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Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 197610142
Report Date: 04/16/2021
Date Signed: 04/16/2021 03:55:28 PM

Document Has Been Signed on 04/16/2021 03:55 PM **- It Cannot Be Edited**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814

FACILITY NAME:	ATRIA TARZANA			FACILITY NUMBER:	197610142
ADMINISTRATOR:	RAFAT, SHAKEB			FACILITY TYPE:	740
ADDRESS:	5325 ETIWANDA AVENUE			TELEPHONE:	(877) 483-6827
CITY:	TARZANA	STATE: CA		ZIP CODE:	91356
CAPACITY: 136		CENSUS:		DATE:	04/16/2021
TYPE OF VISIT:	Office	ANNOUNCED		TIME BEGAN:	03:30 PM
MET WITH:	Rafat, Shakeb			TIME COMPLETED:	03:50 PM

NARRATIVE

Facility Type: Elderly
Application Type: CHOW
Capacity: 136
Census (if any clients in care): 30

Administrator participated in COMP II via telephone call with the analyst at CAB. Identification of the administrator was verified by correctly answering identity verification question. During COMP II, administrator confirmed the understanding of Title 22. Component II was successfully completed. Administrator has been advised to transmit signed LIC 809 with copy of photo ID to CAB.

During COMP II, CAB analyst confirmed Applicant / Administrator's understanding of following areas:

1. *Facility operation: License type, client / resident populations, and program*
2. *Staff qualifications and responsibilities*
3. *Applicant and Administrator qualifications*
4. *Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions*
5. *Grievances, Complaints, Community resources*
6. *Physical plant, food service*
7. *Application document review and technical assistance: Criminal record clearance,*

	Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate, Financial verification, Pre-licensing inspection, Compliance history, Control of property

NAME OF LICENSING PROGRAM MANAGER: Julia Kim
NAME OF LICENSING PROGRAM ANALYST: Nicole Rouse
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 04/16/2021

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 04/16/2021

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