

Department of SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 415600133
Report Date: 03/23/2021
Date Signed: 03/23/2021 03:18:58 PM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 851 TRAEGER AVE., SUITE 360 SAN BRUNO, CA 94066
FACILITY EVALUATION REPORT	

FACILITY NAME: ATRIA PARK OF SAN MATEO	FACILITY NUMBER: 415600133
ADMINISTRATOR: PERRYMAN, DAVID	FACILITY TYPE: 740
ADDRESS: 2883 S NORFOLK ST	TELEPHONE: (650) 378-3000
CITY: SAN MATEO	STATE: CA
CAPACITY: 175	ZIP CODE: 94403
TYPE OF VISIT: Case Management - Incident	CENSUS: DATE: 03/23/2021
MET WITH: Cecilia Dauth, Administrator	UNANNOUNCED TIME BEGAN: 03:00 PM
	TIME COMPLETED: 03:15 PM

NARRATIVE	
1	Licensing Program Analyst (LPA) Raygoza made an unannounced case management virtual visit and
2	stated purpose of visit to Administrator, Cecilia Dauth.
3	
4	During the investigation of complaint 14-AS-20200520143002, information provided indicated that R1
5	had a change of condition, developing a stage 3 pressure wound that is a prohibited health condition.
6	The licensee failed to request an exception to retain the resident and failed to provide higher level of
7	care. The home health nurse communicated the worsening of the resident's condition, but the licensee
8	failed to act appropriately. It was also indicated that no provisions were made to have the resident
9	transfer to a higher level of care facility. Therefore, there is preponderance of evidence to show that the
10	licensee failed to ensure proper care of the resident's needs by failing to follow PCHH instructions on
11	wound care. During the period of 04/18/20 through 4/24/20, the Administrator did not fulfill
12	Administrator's Qualifications and Duties. Therefore, the facility is cited under Section 87405(d)(1)(2)
13	Administrator Qualifications and Duties.
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15	This report was discussed and reviewed with Administrator, Cecilia Dauth.
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NAME OF LICENSING PROGRAM MANAGER: Brenda Chan NAME OF LICENSING PROGRAM ANALYST: Bertha Raygoza

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 03/23/2021

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 03/23/2021

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

LIC809 (FAS) - (06/04)

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Created By: Bertha Raygoza On 03/18/2021 at 03:14 PM

Link to Parent Document Below:

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY FACILITY EVALUATION REPORT (Cont)	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION , 851 TRAEGER AVE., SUITE 360 SAN BRUNO, CA 94066
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FACILITY NAME: ATRIA PARK OF SAN MATEO

FACILITY NUMBER: 415600133

DEFICIENCY INFORMATION FOR THIS PAGE:

VISIT DATE: 03/23/2021

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)	
Type A 03/24/2021 Section Cited	1 87405(d)(1)(2) Administrator - 2 Qualifications and Duties - (d) The 3 administrator shall have the 4 qualifications specified in Sections 5 87405(d)(1) through (7). If the 6 licensee is also the administrator, all 7 requirements for an administrator shall apply. (1) Knowledge of the requirements for providing care and supervision appropriate to the residents. (2) Knowledge of and ability to conform to the applicable laws, rules and regulations.		
	8 This requirement is not met as 9 evidenced by; The licensee failed to 10 request an exception to retain the 11 resident and failed to provide higher 12 level of care. The home health nurse 13 communicated the worsening of the 14 resident's condition, but the licensee failed to act appropriately. Licensee failed to ensure proper care of R1's needs by failing to follow PCHH instructions on wound care.	8 9 10 11 12 13 14	
	1 2 3 4 5 6 7		
	1 2 3 4		

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Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME:	Brenda Chan
LICENSING EVALUATOR NAME:	Bertha Raygoza
LICENSING EVALUATOR SIGNATURE:	
	DATE: 03/19/2021

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

FACILITY REPRESENTATIVE SIGNATURE:	
	DATE: 03/19/2021