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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 435202775
Report Date: 11/20/2020
Date Signed: 11/20/2020 10:58:16 AM

Document Has Been Signed on 11/20/2020 10:58 AM **- It Cannot Be Edited**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814

FACILITY NAME:	ATRIA ALMADEN			FACILITY NUMBER:	435202775
ADMINISTRATOR:	SHEPODD, PAUL			FACILITY TYPE:	740
ADDRESS:	4610 ALMADEN EXPRESSWAY			TELEPHONE:	(502) 779-4700
CITY:	SAN JOSE	STATE: CA		ZIP CODE:	95118
CAPACITY: 240		CENSUS: 0		DATE:	11/20/2020
TYPE OF VISIT:	Office	ANNOUNCED		TIME BEGAN:	09:55 AM
MET WITH:	Paul Shepodd			TIME COMPLETED:	10:36 AM

NARRATIVE

Facility Type: RCFE
Application Type: Initial, new construction
Applicant/administrator participated in COMP II via call with analyst at CAB. Identification of the applicant and administrator was verified. During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed. Applicant and administrator were advised to email/fax signed LIC 809 with copy of photo ID to CAB.
During COMP II, CAB analyst confirmed Applicant/administrator's understanding of following areas:
1.Facility operation: License type, client/resident populations, and program
2.Staff qualifications and responsibilities
3.Applicant and Administrator qualifications
4.Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions
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: Bethany Hunter

LICENSING PROGRAM ANALYST SIGNATURE:	
	**DATE:** 11/20/2020
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.	
FACILITY REPRESENTATIVE SIGNATURE:	
	**DATE:** 11/20/2020

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