

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/16/2023
NAME OF PROVIDER OR SUPPLIER THE WATERFORD AT CREEKSIDE		STREET ADDRESS, CITY, STATE, ZIP CODE 9015 UNIVERSITY PARKWAY 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 On May 16, 2023, an unannounced desk review revisit survey was completed for the complaint investigation (complaint numbers 2022018582, 2022017242, 2022018006, 2022011411, 2022011193, and 2022016702) ending March 7, 2023, at The Waterford At Creekside. Based on documentation the deficiency was found to be corrected.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE