

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969319	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/14/2019
NAME OF PROVIDER OR SUPPLIER THE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 10075 HILLVIEW RD PENSACOLA, FL 32514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An unannounced Extended Congregate Care monitoring visit was conducted in conjunction with a complaint survey for allegations contained within compliant 2019004071 on 5/14/19 at The Residence. No deficient practice was identified at the time of the survey.	A 000			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE