

Department of

# SOCIAL SERVICES

Community Care Licensing

## FACILITY EVALUATION REPORT

Facility Number: 079201318

Report Date: 12/28/2023

Date Signed: 12/28/2023 04:06:39 PM

Document Has Been Signed on 12/28/2023 04:06 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
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: SAFE HAVEN BRENTWOOD RESIDENTIAL CARE HOME, LLC	FACILITY NUMBER: 079201318
ADMINISTRATOR: POQUIZ, AILEEN	FACILITY TYPE: 740
ADDRESS: 960 GRIFFITH LANE	TELEPHONE: (510) 224-6165
CITY: BRENTWOOD	STATE: CA
CAPACITY: 6	ZIP CODE: 94513
TYPE OF VISIT: Office	CENSUS: 0
MET WITH: Aileen Poquiz	ANNOUNCED
	DATE: 12/28/2023
	TIME BEGAN: 02:00 PM
	TIME COMPLETED: 02:30 PM

NARRATIVE	
1	
2	Facility Type: RCFE
3	
4	Application Type: Initial
5	
6	Capacity: 6
7	
8	Census (if any clients in care): 0
9	
10	COMP II Participants: Name, Title: Aileen Poquiz, Administrator/Licensee
11	
12	Interview Method: Virtual interview MS Teams
13	
14	
15	
16	On 12/28/2023, applicant/administrator participated in COMP II. Identification of
17	the applicant and administrator was verified through interview questions based on
18	photo ID and other identifying personal information. During COMP II, applicant
19	and administrator confirmed that they have read and understand community care
20	facility licensing laws included in the Health and Safety Codes and the California
21	Code of Regulations Title 22. Signed LIC 809 with copy of photo ID have been
22	obtained.
23	
24	
25	

During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of following areas:

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:** Darla Neeley

**NAME OF LICENSING PROGRAM ANALYST:** Ahmad Reshad

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 12/28/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 12/28/2023

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