

Department of SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 312700996
Report Date: 04/23/2021
Date Signed: 04/26/2021 09:40:52 AM

Document Has Been Signed on 04/26/2021 09:40 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 8-3-91 SACRAMENTO, CA 95814 |
| FACILITY EVALUATION REPORT | |
| FACILITY NAME: WELLQUEST GRANITE BAY TENANTCO LLC | FACILITY NUMBER: 312700996 |
| ADMINISTRATOR: MANOMHEHRI, PARI | FACILITY TYPE: 740 |
| ADDRESS: 9747 SIERRA COLLEGE BLVD | TELEPHONE: (801) 815-0808 |
| CITY: GRANITE BAY STATE: CA | ZIP CODE: 95661 |
| CAPACITY: 135 | CENSUS: DATE: 04/23/2021 |
| TYPE OF VISIT: Office | ANNOUNCED TIME BEGAN: 10:00 AM |
| MET WITH: Dean Mattsson and Pari Manomhehri | 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: 135 |
| 8 | Census (if any clients in care): NO |
| 9 | Method: Telephone at CAB |
| 10 | COMP II Participants: Dean Mattsson (Applicant) and Pari Manomhehri |
| 11 | (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

NAME OF LICENSING PROGRAM MANAGER: Julia Kim

NAME OF LICENSING PROGRAM ANALYST: Thai Doan

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 04/26/2021

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 04/26/2021

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