

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 02/03/2023
NAME OF PROVIDER OR SUPPLIER BEACON AT GULF BREEZE (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563			
(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 February 3, 2023, an unannounced desk review revisit survey was completed for the relicensure and complaint survey for complaint numbers 2022003280, 2022014089, 2022006832, 2022008048, 2022009199 and 2022011495 ending 11/10/22 at The Beacon at Gulf Breeze. Based on supporting documentation, deficiencies were found to be corrected.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE