

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965241	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/23/2020
NAME OF PROVIDER OR SUPPLIER STANLEY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 718 WALTON RD DEFUNIAK SPRINGS, FL 32433			
(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 licensure renewal with Limited Nursing Services, Comprehensive Emergency Management Plan, Focus infection control, Generator Assessment and complaint for allegations contained within complaint 2020003252 were conducted on 12/22/20 through 12/23/20 at Stanley House. No deficient practice was identified at the time of this visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE