

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/05/2021
NAME OF PROVIDER OR SUPPLIER OUR HOME AT BEACON HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 141 KAELYN LANE PORT SAINT JOE, FL 32456		
(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 On October 5, 2021 a second unannounced revisit survey was conducted to the licensure survey originally conducted on March 8, 2021 at Our Home at Beacon Hill in Port St. Joe, FL. An unannounced revisit to a complaint survey (2021006663 and 2021006080) originally conducted on June 21, 2021 was conducted in conjunction. At the time of the revisit, deficient practice was identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE