

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969642	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/04/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ARCADIA SENIOR LIVING PACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3343 BERRYHILL RD PACE, FL 32571
---	--

(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 A re-licensure survey was conducted at Arcadia Senior Living Pace, an assisted living facility in Pace, FL, on January 4, 2023. During the survey a generator assessment, Comprehensive Emergency Management Plan review, and a review of the visitation policy were performed. The provider had no deficiencies at the time of the visit.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE