

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 374603231

Report Date: 12/30/2020

Date Signed: 12/31/2020 08:39:09 AM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 7575 METROPOLITAN DR. #109 SAN DIEGO, CA 92108
FACILITY EVALUATION REPORT	

FACILITY NAME:	BELMONT VILLAGE CARDIFF			FACILITY NUMBER:	374603231
ADMINISTRATOR:	ASHLEY MARCELLUS			FACILITY TYPE:	740
ADDRESS:	3535 MANCHESTER AVE			TELEPHONE:	(760) 436-8900
CITY:	CARDIFF BY THE SEA			STATE:	CA
CAPACITY:	175			CENSUS:	134
TYPE OF VISIT:	Case Management - Other			ANNOUNCED	DATE: 12/30/2020
MET WITH:	Mary Jane Rodriguez, interim ED			TIME BEGAN:	01:30 PM
				TIME COMPLETED:	03:35 PM

NARRATIVE	
1	Licensing Program Manager (LPM) Denise Powell, County of San Diego Nurse
2	Contractors, Robert Montinallo and Melanie Rodriguez; and California Department
3	Public Health (CDPH), Health Facility Evaluator Nurse (HFEN), Michelle House with
4	the HAI Program, conducted an on-site visit. LPM and team identified themselves
5	and discussed the purpose of the visit with interim Executive Director (ED) Mary
6	Jane Rodriguez. Administrator Ashley Marcellus participated in discussions via
7	telephone.
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10	The Department conducted an on-site visit to provide technical assistance and to
11	evaluate the facility's mitigation plan to include disinfection, testing surveillance, and
12	screening protocols as well as the use of personal protective equipment (PPE).
13	During today's visit, the team interviewed Administrator and other facility staff and
14	conducted a walk-through of the facility, including Memory Care areas. A debriefing
15	was conducted at the conclusion of the visit.
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19	During today's visit, no deficiencies were issued. An exit interview was conducted
20	with the Administrator and other facility staff and a copy of this report, along with
21	Licensee Rights (LIC 9058 01/16), were provided via electronic mail. An electronic
22	receipt of confirmation was requested to be sent by the facility representative upon
23	receipt of the documents.
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NAME OF LICENSING PROGRAM MANAGER: Icela Estrada

NAME OF LICENSING PROGRAM ANALYST: Denise Powell

LICENSING PROGRAM ANALYST SIGNATURE:**DATE:** 12/30/2020

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

FACILITY REPRESENTATIVE SIGNATURE:**DATE:** 12/30/2020

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