Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969335	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER

BEACH HOUSE ASSISTED LIVING AND MEMORY CAI

STREET ADDRESS, CITY, STATE, ZIP CODE

30070 STATE RD 56
WESLEY CHAPEL, FL 33543

(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 biennial re-licensure survey in conjunction with a complaint investigation (#2024002348) and a generator monitoring visit was conducted at Beach House Assisted Living and Memory Care at Wiregrass Ranch on 03/08/2024. No deficiencies were identified at the time of the survey.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE