Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942846	A. BUILDING: _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY BREEZE SENIOR LIVING & REHABILITATION CE	3387 GULF BREEZE PKWY GULF BREEZE, FL 32561

(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 complaint survey for allegations contained in complaint numbers 2020011918 and 2020017139, was conducted at Bay Breeze Senior Living & Rehabilitation on 11/24/2020. A focused infection control survey was conducted in conjunction. At the time of survey, no deficiencies were identified.	A 000		