

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968796	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/17/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SUPERIOR RESIDENCES OF PANAMA CITY BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 95 GRAND HERON DR PANAMA CITY BEACH, FL 32407
---	---

(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 An unannounced complaint survey for complaint numbers 2025005459 and 2025008533 was conducted in conjunction with an emergency environmental control survey at Superior Residences of Panama City Beach, an assisted living facility in Panama City, FL, on 7/16/25-7/17/25. Deficient practice was not identified at the time of the survey.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE