

# Department of SOCIAL SERVICES

Community Care Licensing

## FACILITY EVALUATION REPORT

Facility Number: 079200962  
Report Date: 10/18/2021  
Date Signed: 10/18/2021 03:56:17 PM

Document Has Been Signed on 10/18/2021 03:56 PM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1515 CLAY STREET, STE. 310 OAKLAND, CA 94612
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: WATERMARK AT SAN RAMON, THE	FACILITY NUMBER: 079200962
ADMINISTRATOR: HARRISON, NANCY	FACILITY TYPE: 740
ADDRESS: 12720 ALCOSTA BLVD	TELEPHONE: (925) 725-1485
CITY: SAN RAMON	STATE: CA
CAPACITY: 95	ZIP CODE: 94583
TYPE OF VISIT: Required - 1 Year	CENSUS: 31
MET WITH: Angeles Sticka, Executive Director	DATE: 10/18/2021
	UNANNOUNCED TIME BEGAN: 02:30 PM
	TIME COMPLETED: 04:10 PM

NARRATIVE	
1	On 10/18/2021 starting at 2:30pm, Licensing Program Analyst (LPA) L. Francisco arrived unannounced
2	to conduct Infection Control Inspection. LPA met with Executive Director, Angeles Sticka and explained
3	the purpose of the visit.
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5	During the Infection Control Inspection, LPA toured facility with Executive Director and Resident Care
6	Director, Edward Dewitt including but not limited to front entrance, screening station, hand washing
7	stations, apartments, common areas, dining area, activity room, kitchen and courtyard. Facility has a
8	sufficient 2-day perishable and one week non-perishable food supply. There is one central entry point for
9	universal screening for staff, residents and visitors. A sign-in kiosk and hand sanitizer were observed.
10	Cough/sneeze etiquette, social distancing and hand washing posters were observed. Facility staff were
11	observed to be wearing proper PPE. Facility has a 30-day supply of PPEs maintained at central location
12	and easily accessible for staff. Facility maintains record of routine screening for residents and staff.
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14	No deficiencies cited during visit. Exit interview conducted and a copy of this report provided.
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NAME OF LICENSING PROGRAM MANAGER: Harpreet Humpal
NAME OF LICENSING PROGRAM ANALYST: Lizette Francisco

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 10/18/2021

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 10/18/2021

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