

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 R 03/10/2026
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 On March 10, 2026, an unannounced desk review revisit survey was completed for the complaint survey that originally ended on 12/23/2025 for Superior Residences of Panama City Beach, an assisted living facility in Panama City Beach, FL. The deficiency was found to be corrected.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE