

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 216804010

Report Date: 10/12/2021

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

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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 ZIP CODE: 94903
CAPACITY: 126	CENSUS: ANNOUNCED DATE: 10/12/2021
TYPE OF VISIT: Office	TIME BEGAN: 10:30 AM
MET WITH: Susan McPherson, Applicant Representative; 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
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8	Method: Telephone call with CAB
9	COMP II Participants: Susan McPherson, Applicant Representative; Melon Rivera, Administrator
10	<i>Applicant/administrator participated in COMP II via telephone call with the analyst at CAB. During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed.</i>
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17	<i>During COMP II, CAB analyst confirmed Applicant/ Administrator's understanding of following areas:</i>
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20	1. <i>Facility operation: License type, client/resident populations, and program</i>
21	2. <i>Staff qualifications and responsibilities</i>
22	3. <i>Applicant and Administrator qualifications</i>
23	4. <i>Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions</i>
24	5. <i>Grievances, Complaints, Community resources</i>
25	6. <i>Physical plant, food service</i>
	7. <i>Application document review and technical assistance: Criminal record clearance,</i>

*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.