

# Department of SOCIAL SERVICES

## Community Care Licensing

# FACILITY EVALUATION REPORT

Facility Number: 365530146  
Report Date: 10/18/2023  
Date Signed: 10/18/2023 01:17:46 PM

**Document Has Been Signed on 10/18/2023 01:17 PM - 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 9-14-8201 , CA 95814
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: CASSANDRA'S CARE HOME	FACILITY NUMBER: 365530146
ADMINISTRATOR: ELLISON, CASSANDRA	FACILITY TYPE: 740
ADDRESS: 10175 GOLDEN YARROW LANE	TELEPHONE: (909) 664-7137
CITY: RANCHO CUCAMONGA	STATE: CA
CAPACITY: 6	ZIP CODE: 91701
TYPE OF VISIT: Office	CENSUS: ANNOUNCED
MET WITH: Cassandra Ellison	DATE: 10/18/2023
	TIME BEGAN: 01:00 PM
	TIME COMPLETED: 01:17 PM

NARRATIVE	
1	Component II completion: Successful
2	
3	Facility Type: RCFE
4	Application Type: Initial
5	Capacity: 6
6	Census (if any clients in care): 0
7	COMP II Participants: Cassandra Ellison (applicant/licensee, administrator)
8	Interview Method: microsoft teams
9	
10	On [DATE], applicant/administrator participated in COMP II. Identification of the applicant and
11	administrator was verified through interview questions based on photo ID and other identifying personal
12	information. During COMP II, applicant and administrator confirmed that they have read and understand
13	community care facility licensing laws included in the Health and Safety Codes and the California Code
14	of Regulations Title 22. Signed LIC 809 with copy of photo ID have been obtained.
15	
16	During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of following areas:
17	1. Facility operation: License type, client/resident populations, and program
18	2. Admission Policies
19	3. Staffing requirements & Training
20	4. Restrictive/Prohibited Health Conditions
21	5. General provisions
22	6. Emergency Preparedness
23	7. Complaints & Reporting
24	8. Pre-licensing readiness
25	

<b>NAME OF LICENSING PROGRAM MANAGER:</b> Tracy Thompson
<b>NAME OF LICENSING PROGRAM ANALYST:</b> Susan Nguyen

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 10/18/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 10/18/2023

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