

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/09/2024
NAME OF PROVIDER OR SUPPLIER THE CAMELLIA AT GULF BREEZE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 MCABEE COURT GULF BREEZE, FL 32561		
(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 September 9, 2024, an unannounced desk review revisit survey was completed for the complaint survey for complaint #2024009016, which originally ended on July 3, 2024 at The Camellia at Gulf Breeze, an assisted living facility in Gulf Breeze, FL. Based on photographic evidence and supporting documentation, the deficiency was found to be corrected.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE