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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 425850264
Report Date: 05/09/2022
Date Signed: 05/09/2022 09:52:48 AM

Document Has Been Signed on 05/09/2022 09:52 AM **- It Cannot Be Edited**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814

FACILITY NAME:	DIVINE CARE FOR THE ELDERLY		FACILITY NUMBER:	425850264
ADMINISTRATOR:	JOSE, MARINO		FACILITY TYPE:	740
ADDRESS:	4866 FRANCES STREET		TELEPHONE:	(805) 967-5237
CITY:	SANTA BARBARA	STATE: CA	ZIP CODE:	93111
CAPACITY: 6		CENSUS: 4	DATE:	05/09/2022
TYPE OF VISIT:	Office	ANNOUNCED	TIME BEGAN:	09:30 AM
MET WITH:	Applicant/Adminstrator, Marino Jose		TIME COMPLETED:	10:00 AM

NARRATIVE

Facility Type: RCFE
Application Type: CHOW
Capacity: 6
Census (if any clients in care): 4
COVID Mitigation Plan discussed? Yes

Method: Telephone call with CAB
COMP II Participants: Applicant/Administrator, Marino Jose

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.

During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of following areas:
1. *Facility operation: License type, client/resident populations, and program*
2. *Staff qualifications and responsibilities*
3. *Applicant and Administrator qualifications*
4. *Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions*
5. *Grievances, Complaints, Community resources*
6. *Physical plant, food service*

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: Darla Neeley
NAME OF LICENSING PROGRAM ANALYST: Biridiana Cisneros
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 05/09/2022

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/09/2022

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