

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 331881549

Report Date: 09/09/2024

Date Signed: 09/09/2024 02:15:07 PM

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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: MENIFEE ASSISTED LIVING LLC	FACILITY NUMBER: 331881549
ADMINISTRATOR/ROPER, KAREN	FACILITY TYPE: 740
DIRECTOR:	
ADDRESS: 29620 BRADLEY RD	TELEPHONE: (951) 679-3355
CITY: MENIFEE	STATE: CA
CAPACITY: 116	ZIP CODE: 92586
TYPE OF VISIT: Office	CENSUS: DATE: 09/09/2024
	ANNOUNCED
	TIME VISIT/INSPECTION
	BEGAN: 02:00 PM
MET WITH:	TIME VISIT/INSPECTION
	COMPLETED: 02:12 PM

NARRATIVE	
1	COMP II by CAB successfully completed
2	
3	
4	Facility Type: RCFE
5	Application Type: CHOW
6	Capacity: 116
7	Census (if any clients in care): 91
8	Method: Telephone call with CAB
9	COMP II Participants: Karen Roper, Administrator, Steven Atlas, CEO; Shannon
10	Betker, analyst.
11	
12	
13	
14	Applicant/administrator participated in COMP II at CAB via telephone call with
15	analyst at CAB. Identification of the applicant and administrator was verified by
16	confirming driver's license number. During COMP II, applicant and administrator
17	confirmed the understanding of Title 22. Component II was successfully completed.
18	Applicant and administrator were advised to email/fax signed LIC 809 with copy of
19	photo ID to CAB.
20	
21	
22	
23	During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of
24	following areas:
25	1. Facility operation: License type, client/resident populations, and program
	2. Admission Policies

3. Staffing requirements & Training
4. Restrictive/Prohibited Health Conditions
5. General provisions
6. Emergency Preparedness
7. Complaints & Reporting
8. Pre-licensing readiness

NAME OF LICENSING PROGRAM MANAGER: Jude De La Concepcion

NAME OF LICENSING PROGRAM ANALYST: Shannon Betker

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 09/09/2024

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 09/09/2024

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