

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/10/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ZON BEACHSIDE LLC

**1894 S PATRICK DR
INDIAN HARBOR BEACH, FL 32937**

(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
{ZZ000}	Initial Comments A re-visit to a complaint survey (CCR# 2025006307 & 2025006287) and generator monitoring was conducted at Zon Beachside in Indian Harbor on 09/10/25. The facility did not have a deficiency at the time of the survey.	{ZZ000}		
{A 000}	Initial Comments A re-visit to a complaint survey (CCR# 2025006307 & 2025006287) and generator monitoring was conducted at Zon Beachside in Indian Harbor on 09/10/25. The facility did not have a deficiency at the time of the survey.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X8) DATE