

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 435202780

Report Date: 12/03/2020

Date Signed: 12/03/2020 02:25:33 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, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814	
FACILITY EVALUATION REPORT			
FACILITY NAME: SONNET HILL		FACILITY NUMBER: 435202780	
ADMINISTRATOR:HAHKLOTUBBE, DAVID		FACILITY TYPE: 740	
ADDRESS: 429 MERIDIAN AVE		TELEPHONE: (408) 731-0019	
CITY: SAN JOSE		ZIP CODE: 95126	
CAPACITY: 80		DATE: 12/03/2020	
TYPE OF VISIT: Office		ANNOUNCED TIME BEGAN: 02:00 PM	
MET WITH: David Hahklotubbe		TIME COMPLETED: 02:24 PM	
NARRATIVE			
1	Facility Type: Residential Care Facility for the Elderly		
2	Application Type: Initial, new construction		
3	Applicant/administrator participated in COMP II via call with analyst at CAB.		
4	Identification of the applicant and administrator was verified. During COMP II,		
5	applicant and administrator confirmed the understanding of Title 22. Component II		
6	was successfully completed. Applicant and administrator were advised to email/fax		
7	signed LIC 809 with copy of photo ID to CAB.		
8	During COMP II, CAB analyst confirmed Applicant/administrator's understanding of		
9	following areas:		
10	1.Facility operation: License type, client/resident populations, and program		
11	2.Staff qualifications and responsibilities		
12	3.Applicant and Administrator qualifications		
13	4.Program policy: Abuse, admission agreement, medication management, reporting		
14	incidents to CCL, restricted & prohibited conditions		
15	5.Grievances, Complaints, Community resources		
16	6.Physical plant, food service		
17	7.Application document review and technical assistance: Criminal record clearance,		
18	Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate,		
19	Financial verification, Pre-licensing inspection, Compliance history, Control of		
20	property		
21			
22			
23			
24			
25			
NAME OF LICENSING PROGRAM MANAGER: Jude De La Concepcion			
NAME OF LICENSING PROGRAM ANALYST: Bethany Hunter			

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 12/03/2020

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 12/03/2020

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