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
	AL11969840	A. BUILDING: _____ B. WING _____	R 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKE AT PANAMA CITY BEACH THE	12219 PANAMA CITY BEACH PKWY 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
ZZ000	Initial Comments On September 23, 2025, an unannounced desk review revisit survey was completed for the biennial survey originally ending on 7/24/2025 at The Blake at Panama City Beach, an assisted living facility in Panama City Beach, FL. This included a review of the CORE regulation deficiencies. Based on provided documentation, the CORE regulation deficiencies were found to be corrected.	ZZ000		
A 000	Initial Comments On September 23, 2025, an unannounced desk review revisit survey was completed for the biennial survey originally ending on 7/24/2025 at The Blake at Panama City Beach, an assisted living facility in Panama City Beach, FL. Based on provided documentation, the deficiencies were found to be corrected.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE