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Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 197610184
Report Date: 08/20/2021
Date Signed: 09/27/2021 12:28:47 PM

Document Has Been Signed on 09/27/2021 12:28 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 9-14-8201 SACRAMENTO, CA 95814

FACILITY NAME:	OAKMONT OF SANTA CLARITA			FACILITY NUMBER:	197610184
ADMINISTRATOR:	PARK, TOM			FACILITY TYPE:	740
ADDRESS:	28650 NEWHALL RANCH ROAD			TELEPHONE:	(661) 295-2025
CITY:	SANTA CLARITA	STATE: CA		ZIP CODE:	91355
CAPACITY: 121		CENSUS:		DATE:	08/20/2021
TYPE OF VISIT:	Office	ANNOUNCED		TIME BEGAN:	11:00 PM
MET WITH:	TOM PARK			TIME COMPLETED:	11:30 PM

NARRATIVE

Facility Type: RCFE
Application Type: CHOW
Capacity: 0121
Census (if any clients in care):

COMP II by CAB successfully completed

Method: Telephone call

COMP II Participant: TOM PARK

Applicant/administrator participated in COMP II via telephone call with the analyst at CAB. Identification of the applicant and administrator was verified by photo ID . During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed.

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: Mirella Quaranta
NAME OF LICENSING PROGRAM ANALYST: Stefania Fonteno
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 09/27/2021

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 09/27/2021

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