

## Community Care Licensing

# FACILITY EVALUATION REPORT

Facility Number: 374604533

Report Date: 02/17/2022

Date Signed: 02/17/2022 02:37:49 PM

Document Has Been Signed on 02/17/2022 02:37 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 SACRAMENTO, CA 95814
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME:	SANTIANKA OAKMONT SIGNATURE LIVING	FACILITY NUMBER:	374604533
ADMINISTRATOR:	THARP, CHRISTOPHER	FACILITY TYPE:	740
ADDRESS:	2560 FARADAY AVE	TELEPHONE:	(442) 325-8090
CITY:	CARLSBAD	STATE:	CA
CAPACITY:	226	CENSUS:	92010
TYPE OF VISIT:	Office	ANNOUNCED	DATE: 02/17/2022
MET WITH:	Christopher Tharp, Administrator	TIME BEGAN:	02:00 PM
		TIME COMPLETED:	02:30 PM

NARRATIVE	
1	Facility Type: RCFE
2	Application Type: Initial
3	Capacity: 226
4	Census (if any clients in care): None
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8	Method: Telephone call with CAB
9	COMP II Participants: Christopher Tharp, Administrator
10	<i>Applicant/administrator participated in COMP II via telephone call with the analyst at CAB. During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed.</i>
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16	<i>During COMP II, CAB analyst confirmed Applicant/ Administrator's understanding of following areas:</i>
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19	1. Facility operation: License type, client/resident populations, and program
20	2. Staff qualifications and responsibilities
21	3. Applicant and Administrator qualifications
22	4. Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions
23	5. Grievances, Complaints, Community resources
24	6. Physical plant, food service
25	7. Application document review and technical assistance: Criminal record clearance,

*Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate,  
Financial verification, Pre-licensing inspection, Compliance history, Control of property*

**NAME OF LICENSING PROGRAM MANAGER:** Jude De La Concepcion

**NAME OF LICENSING PROGRAM ANALYST:** Victoria Christiansen

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 02/17/2022

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 02/17/2022

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