

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 374604722

Report Date: 09/15/2023

Date Signed: 09/15/2023 02:14:25 PM

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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
FACILITY EVALUATION REPORT	

FACILITY NAME: NOVELLUS CLAIREMONT LLC	FACILITY NUMBER: 374604722
ADMINISTRATOR: LAIRD, CANDI	FACILITY TYPE: 740
ADDRESS: 5219 CLAIREMONT MESA BLVD.	TELEPHONE: (858) 292-8044
CITY: SAN DIEGO	STATE: CA
CAPACITY: 214	ZIP CODE: 92117
TYPE OF VISIT: Office	CENSUS: 79
MET WITH: Candi Laird, Administrator	ANNOUNCED
Larry John, Applicant	DATE: 09/15/2023
	TIME BEGAN: 01:06 PM
	TIME COMPLETED: 02:07 PM

NARRATIVE	
1	Component II completion: Successful
2	
3	
4	Facility Type: Residential Care Facility for the Elderly (RCFE)
5	Application Type: Change in Ownership (CHOW)
6	Capacity: 214
7	Census (if any clients in care): 79
8	COMP II Participants: Candi Laird, Administrator
9	Larry John, Applicant
10	Interview Method: Telephone interview
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14	On September 15, 2023 , Applicant and Administrator participated in COMP II.
15	Identification of the Applicant and Administrator was verified through interview
16	questions based on photo ID and other identifying personal information. During
17	COMP II, Applicant and Administrator confirmed that they have read and understand
18	community care facility licensing laws included in the Health and Safety Codes and
19	the California Code of Regulations Title 22.
20	
21	
22	During COMP II, CAB Analyst confirmed Applicant and Administrator's
23	understanding of following areas:
24	1. Facility Operation: License type, client/resident populations, and program
25	2. Admission Policies
	3. Staffing Requirements & Training
	4. Restrictive/Prohibited Health Conditions
	5. General Provisions
	6. Emergency Preparedness

- 7. Complaints & Reporting
- 8. Pre-licensing Readiness

Exit interview conducted with Administrator and Applicant. Report sent via pdf email and informed to return sign copy to CAB by end of business day today.

NAME OF LICENSING PROGRAM MANAGER: Darla Neeley
NAME OF LICENSING PROGRAM ANALYST: Celia Phomphachanh
LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 09/15/2023

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 09/15/2023

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