

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/30/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965405	(X3) DATE SURVEY COMPLETED R 11/23/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE SANTA BARBARA	STREET ADDRESS, CITY, STATE, ZIP CODE 911 SANTA BARBARA BLVD CAPE CORAL, FL 33991	

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

0000 Initial Comments

An unannounced revisit survey was conducted on 11/23/15 at Brookdale Santa Barbara, an assisted living facility in Cape Coral, Florida. This was a follow up to the Biennial and limited nursing service survey completed on 10/6/15.

No deficiencies were found at the time of the visit.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11965405	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/23/2015
Name of Facility BROOKDALE SANTA BARBARA		Street Address, City, State, Zip Code 911 SANTA BARBARA BLVD CAPE CORAL, FL 33991

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0028	Correction Completed 11/23/2015	ID Prefix A0086	Correction Completed 11/23/2015	ID Prefix	Correction Completed
Reg. # 58A-5.0182(4) FAC		Reg. # 58A-5.0191(9) FAC		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
[Signature]
Reviewed By

Date:
11/30/2015
Date:

Signature of Surveyor:
[Signature]
Signature of Surveyor

Date:
11.30.15
Date:

Followup to Survey Completed on:
10/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 30, 2015

Administrator
Brookdale Santa Barbara
911 Santa Barbara Blvd
Cape Coral, FL 33991

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on November 23, 2015 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 this office at (239) 335-1315.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jon Seehawer".

Jon Seehawer, R.N.
Field Office Manager

sh

Enclosure: State Form and Revisit Report

DT9D

