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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 361880646
Report Date: 11/16/2020
Date Signed: 11/16/2020 12:44:18 PM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1650 SPRUCE ST STE 200 MS29-27 RIVERSIDE, CA 92507

FACILITY NAME:	WHISPERING WINDS OF APPLE VALLEY ASSISTED LIVING		FACILITY NUMBER:	361880646
ADMINISTRATOR:	MONYA HENRY		FACILITY TYPE:	740
ADDRESS:	11825 APPLE VALLEY ROAD		TELEPHONE:	(760) 961-1212
CITY:	APPLE VALLEY	STATE: CA	ZIP CODE:	92308
CAPACITY: 115		CENSUS:	DATE:	11/16/2020
TYPE OF VISIT:	Case Management - Other	UNANNOUNCED	TIME BEGAN:	11:23 AM
MET WITH:	Monya Henry		TIME COMPLETED:	11:24 AM

NARRATIVE

Licensing Program Analyst (LPA) Kathleen Wiggins contacted the facility via telephone to commence a case management visit via telephone due to COVID-19. LPA identified herself and discussed the purpose of the call with Administrator - Monya Henry

Based on evidence obtained during today's visit, the LPA has verified that the individual is not present, employed, or residing at the facility. The individual named in the Confirmation of Removal letter dated 09/08/2020 is Tavares Andrews.

LPA was informed by the administrator that Jackson applied to work at the facility and was pending background check clearance. Administrator stated Jackson never worked in the community. The administrator stated she understood that during this process Jackson cannot work, reside, or be present at a licensed facility.

No deficiencies were cited during this visit. An exit interview was conducted with the Administrator via telephone and copies of this report and Non-Exemptible conviction letter were provided to the Administrator via email. Report with facility representative signature was obtained. Verification of removal is complete.

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.