

**COMPLAINT INVESTIGATION REPORT (Cont)**

FACILITY NAME: HERITAGE HOME  
DEFICIENCY INFORMATION FOR THIS PAGE:

FACILITY NUMBER: 075650113  
VISIT DATE: 06/23/2015

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 06/24/2015 Section Cited 80061(b)	<p>1 80061(b) Reporting Requirements. Upon the 2 occurrence, of specified events, reports shall be 3 made to the licensing agency within the agency's 4 next working day. In addition, written reports shall 5 be submitted to the licensing agency within seven 6 days following the occurrence of such events. 7</p> <p>8 <u>A client was injured in the facility, resulting in two</u> 9 <u>broken bones. The facility did not report the injury</u> 10 <u>to CCL within 24 hours. In addition a written report</u> 11 <u>was not submitted to CCL within 7 days.</u> 12 13 14</p>	<p>1 By 6/24/15, facility will schedule mandatory staff 2 training by an outside vendor, to cover reporting 3 requirements. This training shall be held by 4 7/24/15, proof of training to be submitted to CCL. 5 6 7</p>
Type B 06/30/2015 Section Cited 84064(c)	<p>1 84064(c) Administrator Qualifications. 2 Administrators shall be on the premises for the 3 number of hours necessary to manage and 4 administer the facility. 5 6 Rodina Ventura is not on the premises for the 7 number of hours necessary to keep the facility in compliance. 1 2 3 4 5 6 7</p>	<p>1 By 6/30/15, facility will submit current LIC 500 2 documenting the Administrators hours, totaling a 3 minimum of 20 hours per week. Administrator will 4 keep a sign-in sheet of hours worked at the facility 5 for licensing to review upon request. 6 7</p>

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: Glenn A Schnell

TELEPHONE: (408) 324-2116

LICENSING EVALUATOR NAME: Katie L Kistler

TELEPHONE: (408) 406-2326

LICENSING EVALUATOR SIGNATURE:



DATE: 06/23/2015

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 06/23/2015

**COMPLAINT INVESTIGATION REPORT**CCLD Regional Office, 851 TRAEGER AVE., SUITE 360  
SAN BRUNO, CA 94069

This is an official report of an unannounced visit/investigation of a complaint received in our office on  
03/23/2015 and conducted by Evaluator Katie L Kistler

**COMPLAINT CONTROL NUMBER: 14-CR-20150323161129**

**FACILITY NAME:** HERITAGE HOME  
**ADMINISTRATOR:** VENTURA, RODINA  
**ADDRESS:** 14 RED BARN CT.  
**CITY:** OAKLEY  
**CAPACITY:** 6

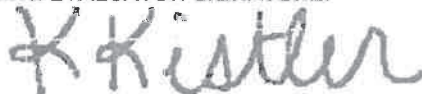
**FACILITY NUMBER:** 075650113  
**FACILITY TYPE:** 730  
**TELEPHONE:** (925) 679-0845  
**ZIP CODE:** 94561  
**DATE:** 06/23/2015  
**TIME VISIT BEGAN:** 09:45 AM  
**TIME COMPLETED:** 11:15 AM

**MET WITH:** George Clamor**ALLEGATION(S):**

- 1 Facility failed to report a serious injury of a client
- 2 Facility Administrator does not spend an adequate amount of time at the facility to perform required job duties.
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**INVESTIGATION FINDINGS:**

- 1 LPA Kistler met with George Clamor to deliver the findings of the above allegations. Interviews were conducted
- 2 and paperwork was reviewed. On 2/05/15 a client fell in the facility breaking their fibula and tibia. This incident
- 3 was not reported to CCL. CCL became aware of the incident at a visit to the facility on 3/24/15 when the LPAs
- 4 arrived and found the client in the home using a wheelchair due to the broken leg. The incident report that was
- 5 provided on 3/24/15 was not completed accurately, as it did not disclose all the staff members present during
- 6 the incident. The allegation that the facility Administrator is not spending adequate time in the facility to perform
- 7 required job duties is substantiated due to the facility failing to report this incident and not submitting an
- 8 accurate and complete exception request for the use of the wheelchair. In addition, the facility has been cited in
- 9 the past for incomplete paperwork, reporting requirements, and not having a facility manager. The facility staff
- 10 either did not know to or neglected to report suspected child abuse and are mandated reporters. Based on the
- 11 preponderance of evidence the above allegations are substantiated. See 9099-D for deficiencies cited per
- 12 California Code of Regulations, Title 22. Civil penalties were assessed for repeat violations.
- 13 Exit interview was conducted. Appeal Rights provided.

**Substantiated****Estimated Days of Completion:****SUPERVISOR'S NAME:** Glenn A Schnell**TELEPHONE:** (408) 324-2116**LICENSING EVALUATOR NAME:** Katie L Kistler**TELEPHONE:** (408) 406-2326**LICENSING EVALUATOR SIGNATURE:****DATE:** 06/23/2015**I acknowledge receipt of this form and understand my appeal rights as explained and received.****FACILITY REPRESENTATIVE SIGNATURE:****DATE:** 06/23/2015**This report must be available at Child Care and Group Home facilities for public review for 3 years.**