

Department of

# SOCIAL SERVICES

*Community Care Licensing*

## *FACILITY EVALUATION REPORT*

Facility Number: 502701239

Report Date: 02/17/2023

Date Signed: 02/17/2023 04:04:19 PM

**Document Has Been Signed on 02/17/2023 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, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814	
<b>FACILITY EVALUATION REPORT</b>			
FACILITY NAME: BRIGHTER LIVING		FACILITY NUMBER:	502701239
ADMINISTRATOR: TURPO, PAULA ALICIA		FACILITY TYPE:	740
ADDRESS: 3932 FELTON WAY		TELEPHONE:	(510) 735-4057
CITY: MODESTO	STATE: CA	ZIP CODE:	95356
CAPACITY: 6	CENSUS: 0	DATE:	02/17/2023
TYPE OF VISIT: Office	ANNOUNCED	TIME BEGAN:	02:00 PM
MET WITH: Administrator/Licensee Paula A. Turpo		TIME COMPLETED:	02:30 PM
<b>NARRATIVE</b>			
1	Facility Type: RCFE		
2	Application Type: Initial		
3	Capacity: 6		
4	Census (if any clients in care): 0		
5	COMP II Participants: Administrator/Licensee Paula A. Turpo		
6	Interview Method: Telephone interview		
7			
8	On 2/17/2023, applicant/administrator participated in COMP II.		
9	Identification of the applicant and administrator was verified through		
10	interview questions based on photo ID and other identifying personal		
11	information. During COMP II, applicant and administrator confirmed that		
12	they have read and understand community care facility licensing laws included		
13	in the Health and Safety Codes and the California Code of Regulations Title		
14	22. Signed LIC 809 with copy of photo ID have been obtained.		
15			
16	During COMP II, CAB analyst confirmed Applicant/Administrator's		
17	understanding of following areas:		
18	1. Facility operation: License type, client/resident populations, and program		
19	2. Admission Policies		
20	3. Staffing requirements & Training		
21	4. Restrictive/Prohibited Health Conditions		
22	5. General provisions		
23			
24			
25			

- 6. Emergency Preparedness
- 7. Complaints & Reporting
- 8. Pre-licensing readiness

**NAME OF LICENSING PROGRAM MANAGER:** Jude De La Concepcion

**NAME OF LICENSING PROGRAM ANALYST:** Marisa Holabird

**LICENSING PROGRAM ANALYST SIGNATURE:**



**DATE:** 02/17/2023

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

**FACILITY REPRESENTATIVE SIGNATURE:**



**DATE:** 02/17/2023

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