

Department of

# SOCIAL SERVICES

Community Care Licensing

## FACILITY EVALUATION REPORT

Facility Number: 486804218

Report Date: 07/26/2024

Date Signed: 07/26/2024 02:11:22 PM

Document Has Been Signed on 07/26/2024 02:11 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: SOLANO LIFE HOUSE ASSISTED LIVING & MEMORY CARE	FACILITY NUMBER: 486804218
ADMINISTRATOR/FELIX, MARY	FACILITY TYPE: 740
DIRECTOR:	
ADDRESS: 575 S JEFFERSON ST	TELEPHONE: (707) 678-1651
CITY: DIXON	STATE: CA
CAPACITY: 38	ZIP CODE: 95620
TYPE OF VISIT: Office	CENSUS: 07/26/2024
	ANNOUNCED
	TIME VISIT/INSPECTION BEGAN: 02:00 PM
MET WITH:	TIME VISIT/INSPECTION COMPLETED: 02:10 PM

NARRATIVE	
1	COMP II by CAB successfully completed
2	
3	
4	Facility Type: RCFE
5	Application Type: CHOW
6	Capacity: 38
7	
8	Census (if any clients in care): 25
9	Method: Telephone call with CAB
10	COMP II Participants: Mary Felix, Administrator; Amy Buccat CEO/Owner; Shannon
11	Betker, analyst.
12	
13	
14	Applicant/administrator participated in COMP II at CAB via telephone call with
15	analyst at CAB. Identification of the applicant and administrator was verified by
16	confirming driver's license number. During COMP II, applicant and administrator
17	confirmed the understanding of Title 22. Component II was successfully completed.
18	Applicant and administrator were advised to email/fax signed LIC 809 with copy of
19	photo ID to CAB.
20	
21	
22	
23	During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of
24	following areas:
25	1. Facility operation: License type, client/resident populations, and program

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

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

**NAME OF LICENSING PROGRAM ANALYST:** Shannon Betker

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 07/26/2024

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 07/26/2024

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