

FACILITY EVALUATION REPORT

Facility Number: 565850509
Report Date: 10/04/2024
Date Signed: 11/20/2024 02:09:27 PM

Document Has Been Signed on 11/20/2024 02:09 PM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY		CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CENTRALIZED APP UNIT, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814	
FACILITY EVALUATION REPORT			
FACILITY NAME: GREEN VALLEY HOME CARE		FACILITY NUMBER:	565850509
ADMINISTRATOR/ZANDERS, VANNESSA		FACILITY TYPE:	740
DIRECTOR:		TELEPHONE:	(805) 579-0040
ADDRESS: 2651 BANCOCK ST	STATE: CA	ZIP CODE:	93065
CITY: SIMI VALLEY	CENSUS:	DATE:	10/04/2024
CAPACITY: 6	UNANNOUNCED	TIME VISIT/INSPECTION	12:30 PM
TYPE OF VISIT: Office		BEGAN:	
MET WITH: Norma Zanders & Vannessa Zanders		TIME VISIT/INSPECTION	02:07 PM
		COMPLETED:	

NARRATIVE	
1	COMP II by CAB successfully completed
2	
3	
4	Method: Phone Call at CAB
5	
6	<i>Applicant/administrator participated in COMP II at CAB telephone call with</i>
7	<i>analyst at CAB. Identification of the applicant and administrator was</i>
8	<i>verified by presenting photo ID via phone. During COMP II, applicant and</i>
9	<i>administrator confirmed the understanding of Title 22. Component II was</i>
10	<i>successfully completed. Applicant and administrator were advised to</i>
11	<i>email/fax signed LIC 809 with copy of photo ID to CAB.</i>
12	
13	<i>During COMP II, CAB analyst confirmed Applicant/Administrator's</i>
14	<i>understanding of following areas:</i>
15	
16	<i>1. Facility operation: License type, client/resident populations, and program</i>
17	
18	<i>2. Staff qualifications and responsibilities</i>
19	
20	<i>3. Applicant and Administrator qualifications</i>
21	
22	
23	
24	
25	

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: Gina Baldwin

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 11/20/2024

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 11/20/2024

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