed: 06/13/2025 10:32:31 AM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION OAKLAND ASC, 1515 CLAY STREET, STE. 310 OAKLAND, CA 94612
COMPLAINT INVESTIGATION REPORT	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **05/02/2025** and conducted by Evaluator Alona Gomez

	COMPLAINT CONTROL NUMBER: 15-AS-20250502163330
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FACILITY NAME: BROOKDALE SAN RAMON	FACILITY NUMBER: 079200355
ADMINISTRATOR: FEASTER, NIARE DAWN	FACILITY TYPE: 740
ADDRESS: 18888 BOLLINGER CANYON RD	TELEPHONE: (925) 831-3964
CITY: SAN RAMON	STATE: CA ZIP CODE: 94583
CAPACITY: 110	DATE: 06/13/2025
MET WITH: Executive Director, Lola Bullock	UNANNOUNCED TIME BEGAN: 09:00 AM
	TIME COMPLETED: 11:00 AM

ALLEGATION(S):

1	Licensee does not maintain the facility in good repair
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INVESTIGATION FINDINGS:

1	On 6/13/25 at 9:00 a.m., Licensing Program Analyst (LPA) A Gomez arrived unannounced to deliver
2	finding complaint investigation in regard to the allegation above. LPA met with Executive Director, Lola
3	Bullock and explained the purpose of the visit.
4	
5	During prior visit LPA interviewed S1, S2, ED and HWD and found that the southside elevator has been
6	sporadically going down over the past few years and has been increasing in how often there are outages.
7	ED states that they have been actively implementing solutions and has a work order out for repairs.
8	Therefore the above allegation is Substantiated.
9	
10	Based on LPAs observations and interviews which were conducted and record reviews, the
11	preponderance of evidence standard has been met, therefore the above allegations are found to be
12	SUBSTANTIATED. California Code of Regulations (Title 22, Division 6, Chapter 8), are being cited on the
13	attached LIC 9099D.
	Exit interview conducted and a copy of this report provided.

Substantiated	Estimated Days of Completion:
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NAME OF LICENSING PROGRAM MANAGER: Yvonne Flores-Larios
NAME OF LICENSING PROGRAM ANALYST: Alona Gomez
LICENSING PROGRAM ANALYST SIGNATURE: _____ **DATE:** 06/13/2025

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

FACILITY REPRESENTATIVE SIGNATURE: _____ **DATE:** 06/13/2025

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 15-AS-20250502163330

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY COMPLAINT INVESTIGATION REPORT (Cont)	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION OAKLAND ASC, 1515 CLAY STREET, STE. 310 OAKLAND, CA 94612
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FACILITY NAME: BROOKDALE SAN RAMON **FACILITY NUMBER:** 079200355
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 06/13/2025

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type B 07/11/2025 Section Cited CCR 87303(a)	1 (a) The facility shall be ...in good repair 2 at all times...for the safety and well- 3 being of residents... 4 This requirement is not met as 5 evidence by: 6 7	1 By POC facility agrees to submit 2 documents for the work being done and 3 notify CCLD of the completed repairs. 4 LPA may conduct a case management 5 once repairs are complete. 6 7
	8 Based on interviews the facility did not 9 comply with the section cited above by 10 the southside elevator going in and out 11 of service over the last few years which 12 poses a potential safety and personal 13 rights risk to residents in care. 14	
	1 2 3 4 5 6 7	
	1 2 3 4 5 6 7	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

NAME OF LICENSING PROGRAM MANAGER: Yvonne Flores-Larios
NAME OF LICENSING PROGRAM ANALYST: Alona Gomez
LICENSING PROGRAM ANALYST SIGNATURE: _____ **DATE:** 06/13/2025

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

FACILITY REPRESENTATIVE SIGNATURE: _____ **DATE:** 06/13/2025