

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 565850509

Report Date: 10/04/2024

Date Signed: 11/20/2024 02:09:27 PM

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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, VANESSA		FACILITY TYPE:	740
DIRECTOR:			
ADDRESS:	2651 BANCOCK ST	TELEPHONE:	(805) 579-0040
CITY:	SIMI VALLEY	STATE: CA	ZIP CODE: 93065
CAPACITY:	6	CENSUS:	DATE: 10/04/2024
TYPE OF VISIT:	Office	UNANNOUNCED TIME VISIT/	INSPECTION BEGAN: 12:30 PM
MET WITH:	Norma Zanders & Vanessa Zanders	TIME VISIT/	INSPECTION COMPLETED: 02:07 PM

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