

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 565850291

Report Date: 11/30/2022

Date Signed: 11/30/2022 11:36:58 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 9-14-8201 SACRAMENTO, CA 95814
FACILITY EVALUATION REPORT	
FACILITY NAME: OAKMONT OF SIMI VALLEY	FACILITY NUMBER: 565850291
ADMINISTRATOR: SIDNEY, KEVAN	FACILITY TYPE: 740
ADDRESS: 3110 ROYAL AVE	TELEPHONE: (949) 744-5200
CITY: SIMI VALLEY	STATE: CA ZIP CODE: 93065
CAPACITY: 121	CENSUS: DATE: 11/30/2022
TYPE OF VISIT: Office	ANNOUNCED TIME BEGAN: 11:00 AM
MET WITH: SIDNEY, KEVAN	TIME COMPLETED: 11:30 AM

NARRATIVE	
1	Facility Type: KEVAN SIDNEY
2	Application Type: CHOW
3	Capacity: 121
4	Census (if any clients in care):
5	
6	
7	COMP II by CAB successfully completed
8	
9	Method: Telephone call
10	
11	
12	
13	COMP II Participant: KEVAN SIDNEY
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: 11/30/2022

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 11/30/2022

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