

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL11969319

 Provider/Supplier Name
 THE RESIDENCE

Type of Survey (select all that apply)

3	K	D		
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A	Complaint Investigation	E	Initial Certification	I	Recertification
B	Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing
C	Federal Monitoring	G	Validation	K	State License
D	Follow-up Visit	H	Life Safety Code	L	CHOW
M	Other				

Extent of Survey (select all that apply)

A	D			
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A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHIA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 20377			1.25	0.00	0.00	0.00	0.00	3.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

1.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

2.00

Total RO Clerical/Data Entry Hours....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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 R 06/09/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCE

**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 revisit survey for the licensure and complaint survey (2022002572) was conducted by desk review for The Residence on June 9, 2022. The deficiencies were found to be corrected at the time of the survey.	A 000		

AHCA Form 3020-0001

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

TITLE

(X6) DATE