

# Department of SOCIAL SERVICES

Community Care Licensing

## FACILITY EVALUATION REPORT

Facility Number: 347005010  
Report Date: 10/28/2021  
Date Signed: 10/28/2021 04:04:05 PM

Document Has Been Signed on 10/28/2021 04:04 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, 520 COHASSET RD., STE. 170 CHICO, CA 95926
<b>FACILITY EVALUATION REPORT</b>	

FACILITY NAME: ALL SEASONS, LLC	FACILITY NUMBER: 347005010
ADMINISTRATOR: ANATOLIY MOLITVENIK	FACILITY TYPE: 740
ADDRESS: 8731 CENTRAL AVENUE	TELEPHONE: (916) 776-6665
CITY: ORANGEVALE	STATE: CA
CAPACITY: 6	ZIP CODE: 95662
TYPE OF VISIT: Required - 1 Year	CENSUS: 6
MET WITH: Anatoliy Molitvenik, Administrator	DATE: 10/28/2021
	UNANNOUNCED TIME BEGAN: 03:45 PM
	TIME COMPLETED: 04:25 PM

NARRATIVE	
1	Licensing Program Analyst (LPA) Michael Hood arrived at the facility unannounced on 10/28/2021 to
2	conduct a Required-1 Year Inspection utilizing the infection control domain. LPA met with Administrator,
3	Anatoliy Molitvenik, and explained the purpose of the visit. Prior to initiating the annual inspection, LPA
4	completed required COVID-19 testing protocols, the daily self-screening questionnaire for symptoms of
5	COVID-19 infection to affirm no COVID-19 related symptoms, and contacted facility and completed a
6	facility risk assessment. LPA ensured to apply hand sanitizer before entering the facility and the
7	following Personal Protective Equipment (PPE) was worn: N-95 Mask.
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9	LPA toured the facility to ensure the health and safety of residents in care. Areas toured include but are
10	not limited to: 6 bedrooms and 6 bathrooms for residents, common area, dining room, kitchen, laundry
11	room, and outdoor area. In the areas toured no immediate health, safety, or personal rights violations
12	were observed. LPA and Administrator completed the infection control domain and facility was found to
13	be in substantial compliance at this time.
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15	No deficiencies are being cited. Exit interview conducted and copy of report left at the facility.
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NAME OF LICENSING PROGRAM MANAGER: Anthony Perez
NAME OF LICENSING PROGRAM ANALYST: Michael Hood

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 10/28/2021

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 10/28/2021

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