

*Community Care Licensing*

**FACILITY EVALUATION REPORT**

**Facility Number:** 565850067

**Report Date:** 11/16/2020

**Date Signed:** 11/16/2020 11:23:24 AM

**Document Has Been Signed on** 11/16/2020 11:23 AM - **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 8-3-91 SACRAMENTO, CA 95814
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME:	VISTA AT SIMI VALLEY	FACILITY NUMBER:	565850067	
ADMINISTRATOR:	UNKNOWN	FACILITY TYPE:	740	
ADDRESS:	1236 ERRIGNER ROAD	TELEPHONE:	(530) 242-8300	
CITY:	SIMI VALLEY	ZIP CODE:	93065	
CAPACITY:	130	CENSUS:	DATE:	11/16/2020
TYPE OF VISIT:	Office	ANNOUNCED	TIME BEGAN:	11:00 AM
MET WITH:	DAN ZAHARONI		TIME	11:22 AM
	CAROL ANN LEROSE		COMPLETED:	

NARRATIVE	
1	Facility Type: RCFE
2	Application Type: INITIAL
3	Capacity: 130
4	Census (if any clients in care):
5	
6	
7	COMP II by CAB successfully completed
8	
9	
10	Method: Telephone call
11	
12	
13	COMP II Participant: CAROL ANN LEROSE & DAN ZAHARONI
14	
15	
16	<i>Applicant/administrator participated in COMP II via telephone call with the analyst at CAB.</i>
17	<i>Identification of the applicant and administrator was verified by photo ID. During COMP II,</i>
18	<i>applicant and administrator confirmed the understanding of Title 22. Component II was</i>
19	<i>successfully completed.</i>
20	
21	
22	<i>During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of</i>
23	<i>following areas:</i>
24	1. Facility operation: License type, client/resident populations, and program
25	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:** Mirella Quaranta

**NAME OF LICENSING PROGRAM ANALYST:** Stefania Fonteno

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 11/16/2020

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 11/16/2020

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