

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 216804010

Report Date: 10/12/2021

Date Signed: 10/12/2021 11:05:46 AM

Document Has Been Signed on 10/12/2021 11:05 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, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814
FACILITY EVALUATION REPORT	
FACILITY NAME: OAKMONT OF SAN RAFAEL	FACILITY NUMBER: 216804010
ADMINISTRATOR: RIVERA, MELON	FACILITY TYPE: 740
ADDRESS: 3773 REDWOOD HIGHWAY	TELEPHONE: (628) 336-1400
CITY: SAN RAFAEL	STATE: CA
CAPACITY: 126	ZIP CODE: 94903
TYPE OF VISIT: Office	CENSUS: 10/12/2021
MET WITH: Susan McPherson, Applicant Representative;	ANNOUNCED TIME BEGAN: 10:30 AM
Melon Rivera, Administrator	TIME COMPLETED: 11:00 AM

NARRATIVE	
1	Facility Type: RCFE
2	Application Type: Initial
3	Capacity: 126
4	Census (if any clients in care): None
5	
6	
7	
8	Method: Telephone call with CAB
9	COMP II Participants: Susan McPherson, Applicant Representative; Melon Rivera,
10	Administrator
11	<i>Applicant / administrator participated in COMP II via telephone call with the analyst at</i>
12	<i>CAB. During COMP II, applicant and administrator confirmed the understanding of</i>
13	<i>Title 22. Component II was successfully completed.</i>
14	
15	
16	
17	<i>During COMP II, CAB analyst confirmed Applicant / Administrator's understanding of</i>
18	<i>following areas:</i>
19	
20	1. Facility operation: License type, client / resident populations, and program
21	2. Staff qualifications and responsibilities
22	3. Applicant and Administrator qualifications
23	4. Program policy: Abuse, admission agreement, medication management, reporting
24	incidents to CCL, restricted & prohibited conditions
25	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: Jude De La Concepcion

NAME OF LICENSING PROGRAM ANALYST: Victoria Christiansen

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 10/12/2021

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 10/12/2021

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