

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 502701450

Report Date: 08/07/2024

Date Signed: 08/16/2024 11:38:20 AM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CENTRALIZED APP UNIT, 744 P STREET, MS 9-14-8201 SACRAMENTO, CA 95814
FACILITY EVALUATION REPORT	

FACILITY NAME: CASA DE MODESTO	FACILITY NUMBER: 502701450
ADMINISTRATOR/ISSAKHANI, STEPHANY DIRECTOR:	FACILITY TYPE: 740
ADDRESS: 1745 ELDENA WAY	TELEPHONE: (925) 594-1122
CITY: MODESTO	STATE: CA
CAPACITY: 160	ZIP CODE: 95350
TYPE OF VISIT: Office	CENSUS: DATE: 08/07/2024
	UNANNOUNCED TIME VISIT/INSPECTION BEGAN: 09:45 AM
MET WITH: Stephany Issakhani & Inderjeet Dhillon	TIME VISIT/INSPECTION COMPLETED: 11:37 AM

NARRATIVE	
1	COMP II by CAB successfully completed
2	
3	
4	<i>Applicant/administrator participated in COMP II at CAB telephone call with</i>
5	<i>analyst at CAB. Identification of the applicant and administrator was</i>
6	<i>verified by presenting photo ID via phone. During COMP II, applicant and</i>
7	<i>administrator confirmed the understanding of Title 22. Component II was</i>
8	<i>successfully completed. Applicant and administrator were advised to</i>
9	<i>email/fax signed LIC 809 with copy of photo ID to CAB.</i>
10	
11	
12	
13	<i>During COMP II, CAB analyst confirmed Applicant/Administrator's</i>
14	<i>understanding of following areas:</i>
15	
16	
17	<i>1. Facility operation: License type, client/resident populations, and program</i>
18	
19	<i>2. Staff qualifications and responsibilities</i>
20	
21	
22	<i>3. Applicant and Administrator qualifications</i>
23	
24	<i>4. Program policy: Abuse, admission agreement, medication management,</i>
25	<i>reporting incidents to CCL, restricted & prohibited conditions</i>

5. *Grievances, Complaints, Community resources*

6. *Physical plant, food service*

7. *Application document review and technical assistance: Criminal record clearance, Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate, Financial verification, Pre-licensing inspection, Compliance history, Control of property*

NAME OF LICENSING PROGRAM MANAGER: Darla Neeley

NAME OF LICENSING PROGRAM ANALYST: Gina Baldwin

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 08/16/2024

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 08/16/2024

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