

# Department of SOCIAL SERVICES

## Community Care Licensing

# FACILITY EVALUATION REPORT

Facility Number: 015601255  
Report Date: 07/30/2021  
Date Signed: 07/30/2021 10:39:48 AM

Document Has Been Signed on 07/30/2021 10:39 AM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1515 CLAY STREET, STE. 310 OAKLAND, CA 94612
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: BROOKDALE NORTH FREMONT	FACILITY NUMBER: 015601255
ADMINISTRATOR: EBONY (LADY) REED	FACILITY TYPE: 740
ADDRESS: 38035 MARTHA AVE	TELEPHONE: (510) 797-4011
CITY: FREMONT	STATE: CA
CAPACITY: 40	ZIP CODE: 94536
TYPE OF VISIT: Required - 1 Year	CENSUS: 31
MET WITH: Lady Reed	DATE: 07/30/2021
	UNANNOUNCED TIME BEGAN: 09:03 AM
	TIME COMPLETED: 10:45 AM

NARRATIVE	
1	On 07/30/2021 at 9:03am, Licensing Program Analysts (LPAs) A. O'Hollaren and J. Clancy-Czuleger
2	arrived unannounced to conduct Infection Control Inspection. LPAs met with Administrator Lady Reed
3	and explained the purpose of the visit.
4	
5	During the inspection, LPAs toured facility including but not limited to common areas, hand washing
6	stations, bedrooms, kitchen and courtyard. LPAs observed COVID-19 signage throughout the facility.
7	Hand washing signs were posted at hand washing stations. LPAs observed PPE, food and paper
8	supplies are sufficient. COVID-19 screening questions were maintained at the facility for all staff,
9	residents, and visitors. Hand sanitizer is provided at facility entryway. Common areas are disinfected
10	frequently throughout the day. A carbon monoxide detector was tested and was observed to be working.
11	Smoke detectors are interconnected to the Fire Department.
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13	During record review, LPAs observed facility has a copy of Mitigation Plan on file.
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15	No deficiencies cited during visit. Exit interview conducted and a copy of this report provided.
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NAME OF LICENSING PROGRAM MANAGER: Yvonne Flores-Larios
NAME OF LICENSING PROGRAM ANALYST: Allison O'Hollaren

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 07/30/2021

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 07/30/2021

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