

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 01/04/2022
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 01/04/2022, a desk review revisit survey was completed for the complaint survey (#2021006663 and #2021006080) completed on 10/05/2021 at Our Home at Beacon Hill. Based on an acceptable corrective action plan with supporting documentation, interview with the Administrator, deficiencies were found corrected.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE