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Department of

# SOCIAL SERVICES

*Community Care Licensing*

# *FACILITY EVALUATION REPORT*

**Facility Number:** 502701480
**Report Date:** 09/17/2024
**Date Signed:** 09/19/2024 03:24:05 PM

**Document Has Been Signed on** 09/19/2024 03:24 PM **- It Cannot Be Edited**

| STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY<br>**FACILITY EVALUATION REPORT** | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES<br>COMMUNITY CARE LICENSING DIVISION<br>CCLD Regional Office, 744 P STREET, MS 9-14-8201<br>SACRAMENTO, CA 95814 |
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|---|---|---|---|---|
| FACILITY NAME: | SERENITY HOME CARE II LLC | | FACILITY NUMBER: | 502701480 |
| ADMINISTRATOR/DIRECTOR: | SOUXOUAY, MA.ANGELICA ABEL | | FACILITY TYPE: | 740 |
| ADDRESS: | 3009 SOUTHWELL LN | | TELEPHONE: | (209) 526-2425 |
| CITY: | MODESTO | STATE: CA | ZIP CODE: | 95355 |
| CAPACITY: 6 | | CENSUS: 0 | DATE: | 09/17/2024 |
| TYPE OF VISIT: | Office | ANNOUNCED | TIME VISIT/ INSPECTION BEGAN: | 02:00 PM |
| MET WITH: | Ma. Angelica A. Souxouay CEO/Administrator | | TIME VISIT/ INSPECTION COMPLETED: | 02:30 PM |

**NARRATIVE**

*Component II completion: Successful*

*Facility Type: RCFE*
*Application Type: INITIAL*
*Capacity: 6*
*Census (if any clients in care): 0*

*COMP II Participants: Name - Ma. Angelica A. Souxouay CEO/Administrator*
*Interview Method: Telephone interview*

*On September 17, 2024, Applicant/Administrator participated in COMP II. Identification of the applicant and administrator was verified through interview questions based on photo ID and other identifying personal information. During COMP II, applicant and administrator confirmed that they have read and understand community care facility licensing laws included in the Health and Safety Codes and the California Code of Regulations Title 22. Signed LIC 809 with copy of photo ID have been obtained.*

*During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of the following areas:*
*1. Facility operation: License type, client/resident populations, and program*
*2. Admission Policies*
*3. Staffing requirements & Training*

*4. Restrictive/Prohibited Health Conditions*
*5. General provisions*
*6. Emergency Preparedness*
*7. Complaints & Reporting*
*8. Pre-Licensing Readiness*

**NAME OF LICENSING PROGRAM MANAGER:** Tracy Thompson
**NAME OF LICENSING PROGRAM ANALYST:** Ricmar Soriano
**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 09/17/2024

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

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 09/17/2024

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