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
	AL11964649	A. BUILDING: _____ B. WING _____	R 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE AT AZALEA TRACE	10100 HILLVIEW ROAD 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 August 9, 2023, an unannounced desk review revisit survey was completed for the biennial survey ending June 21, 2023, at Oakbridge Terrace at Azalea Trace. Based on documentation, the deficiencies were found to be corrected.	A 000		
CZ000	Initial Comments On August 9, 2023, an unannounced desk review revisit survey was completed for the biennial survey ending June 21, 2023, at Oakbridge Terrace at Azalea Trace. Based on documentation, the deficiency was found to be corrected.	CZ000		

AHCA Form 3020-0001

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