

Department of SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 216804022
Report Date: 03/01/2022
Date Signed: 03/01/2022 11:09:04 AM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY		CALIFORNIA DEPARTMENT OF SOCIAL SERVICES	
FACILITY EVALUATION REPORT		COMMUNITY CARE LICENSING DIVISION	
		CCLD Regional Office, 744 P STREET, MS 9-14-8201	
		SACRAMENTO, CA 95814	
FACILITY NAME:	OAKMONT OF NOVATO	FACILITY NUMBER:	216804022
ADMINISTRATOR:	DOMIZIO, ANNEMARIE	FACILITY TYPE:	740
ADDRESS:	1465 S. NOVATO BLVD.	TELEPHONE:	(628) 215-1200
CITY:	NOVATO	STATE:	CA
CAPACITY:	118	ZIP CODE:	94947
TYPE OF VISIT:	Office	CENSUS:	DATE: 03/01/2022
MET WITH:	ANNEMARIE DOMIZIO	ANNOUNCED	TIME BEGAN: 11:00 AM
		TIME COMPLETED:	11:30 AM

NARRATIVE	
1	Facility Type: RCFE
2	Application Type: CHOW
3	Capacity: 0118
4	Census (if any clients in care):
5	
6	
7	COMP II by CAB successfully completed
8	
9	Method: Telephone call
10	
11	
12	
13	COMP II Participant: ANNEMARIE DOMIZIO
14	
15	
16	<i>Applicant/administrator participated in COMP II via telephone call with the analyst at CAB.</i>
17	<i>Identification of the applicant and administrator was verified by photo ID . During COMP II,</i>
18	<i>applicant and administrator confirmed the understanding of Title 22. Component II was</i>
19	<i>successfully completed.</i>
20	
21	
22	<i>During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of</i>
23	<i>following areas:</i>
24	<i>1. Facility operation: License type, client/resident populations, and program</i>
25	<i>2. Staff qualifications and responsibilities</i>
	<i>3. Applicant and Administrator qualifications</i>
	<i>4. Program policy: Abuse, admission agreement, medication management, reporting</i>
	<i>incidents to CCL, restricted & prohibited conditions</i>
	<i>5. Grievances, Complaints, Community resources</i>

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: Mirella Quaranta

NAME OF LICENSING PROGRAM ANALYST: Stefania Fonteno

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 03/01/2022

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 03/01/2022

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