COMPLAINT INVESTIGATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 851 TRAEGER AVE., SUITE 360
SAN BRUNO, CA 94066

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

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

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CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
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SAN BRUNO, CA 94066

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		FACILITY NUMBER:	075650113
ADMINISTRATOR:	VENTURA, RODINA		FACILITY TYPE:	730
ADDRESS:	14 RED BARN CT.		TELEPHONE:	(925) 679-0845
CITY:	OAKLEY	STATE:	ZIP CODE:	94561
CAPACITY:	6	CENSUS: 6	DATE:	06/23/2015
		UNANNOUNCED	TIME VISIT BEGAN:	09:45 AM
MET WITH:	George Clamor		TIME COMPLETED:	11:15 AM

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 tibula. 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:

K Kistler

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.