

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 198603545

Report Date: 07/11/2022

Date Signed: 07/11/2022 10:32:17 AM

Document Has Been Signed on 07/11/2022 10:32 AM - It Cannot Be Edited

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|--|---|---|----------------|
| 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 | |
| FACILITY EVALUATION REPORT | | | |
| FACILITY NAME: OAKMONT OF COVINA HILLS | | FACILITY NUMBER: | 198603545 |
| ADMINISTRATOR: CRUZ, MARILEE | | FACILITY TYPE: | 740 |
| ADDRESS: 1054 PARK VIEW DRIVE | | TELEPHONE: | (626) 885-1800 |
| CITY: COVINA | STATE: CA | ZIP CODE: | 91724 |
| CAPACITY: 142 | CENSUS: | DATE: | 07/11/2022 |
| TYPE OF VISIT: Office | ANNOUNCED | TIME BEGAN: | 10:00 AM |
| MET WITH: Sue McPherson and Patricia Gustin | | TIME COMPLETED: | 10:30 AM |
| NARRATIVE | | | |
| 1 | COMP II by CAB successfully completed | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | Facility Type: RCFE | | |
| 6 | Application Type: LLC | | |
| 7 | Capacity: 142 | | |
| 8 | Census (if any clients in care): NO | | |
| 9 | Method: Telephone at CAB | | |
| 10 | COMP II Participants: Sue McPherson (Applicant's Representative) and | | |
| 11 | Patricia Gustin (Administrator) | | |
| 12 | | | |
| 13 | Applicant/Administrator participated in COMP II at CAB via telephone with | | |
| 14 | analyst at CAB. Identification of the Applicant and Administrator was | | |
| 15 | verified by providing California Driver License number. During COMP II, | | |
| 16 | Applicant and Administrator confirmed the understanding of Title 22. | | |
| 17 | Component II was successfully completed. Applicant and Administrator | | |
| 18 | were advised to email/fax signed LIC 809 with copy of photo ID to CAB. | | |
| 19 | | | |
| 20 | During COMP II, CAB analyst confirmed Applicant/Administrator's | | |
| 21 | understanding of following areas: | | |
| 22 | | | |
| 23 | 1. Facility operation: License type, client/resident populations, and program | | |
| 24 | | | |
| 25 | | | |

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
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

Julia Kim
Thai Doan



DATE: 07/11/2022

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 07/11/2022

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