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BEFORE THE
DEPARTMENT OF SOCIAL SERVICES
STATE OF CALIFORNIA

IN THE MATTER OF:	
VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGEMENT GROUP LLC, dba **Villa Capri** 1397 Fountaingrove Parkway Santa Rosa, CA 95403	CDSS No. 7218241101 **ACCUSATION** (LICENSE REVOCATION)
VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGEMENT GROUP LLC, **dba Varenna at Fountaingrove** 1401 Fountaingrove Parkway Santa Rosa, CA 95403	CDSS No. 7218241101B **ACCUSATION** (LICENSE REVOCATION)
DEBORAH SMITH, Executive Director/Administrator Villa Capri	CDSS No. 7218241101C **ACCUSATION** (ADMINISTRATOR DECERTIFICATION)
DEBORAH SMITH, Executive Director/Administrator Villa Capri	CDSS No. 7218241101D **ACCUSATION** (EXCLUSION ACTION)
NATHAN CONDIE, Executive Director/Administrator Varenna at Fountaingrove	CDSS No. 7218241101E **ACCUSATION** (ADMINISTRATOR DECERTIFICATION)

NATHAN CONDIE,
Executive Director/Administrator
Varenna at Fountaingrove

Respondents.

CDSS No. 7218241101F

ACCUSATION
(EXCLUSION ACTION)

JURISDICTION

1. This matter arises under the California Residential Care Facilities for the Elderly Act, Health and Safety Code section 1569 et seq., which governs the licensing and operation of residential care facilities for the elderly ("RCFEs").

2. Regulations governing the licensing and operation of RCFEs are contained in California Code of Regulations, title 22, section 87100 et seq.[1]

3. The California Department of Social Services ("the Department") is the agency of the State of California responsible for the licensing and inspection of RCFEs.

4. Pursuant to Health and Safety Code section 1569.50, the Department may suspend or revoke an RCFE license.

5. The Department may suspend or revoke an RCFE license if any employee or administrator of the licensee's facility has violated the law governing licensed facilities, pursuant to Health and Safety Code section 1569.50(b).

6. Pursuant to Health and Safety Code section 1569.52, the Department may institute or continue a disciplinary proceeding against an RCFE licensee following the suspension, expiration, or forfeiture of a license.

7. The Department may prohibit any person from being a licensee, owning a beneficial ownership interest of 10 percent or more in a licensed facility, or being an administrator, officer, director, member, or manager of a licensee or entity controlling a licensee, and may further prohibit any licensee from employing, or continuing the

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[1] Subsequent references to any regulation section(s) are to Title 22 of the California Code of Regulations.

employment of, or allowing in a licensed facility, or allowing contact with clients of a licensed facility by, any employee, prospective employee, or person who is not a client of an RCFE pursuant to Health and Safety Code section 1569.58 and may revoke or deem forfeited the certificate of an administrator pursuant to Health and Safety Code section 1569.616(h)(2) and Regulation section 87408(a).

8. Pursuant to Health and Safety Code section 1569.58(f), the Department may institute or continue a disciplinary proceeding against a person following the resignation, withdrawal of employment application, or change of duties, or any discharge, failure to hire, or reassignment of the person by the licensee or if the person no longer has contact with clients of the facility.

9. Pursuant to Health and Safety Code sections 1569.51(b), and 1569.58(e), the standard of proof to be applied in this proceeding is a preponderance of evidence.

10. Administrative proceedings before the Department must be conducted in conformity with the provisions of the California Administrative Procedure Act, Chapter 5, Government Code section 11500 et seq.

THE PARTIES

11. Complainant **PAMELA DICKFOSS** is the authorized representative of the Director of the Department pursuant to a delegation of authority. Pursuant to Government Code section 11503, Complainant files this Accusation in her official capacity.

12. Respondents **VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGMENT GROUP LLC** (collectively, "Respondent LICENSEE") are licensed by the Department to operate an RCFE with a total capacity of 80 residents at 1397 Fountaingrove Parkway, Santa Rosa, a facility known as Villa Capri ("Villa Capri").

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A copy of Villa Capri's most recent license setting forth the capacity, limitations, and effective dates accompanies this Accusation as **ATTACHMENT A** and is incorporated by reference.

13. Respondent **LICENSEE** is also licensed by the Department to operate an RCFE with a total capacity of 322 residents at 1401 Fountaingrove Parkway, Santa Rosa, a facility known as Varenna at Fountaingrove ("Varenna"). A copy of Varenna's most recent license setting forth the capacity, limitations, and effective dates accompanies this Accusation as **ATTACHMENT B** and is incorporated by reference.

14. In October 2017, Respondent **DEBORAH SMITH** was employed by Respondent **LICENSEE** as Villa Capri's Executive Director and Administrator.

15. In October 2017, Respondent **NATHAN CONDIE** was employed by Respondent **LICENSEE** as Varenna's Executive Director and Administrator.

16. Respondent **LICENSEE,** by virtue of licensure, must operate in accordance with the statutes and regulations governing the licensing and operation of RCFEs and is subject to RCFE revocation if any employee or administrator of the licensee's facility has violated the law governing licensed facilities, pursuant to Health and Safety Code section 1569.50(b).

17. Respondents **DEBORAH SMITH** and **NATHAN CONDIE,** by virtue of presence in or contact with clients of an RCFE, are subject to the jurisdictional provisions of Health and Safety Code sections 1569.17 and 1569.58. Further, Respondents **DEBORAH SMITH** and **NATHAN CONDIE**, by virtue of administrator certification, must comply with the statutes and regulations governing the certification of administrators pursuant to Health and Safety Code section 1569.616 and Regulation sections 87405, 87408, and 87409. Copies of the applicable statutes and regulations accompany this Accusation as **ATTACHMENT C** and are incorporated by reference.

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FACTUAL ALLEGATIONS

VILLA CAPRI

SUBJECT MATTER: CARE AND SUPERVISION/NIGHT SUPERVISION/STAFF TRAINING/EVACUATION PROCEDURES/PERSONAL RIGHTS (Villa Capri)

APPLICABLE LAW: Health and Safety Code sections 1569.269(a)(6); 1569.50(a) and (b); 1569.58(a); 1569.625; and 1569.695
Regulation sections 87101 (a)(1) and (6) and (n)(2) [definitions]; 87205 [licensee accountability]; 87212(b)(2) [emergency disaster plan]; 87405 [administrator qualifications and duties]; 87411 [personnel requirements]; 87415 [familiarity with planned emergency procedures]; and 87468(a) [personal rights]

ALLEGATIONS:

18. On the night of October 8-9, 2017, 62 elderly and disabled residents were residing and receiving care at Villa Capri. Of those 62 residents, 25 were part of the memory care (dementia) unit and 37 were in assisted living. All 25 of the memory care residents were considered nonambulatory because they were unable to exit unassisted in an emergency, pursuant to section 87101(n)(2). In addition, of the 37 residents in assisted living, at least 22 were nonambulatory.

Four staff were on duty at Villa Capri overnight to care for the 62 residents. Marie So was the substitute administrator at Villa Capri, as required in section 87405(a), supervising Annet Rivas, Cynthia Arroyo, and Elizabeth Lopez.

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1 An evacuation of Villa Capri was required on the night of October 8-9, 2017
2 due to wildfires. Respondent **LICENSEE** failed to ensure that Villa Capri staff members
3 were able to provide adequate care and supervision to residents at Villa Capri on
4 October 8-9, 2017, as follows:

5 A. Respondent **LICENSEE**, and its agents/employees, including
6 Respondent **DEBORAH SMITH**, Villa Capri's administrator, failed to ensure that
7 Marie So, Annet Rivas, Cynthia Arroyo, and Elizabeth Lopez were familiar with
8 Villa Capri's planned emergency procedures or participated in emergency training,
9 as required by Health and Safety Code section 1569.625(c)(6) and Regulation
10 section 87415(a).

11 B. Marie So, Villa Capri's substitute administrator, was unable to direct
12 staff during the evacuation and did not know the facility's evacuation plan. She did
13 not utilize Villa Capri's emergency binder during the evacuation, did not know
14 where keys for facility vehicles were kept, where flashlights were kept, or where
15 batteries for flashlights were kept, nor did she know how to direct the staff she was
16 supervising during the emergency, in violation of Regulation section 87415(a).
17 While employed at Villa Capri, Marie So had never participated in a fire drill
18 involving evacuating all residents.

19 C. Elizabeth Lopez did not know there was an emergency binder or
20 where it was kept, or where the facility vehicle keys were kept. While employed at
21 Villa Capri, Elizabeth Lopez had never participated in a fire drill involving
22 evacuating all residents.

23 D. Cynthia Arroyo did not know where keys to facility vehicles
24 were kept; she spent an hour unsuccessfully searching for facility vehicle keys in
25 the scheduling office, the activities room, the med tech office, and other locations
26 without finding the keys. Cynthia Arroyo had never participated in a fire drill while
27 employed at Villa Capri.

E. Anett Rivas did not know where facility vehicle keys were kept. While employed at Villa Capri, she had never participated in a fire drill involving evacuating all residents in response to an outside fire while employed at Villa Capri.

F. On the night of the fire, Elizabeth Lopez and Cynthia Arroyo were incapable of performing standard caregiver duties, such as transferring residents and turning residents, due to limitations on their ability to lift more than 10 pounds or use both hands.

G. On October 9, 2017, at some point around 3:00 or 3:30 a.m., the exact time of which is unknown to Complainant, Marie So, the designated substitute administrator for Villa Capri, decided to leave two untrained staff, Cynthia Arroyo and Elizabeth Lopez, at the facility with approximately 30 elderly and infirm residents to await evacuation, although there were not adequate vehicles to provide transportation to all of the residents. Anett Rivas had already left the facility with other residents. When Marie So eventually arrived an at evacuation center, she did not notify anyone of the situation, nor did she call 911 to notify emergency responders while she was on her way to the evacuation center as a passenger in a vehicle. After Marie So left Villa Capri on the night of the fire, staff Cynthia Arroyo and Elizabeth Lopez departed from the facility in their personal vehicles with approximately six residents, leaving more than 20 elderly and infirm residents remaining at Villa Capri with no staff supervision.

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H. As a result of the events described above, no staff were at Villa Capri to assist with the evacuation of more than 20 remaining elderly and infirm facility residents. These residents would have perished when the facility burned to the ground during the fire if the following had not happened:

i. After all Villa Capri staff left the facility, family members of Villa Capri residents stayed at the facility alone with residents and continued assisting non-ambulatory residents who were left stranded on the second floor and other residents who remained inside the facility lobby behind a locking door. Melissa Langhals made contact with a police cruiser that was passing by and asked for help.

ii. When emergency responders arrived at Villa Capri, family members assisted them with the evacuation of the more than 20 remaining facility residents after all Villa Capri staff were gone. If these family members and emergency responders had not evacuated Villa Capri residents, more than 20 residents would have perished when Villa Capri burned to the ground after all staff left the facility.

I. When emergency responders arrived at Villa Capri, they noticed a large-capacity bus parked nearby that would have been useful to evacuate residents sitting unused in a parking lot near the facility. They were unable to use the bus because they did not have keys.

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SUBJECT MATTER: ADMINISTRATOR QUALIFICATIONS

APPLICABLE LAW: Health and Safety Code sections 1569.58(a)(1) and (2); 1569.616

Regulation section 87405(d)(1), (2), (4), and (5) and (h)

ALLEGATIONS:

19. Respondent **DEBORAH SMITH**, the administrator of Villa Capri, failed to train facility staff or to adequately direct the work of others, as described in paragraph 18, above, and incorporated here by reference.

20. Respondent **DEBORAH SMITH** was contacted by Villa Capri substitute administrator Marie So at approximately 11:30 p.m. on the night of the fire when the facility's power went out. Because the power was out, the doors to the memory care unit, which housed people with dementia who could be at risk of wandering, were not secure. There were three doors through which demented residents might exit the facility, unsafely. Respondent Deborah Smith directed Marie So to station staff at the facility exits, which compromised staff members' ability to provide direct care to residents. However, Respondent Deborah Smith did not go to Villa Capri to assist at that time, despite the circumstances.

21. Respondent **DEBORAH SMITH** spoke to Marie So at approximately 1:30 a.m. on the night of the fire and was informed that Villa Capri residents were being moved for evacuation. After speaking with Marie So, Respondent Deborah Smith began driving toward Villa Capri, but did not make it to the facility. Instead, Respondent Deborah Smith returned to her home for an unknown amount of time before heading to an evacuation center. She eventually arrived at an evacuation center at approximately 6:00 a.m on October 9, 2018.

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SUBJECT MATTER: SAFEGUARD PERSONAL PROPERTY AND VALUABLES

APPLICABLE LAW: Health and Safety Code sections 1569.50(a) and (b); Regulation section 87217(b) [safeguard personal property and valuables]

ALLEGATIONS:

22. On or about October 17, 2017, Respondent **LICENSEE**, or individuals authorized to act on its behalf, decided to clear the Villa Capri site and began to do so, using large equipment, without allowing residents or their families access to the site to search for personal belongings that may have survived the fire. Between October 10, 2017 and October 16, 2017, at least two Villa Capri residents' family members had been informed by Respondent **LICENSEE**, or individuals authorized to act on its behalf, that they would receive communication about property retrieval.

VARENNA

SUBJECT MATTER: CARE AND SUPERVISION/NIGHT SUPERVISION/STAFF TRAINING/EVACUATION PROCEDURES/PERSONAL RIGHTS (Varenna)

APPLICABLE LAW: Health and Safety Code sections 1569.269; 1569.50(a) and (b); 1569.58(a); 1569.625; and 1569.695
Regulation sections 87205 [licensee accountability]; 87212(b)(2) [emergency disaster plan]; 87405(a), (b), (d), and (h) [administrator qualifications and duties]; 87415 [familiarity with planned emergency procedures]; and 87468(a) [personal rights]

ALLEGATIONS:

23. On October 8-9, 2017, 228 elderly residents were being cared for and resided at Varenna. Of those 228 residents, 142 were in Varenna's main building; 43 were in two separate free standing buildings; and 43 were in individual "casitas." Of the

142 residents in Varenna's main building, 13 residents had been determined by Respondent **LICENSEE** to need care and supervision and a 14th resident was on hospice.

Two direct care staff were on duty at the facility to care for Varenna's 228 residents overnight. Alma Dichoso was the lead direct care staff member in charge and Theresa Martinez was the second direct care staff member. Two maintenance staff members, Andre Blakely and Michael Rodriquez, were also on night duty.

An evacuation of the facility was required due to wildfires. Respondent **LICENSEE** failed to ensure that facility staff members were able to provide adequate care and supervision to elderly clients at the facility on October 8-9, 2017, as follows:

A. Facility staff, including Alma Dichoso and Theresa Martinez, were not trained in emergency evacuations or fire emergencies. Staff Maria Cervantes (a.k.a Jophell), who was not on duty but who came to the facility during the fire to help, also had not received training in emergency evacuations or fire emergencies.

B. Respondent **NATHAN CONDIE**, the administrator for Varenna, arrived at the facility at approximately 12:30 a.m - 1:00 a.m. As the facility administrator, he was in charge of Varenna staff. However, Respondent **NATHAN CONDIE** did not provide any response to questions from Theresa Martinez, Andre Blakely, or Michael Rodriguez, each of whom separately asked Respondent **NATHAN CONDIE** about Varenna's evacuation plan that night.

C. Varenna staff, including Alma Dichoso, Andre Blakely, and Michael Rodriguez, were evacuating facility residents from their rooms at approximately 2:00 a.m. - 2:30 a.m. when Respondent **NATHAN CONDIE** directed them to return the residents to their rooms instead of continuing with the evacuation. Respondent **NATHAN CONDIE** stated that he did not want to cause issues or make trouble for Respondent **LICENSEE**.

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D. Respondent **NATHAN CONDIE** left Varenna at approximately 3:30 a.m. without notifying staff that he was leaving permanently or directing them how to proceed. Respondent **NATHAN CONDIE** left behind more than 70 residents with three on-duty staff members who were not trained in evacuation procedures: Alma Dichoso, Theresa Martinez, and Andre Blakely. Facility staff received no further communication from Respondent **NATHAN CONDIE** during the evacuation.

E. When Respondent **NATHAN CONDIE** left the facility, he was aware that a large-capacity facility bus was in the parking lot, in sight of the facility, and that the keys for the vehicle were in the drawer of a desk at the facility. However, Respondent **NATHAN CONDIE** did not ensure that staff on site, under his supervision, were aware of the location of those keys or tell them to use the bus to evacuate residents. In addition, Respondent **NATHAN CONDIE** did not use the large facility bus himself to evacuate residents; instead, he took a small number of residents in his personal car and left the facility. The bus could have been used to evacuate approximately 26 residents. Respondent **NATHAN CONDIE** did not ensure that all residents at Varenna were awake or alerted to the situation when he left.

F. At some point after Respondent **NATHAN CONDIE** left, the remaining staff departed from Varenna while residents remained asleep in their rooms. As a result, residents, their families and friends, and emergency responders had to evacuate approximately 70 residents, as follows, without staff assistance:

i. A friend of Resident # 1's granddaughter arrived and evacuated Resident # 1 sometime between 3:30 a.m. and 4:30 a.m.

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1 ii. Resident # 2 and Resident # 3 were awakened by a neighbor
2 knocking on their door at approximately 4:00 a.m., saying that they had to
3 evacuate immediately. They did so without ever seeing or being notified
4 by facility staff.
5 iii. Resident # 4's grandson arrived at approximately 4:00 a.m. to
6 help his grandfather. His grandfather had already left the facility, but he
7 was besieged by questions about what to do and became aware that there
8 were many residents in the darkened, smoky building who needed help.
9 Resident # 4's grandson ran door-to-door banging on doors to locate and
10 awaken residents, assisted them into the building lobby, and started a list
11 of resident names. Resident # 4's grandson voluntarily stayed at the
12 facility for approximately three hours, actively helping to evacuate
13 residents for the full time.
14 iv. Emergency responders arrived at approximately 4:15 a.m. and
15 joined Resident # 4's grandson in waking and evacuating residents. No
16 facility staff were present when emergency responders arrived at the
17 facility. Therefore, emergency responders had no staff assistance in
18 obtaining resident names, identifying residents who had been
19 evacuated, identifying residents who were still in the building, or providing
20 a list of evacuated room numbers to ensure that all residents were
21 accounted for. They kicked in locked doors throughout the facility and
22 alerted sleeping residents. Eventually, busses ordered by emergency
23 responders arrived. According to estimates by Santa Rosa Police, "close
24 to 100 residents" were evacuated from the facility, including many who
25 used walkers and wheelchairs.
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v. Resident # 5 voluntarily assisted emergency responders by showing them where to look for residents in outlying buildings, where many residents were found asleep.

vi. After speaking with her brother by phone, Resident # 4's granddaughter arrived at the facility at approximately 4:50 a.m. and helped emergency responders locate and evacuate residents. Resident # 4's granddaughter voluntarily stayed at the facility for approximately two hours, helping to evacuate residents.

G. The following Varenna residents were never evacuated and learned the following morning that an evacuation had taken place while they were asleep:

i. Resident # 6,

ii. Resident # 7, and

iii. Resident # 8.

SUBJECT MATTER: ADMINISTRATOR QUALIFICATIONS; CONDUCT INIMICAL

APPLICABLE LAW: Health and Safety Code sections 1569.58(a) and 1569.616
Regulation section 87405(d)(1), (2), and (5) and (h) (4)

ALLEGATIONS:

24. Respondent **NATHAN CONDIE** did not demonstrate that he had knowledge of the requirements for providing appropriate care and supervision to residents; that he had knowledge of and ability to conform to applicable laws relating to oversight of the facility; or that he behaved in a manner that demonstrated good character on October 8-9, 2017, in violation of regulation section 87405(d)(1), (2), and (5), as described in Paragraph 23, above, and incorporated here by reference.

25. Respondent **NATHAN CONDIE** failed to train facility staff, as required by regulation section 87405(h)(4), as described in Paragraph 23, above, and incorporated here by reference.

1 SUBJECT MATTER: FALSE CLAIMS
2 APPLICABLE LAW: Health and Safety Code sections 1569.30 and 1569.50
3 Regulation section 87207
4 ALLEGATIONS:

5 26. On or about July 31, 2018, Respondent **LICENSEE** published
6 information online, available to the public, entitled "The Real Story of Oakmont Senior
7 Living and the Tubbs Fire," which contains false and misleading statements, in violation
8 of regulation section 87207. The false or misleading statements contained therein
9 include, but are not limited to, the following:

10 A. "A total of 7 employees successfully evacuated all residents at
11 Villa Capri." This is a false and misleading statement; see Paragraph
12 18(H).

13 B. "This [the evacuation of Villa Capri] was a team effort led by
14 staff, with help from family members, which we [Oakmont] greatly appreciated.
15 Staff members, along with family members evacuated the last residents." These
16 are false and misleading statements; see Paragraph 18(H).

17 27. On or about October 26, 2018, Pooya Ansari, an employee of
18 Respondent **LICENSEE**, told a Department representative that he had returned to
19 Varenna with two other staff members in the morning following the fire to ensure that no
20 residents remained at the facility. He told the Department that the three searched
21 Varenna and found no remaining residents. He stated that all areas of Varenna had
22 been evacuated. These statements were false; Pooya Ansari and the two other staff
23 found at least three residents at the facility in the morning following the fire and
24 transported those residents from the facility.

25 28. On or about October 26, 2018, Joel Ruiz, an employee of Respondent
26 **LICENSEE**, told a Department representative that had returned to Varenna with two
27 other staff members in the morning following the fire to ensure that no residents

remained at the facility. He told the Department that he went to every room of Varenna, including the "casitas," and found no remaining residents. He said all residents had been evacuated. This statement was false; Joel Ruiz and the two other staff found at least three residents at the facility in the morning following the fire and transported those residents from the facility after they were found.

SUBJECT MATTER: CONDUCT INIMICAL

APPLICABLE LAW: Health and Safety Code sections 1569.50(a) and 1569.58

ALLEGATIONS:

29. Respondent **LICENSEE**, or its agents/employees, engaged in conduct that is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility, or the people of the State of California, as alleged in Paragraphs 18 through 28, above, and incorporated here by reference.

30. Respondent **DEBORAH SMITH** engaged in conduct that is inimical to the health, morals, welfare, or safety of an individual in or receiving services from the facility, or the people of the State of California, as described in Paragraphs 18, 19, 20, and 21, above, and incorporated here by reference.

31. Respondent **NATHAN CONDIE** engaged in conduct that is inimical to the health, morals, welfare, or safety of an individual in or receiving services from the facility, or the people of the State of California, as described in Paragraphs 23, 24, and 25, above, and incorporated here by reference.

CAUSE FOR LICENSE REVOCATION, ORDERS OF EXCLUSION, AND ADMINISTRATOR DECERTIFICATIONS

32. The facts alleged in paragraphs 18 through 28, individually and/or jointly, provide cause, pursuant to Health and Safety Code section 1569.50(a)-(b) to revoke Respondents **VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGEMENT GROUP LLC's** license to operate Villa Capri and Varrena.

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33. The facts alleged in paragraphs 18 through 28, individually and/or jointly, constitute conduct by Respondents **VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGEMENT GROUP LLC** that is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility or the people of the State of California. These facts provide cause, pursuant to Health and Safety Code section 1569.50(a)(3), to revoke Respondents' license to operate the Villa Capri and Varenna.

34. The facts alleged in paragraphs 18, 19, 20, and 21, individually and/or jointly, provide cause, pursuant to Health and Safety Code section and 1569.58(a)(1) and (2) and Welfare and Institutions Code section 16519.6(g)(1) to prohibit Respondent **DEBORAH SMITH** from being a licensee; owning a beneficial ownership interest of 10 percent or more in a licensed facility; or being an administrator, officer, director, member, or manager of a licensee or entity controlling a licensee; and, further, from employment in, presence in, and contact with clients of, any facility licensed by the Department or certified by a licensed foster family agency, or any resource family home, for the remainder of Respondent's life, as well as to revoke Respondent **DEBORAH SMITH's** administrator certificate.

35. The facts alleged in paragraphs 23, 24, and 25, individually and/or jointly, provide cause, pursuant to Health and Safety Code section and 1569.58(a)(1) and (2) and Welfare and Institutions Code section 16519.6(g)(1) to prohibit Respondent **NATHAN CONDIE** from being a licensee; owning a beneficial ownership interest of 10 percent or more in a licensed facility; or being an administrator, officer, director, member, or manager of a licensee or entity controlling a licensee; and, further, from employment in, presence in, and contact with clients of, any facility licensed by the Department or certified by a licensed foster family agency, or any resource family home, for the remainder of Respondent **NATHAN CONDIE's** life, as well as to revoke Respondent **NATHAN CONDIE's** administrator certificate.

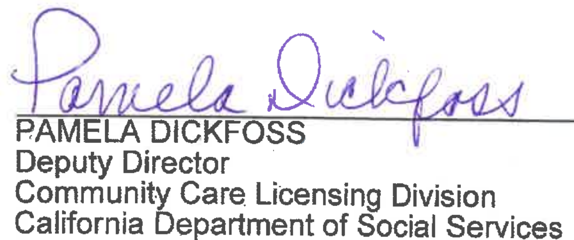
PETITION FOR RELIEF

36. WHEREFORE, Complainant requests that Respondents **VARENNA LLC, OAKMONT SENIOR LIVING LLC, and OAKMONT MANAGEMENT GROUP LLC's** license to operate the facility be revoked.

37. WHEREFORE, Complainant requests that Respondent **DEBORAH SMITH** be prohibited for the remainder of her life from being a licensee; owning a beneficial ownership interest of 10 percent or more in a licensed facility; or being an administrator, officer, director, member, or manager of a licensee or entity controlling a licensee; and, further, from employment in, presence in, and from contact with clients of, any facility licensed by the Department or certified by a licensed foster family agency, or any resource family home[2] and that her administrator certificate be revoked.

38. WHEREFORE, Complainant requests that Respondent **NATHAN CONDIE** be prohibited for the remainder of his life from being a licensee; owning a beneficial ownership interest of 10 percent or more in a licensed facility; or being an administrator, officer, director, member, or manager of a licensee or entity controlling a licensee; and, further, from employment in, presence in, and from contact with clients of, any facility licensed by the Department or certified by a licensed foster family agency, or any resource family home[3] and that his administrator certificate be revoked.

DATED:



PAMELA DICKFOSS
Deputy Director
Community Care Licensing Division
California Department of Social Services

9/4/18

[2] If an exclusion is granted, Government Code section 11522 allows for a petition to the Department after one year, and annually thereafter, for a reduction in penalty.
[3] If an exclusion is granted, Government Code section 11522 allows for a petition to the Department after one year, and annually thereafter, for a reduction in penalty.