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
	AL11966504	A. BUILDING: _____ B. WING _____	R-C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME AT BEACON HILL	141 KAELYN LANE PORT SAINT JOE, FL 32456

(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 January 30, 2025, an unannounced desk review revisit survey was completed for the complaint survey for complaint numbers 2024011171 and 2024010971 that originally ended on September 18, 2024, at Our Home at Beacon Hill, an assisted living facility in Port St. Joe, FL. Based on review of the documentation provided and electronic interview, the deficiency was found to be corrected.	A 000		