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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 306006224
Report Date: 11/23/2022
Date Signed: 11/23/2022 11:21:57 AM

Document Has Been Signed on 11/23/2022 11:21 AM **- 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 FULLERTON		FACILITY NUMBER:	306006224
ADMINISTRATOR:	SCHROEDER, LINDSAY		FACILITY TYPE:	740
ADDRESS:	433 W. BASTENCHURY ROAD		TELEPHONE:	(805) 416-8600
CITY:	FULLERTON	STATE: CA	ZIP CODE:	92835
CAPACITY: 152		CENSUS:	DATE:	11/23/2022
TYPE OF VISIT:	Office	ANNOUNCED	TIME BEGAN:	11:00 AM
MET WITH:	SCHROEDER, LINDSAY		TIME COMPLETED:	11:30 AM

NARRATIVE

Facility Type: RCFE
Application Type: CHOW
Capacity: 152
Census (if any clients in care):

COMP II by CAB successfully completed

Method: Telephone call

COMP II Participant: LINDSAY SCHROEDER

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: 11/23/2022

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 11/23/2022

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