

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 157209136

Report Date: 04/27/2021

Date Signed: 04/27/2021 02:21:28 PM

Document Has Been Signed on 04/27/2021 02:21 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, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814
FACILITY EVALUATION REPORT	

FACILITY NAME: REDWOOD SENIOR LIVING BAKERSFIELD	FACILITY NUMBER: 157209136
ADMINISTRATOR: HUSSAIN, BARKET	FACILITY TYPE: 740
ADDRESS: 810 S UNION AVE	TELEPHONE: (415) 810-0145
CITY: BAKERSFIELD	STATE: CA ZIP CODE: 93307
CAPACITY: 41	CENSUS: DATE: 04/27/2021
TYPE OF VISIT: Office	ANNOUNCED TIME BEGAN: 02:00 PM
MET WITH:	TIME COMPLETED: 02:15 PM

NARRATIVE	
1	COMP II by CAB successfully completed
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4	Facility Type: RCFE
5	Application Type: CHOW
6	Capacity: 41
7	Census (if any clients in care): 40
8	Method: Telephone call with CAB
9	COMP II Participants: Kenny Espinal, Administrator (Espinal is the new administrator for this facility)/Antony Barbato Owner; Shannon Betker, analyst.
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14	Applicant/administrator participated in COMP II at CAB via telephone call with analyst at CAB. Identification of the applicant and administrator was verified by confirming driver's license number. During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed.
15	Applicant and administrator were advised to email/fax signed LIC 809 with copy of photo ID to CAB.
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23	During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of following areas:
24	1. Facility operation: License type, client/resident populations, and program
25	2. Staff qualifications and responsibilities
	3. Staff training
	4. Applicant and Administrator qualifications
	5. Grievances, Complaints, Community resources

- 6. Food service
- 7. Medication management
- 8. Application document review and technical assistance: Pre-licensing inspection, COVID19 Mitigation Plan Report

NAME OF LICENSING PROGRAM MANAGER: Jude De La Concepcion

NAME OF LICENSING PROGRAM ANALYST: Shannon Betker

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 04/27/2021

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 04/27/2021

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