

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/16/2026
NAME OF PROVIDER OR SUPPLIER OUR HOME AT BEACON HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 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 An unannounced complaint survey for complaints 2025016969, 2025018049, and 2026000363 was conducted at Our Home at Beacon Hill in Port St. Joe, FL on 01/13/2026 to 01/15/2026. Revisits to two previous surveys were performed concurrent to this survey. No new deficiencies were identified as related to these complaints.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE