

Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 547206596

Report Date: 07/19/2021

Date Signed: 07/23/2021 08:13:47 AM

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY		CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1314 E SHAW AVE FRESNO, CA 93710	
FACILITY EVALUATION REPORT			
FACILITY NAME: QUAIL PARK MEMORY CARE RESIDENCES		FACILITY NUMBER:	547206596
ADMINISTRATOR: EGURROLA, THERESA		FACILITY TYPE:	740
ADDRESS:	5050 TULARE AVENUE	TELEPHONE:	(559) 624-3560
CITY:	VISALIA	STATE: CA	ZIP CODE: 93277
CAPACITY: 44		CENSUS: 29	DATE: 07/19/2021
TYPE OF VISIT:	Required - 1 Year	UNANNOUNCED TIME BEGAN:	09:16 AM
MET WITH:	Resident Care Coordinator Melissa Segura	TIME COMPLETED:	10:30 AM
NARRATIVE			
1	Licensing Program Analyst LPA Shawna Doucette conducted an Annual Inspection on this date. LPA		
2	was met by Resident Care Coordinator Melissa Segura and discussed the purpose of the visit. LPA and		
3	Resident Care Coordinator Melissa Segura began the tour at the front entrance of the facility.		
4			
5	Visitor log-in/temperature check, masks, and disinfection station was observed upon entry. Facility has		
6	one entrance/exit point. Hand sanitizer was readily available to residents and visitors. Social distancing		
7	is maintained in the common areas. Hand washing and other various Covid-19 related signs were		
8	observed in the common areas.		
9			
10	LPA observed a two day supply of perishable food and seven day supply of non-perishable food.		
11	Cleaning supplies were observed behind a locked door. LPA observed the following personal protective		
12	equipment in a storage room; gown, face shield, gloves, and masks. Staff records were reviewed for		
13	infection control training. LPA observed all facility staff wearing masks. Resident's files have updated		
14	emergency contact information.		
15			
16	No deficiencies were observed.		
17			
18			
19	Exit interview was conducted and a copy of this report was provided.		
20			
21			
22			
23			
24			
25			
NAME OF LICENSING PROGRAM MANAGER: Sergiy Pidgirny			
NAME OF LICENSING PROGRAM ANALYST: Shawna Doucette			

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 07/19/2021

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

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 07/19/2021

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