

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/25/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11911401	(X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER SANTA BARBARA HOME I	STREET ADDRESS, CITY, STATE, ZIP CODE 3319 SW 24 TERRACE MIAMI, FL 33145	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An Abbreviated Biennial Survey was conducted on 06/03/15. Santa Barbara Home I with a Limited Mental Health component had no deficiencies found at the time of the survey.



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

June 25, 2015

Administrator
Santa Barbara Home I
3319 Sw 24 Terrace
Miami, FL 33145

Dear Administrator:

This letter reports findings of an Abbreviated Biennial licensure survey that was conducted on June 3, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

A handwritten signature in black ink, appearing to read "Arlene Mayo-Davis".

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

1GGN

