

Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 336400075
Report Date: 11/16/2020
Date Signed: 11/16/2020 11:20:29 AM

Document Has Been Signed on 11/16/2020 11:20 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, 1650 SPRUCE ST STE 200 MS29-27 RIVERSIDE, CA 92507
FACILITY EVALUATION REPORT	

FACILITY NAME: ATRIA HACIENDA	FACILITY NUMBER: 336400075
ADMINISTRATOR: BARTON, ROBERT	FACILITY TYPE: 740
ADDRESS: 44600 MONTEREY AVE	TELEPHONE: (760) 341-0890
CITY: PALM DESERT	STATE: CA
CAPACITY: 266	ZIP CODE: 92260
TYPE OF VISIT: Case Management - Other	CENSUS: DATE: 11/16/2020
MET WITH: Sarah Woofe	UNANNOUNCED TIME BEGAN: 11:10 AM
	TIME COMPLETED: 11:11 AM

NARRATIVE

1 Licensing Program Analyst (LPA) Kathleen Wiggins contacted the facility via telephone to commence a
2 case management visit via telephone due to COVID-19. LPA identified herself and discussed the
3 purpose of the call with Community Business Director - Sarah Woofe.
4
5 Based on evidence obtained during today's visit, the LPA has verified that the individual is not present,
6 employed, or residing at the facility. The individual named in the Confirmation of Removal letter dated
7 10/22/2020 is Leticia C Beckwith.
8
9 LPA was informed by the Community Business Director that Jackson applied to work at the facility and
10 was pending background check clearance. Community Business Director stated Beckwith never worked
11 in the community. The community business director stated she understood that during this process
12 Beckwith cannot work, reside, or be present at a licensed facility.
13
14 No deficiencies were cited during this visit. An exit interview was conducted with the Community
15 Business Director via telephone and copies of this report and Non-Exemptible conviction letter were
16 provided to the Community Business Director via email. Report with facility representative signature was
17 obtained. Verification of removal is complete.
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NAME OF LICENSING PROGRAM MANAGER: Leslie Mendiveles
NAME OF LICENSING PROGRAM ANALYST: Kathleen Wiggins

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 11/16/2020

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 11/16/2020

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