

Department of

# SOCIAL SERVICES

Community Care Licensing

## FACILITY EVALUATION REPORT

Facility Number: 374604820

Report Date: 08/02/2024

Date Signed: 08/16/2024 06:45:16 AM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CENTRALIZED APP UNIT, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: NEW WORLD VILLA SOUTH	FACILITY NUMBER: 374604820
ADMINISTRATOR/CHEN, ZAYDEN	FACILITY TYPE: 740
DIRECTOR:	
ADDRESS: 14125 TARZANA RD	TELEPHONE: (858) 748-2888
CITY: POWAY	STATE: CA
CAPACITY: 6	ZIP CODE: 92064
TYPE OF VISIT: Office	CENSUS: 6
	ANNOUNCED
	DATE: 08/02/2024
	TIME VISIT/INSPECTION BEGAN: 08:00 AM
MET WITH: Zayden Chen (Administrator/Licensee)	TIME VISIT/INSPECTION COMPLETED: 08:30 AM

NARRATIVE	
1	<b>Component II completion: Successful</b>
2	
3	Facility Type: RCFE
4	Application Type: CHOW
5	Capacity: 6
6	Census : 6
7	Method: Telephone call with CAB
8	COMP II Participants: Zayden Chen (Administrator/Licensee) & Tammy Edwards
9	(Analyst).
10	
11	
12	
13	Administrator/Licensee participated in COMP II via telephone call with CAB analyst.
14	Identification of the Administrator/Licensee was verified by confirming driver's license
15	number. During COMP II, Administrator/Licensee confirmed the understanding of
16	Title 22. Component II was successfully completed. Administrator/Licensee was
17	advised to email signed LIC 809 with copy of photo ID to CAB.
18	
19	
20	During COMP II, CAB analyst confirmed Administrator/Licensee's understanding of
21	following areas:
22	
23	1. Facility operation: License type, client/resident populations, and program
24	2. Admission Policies
25	3. Staffing requirements & Training
	4. Restrictive/Prohibited Health Conditions

- 5. General provisions
- 6. Emergency Preparedness
- 7. Complaints & Reporting
- 8. Pre-licensing readiness

**NAME OF LICENSING PROGRAM MANAGER:** Darla Neeley  
**NAME OF LICENSING PROGRAM ANALYST:** Tammy Edwards  
**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 08/02/2024

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 08/02/2024

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