

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 435202744

Report Date: 11/24/2020

Date Signed: 11/24/2020 11:14:24 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, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814	
FACILITY EVALUATION REPORT			
FACILITY NAME: WESTMONT OF MILPITAS		FACILITY NUMBER: 435202744	
ADMINISTRATOR: TORTORELLI, TORRIE		FACILITY TYPE: 740	
ADDRESS: 80 CEDAR WAY		TELEPHONE: (858) 729-6720	
CITY: MILPITAS	STATE: CA	ZIP CODE: 95035	
CAPACITY: 225	CENSUS: 0	DATE: 11/24/2020	
TYPE OF VISIT: Office	ANNOUNCED	TIME BEGAN: 10:00 AM	
MET WITH: Sheryl Bravo		TIME COMPLETED: 10:20 AM	
NARRATIVE			
1	Facility Type: RCFE		
2	Application Type: Initial		
3	Applicant/administrator participated in COMP II via call with analyst at CAB.		
4	Identification of the applicant and administrator was verified. During COMP II,		
5	applicant and administrator confirmed the understanding of Title 22. Component II		
6	was successfully completed. Applicant and administrator were advised to email/fax		
7	signed LIC 809 with copy of photo ID to CAB.		
8	During COMP II, CAB analyst confirmed Applicant/administrator's understanding of		
9	following areas:		
10	1. Facility operation: License type, client/resident populations, and program		
11	2. Staff qualifications and responsibilities		
12	3. Applicant and Administrator qualifications		
13	4. Program policy: Abuse, admission agreement, medication management, reporting		
14	incidents to CCL, restricted & prohibited conditions		
15	5. Grievances, Complaints, Community resources		
16	6. Physical plant, food service		
17	7. Application document review and technical assistance: Criminal record clearance,		
18	Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate,		
19	Financial verification, Pre-licensing inspection, Compliance history, Control of		
20	property		
21			
22			
23			
24			
25			
NAME OF LICENSING PROGRAM MANAGER: Jude De La Concepcion			
NAME OF LICENSING PROGRAM ANALYST: Bethany Hunter			

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 11/24/2020

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 11/24/2020

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