

## Community Care Licensing

# FACILITY EVALUATION REPORT

Facility Number: 198320494

Report Date: 01/23/2025

Date Signed: 01/23/2025 10:29:58 AM

Document Has Been Signed on 01/23/2025 10:29 AM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814
<b>FACILITY EVALUATION REPORT</b>	
FACILITY NAME: HOUSE OF FAITH	FACILITY NUMBER: 198320494
ADMINISTRATOR/ZACHERY, TIFFANY	FACILITY TYPE: 740
DIRECTOR:	
ADDRESS: 5025 11TH AVE	TELEPHONE: (213) 946-2097
CITY: LOS ANGELES	ZIP CODE: 90043
CAPACITY: 4	STATE: CA
TYPE OF VISIT: Office	CENSUS: ANNOUNCED
MET WITH: Tiffany Zachery, Managing Member/Administrator	DATE: 01/23/2025
	TIME VISIT/INSPECTION BEGAN: 10:01 AM
	TIME VISIT/INSPECTION COMPLETED: 10:17 AM

NARRATIVE	
1	Facility Type: RCFE
2	Application Type: Initial
3	Capacity: 4
4	COMP II Participant: Tiffany Zachery, Managing Member/Administrator
5	Interview Method: Telephone interview
6	
7	
8	On 1/23/25, applicant/administrator participated in COMP II. Identification of the
9	applicant/administrator was verified through interview questions based on photo ID
10	and other identifying personal information. During COMP II, applicant/administrator
11	confirmed that they have read and understand community care facility licensing laws
12	included in the Health and Safety Codes and the California Code of Regulations Title
13	22. Signed LIC 809 with copy of photo ID have been obtained.
14	
15	
16	During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of
17	following areas:
18	1. Facility operation: License type, client/resident populations, and program
19	2. Admission Policies
20	3. Staffing requirements & Training
21	4. Restrictive/Prohibited Health Conditions
22	5. General provisions
23	6. Emergency Preparedness
24	
25	

7. Complaints & Reporting
8. Pre-licensing readiness

**NAME OF LICENSING PROGRAM MANAGER:** Mirella Quaranta

**NAME OF LICENSING PROGRAM ANALYST:** Anna Barrios

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 01/23/2025

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 01/23/2025

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