STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968796	08/13/2015
NAME OF PROVIDER OR SUPPLIER RESIDENCES OF PANAMA CITY BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 95 GRAND HERON DR PANAMA CITY, FL 32407	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced complaint survey was conducted at Residences of Panama City Beach Assisted Living Facility to review CCR 2015006834 in conjunction with an Extended Congregate Care monitoring visit on . Deficient practice was identified at the time of the survey.

0093 Food Service - Dietary Standards

Based on observation and staff interviews the facility failed to maintain approved menus on file in the facility.

The findings include:

Observation of the lunch meal was conducted on beginning at approximately 12 noon. The meal consisted of a breaded veal patty with gravy, sweet potato mash, vegetables and a desert. After the meal the Chef was asked to produce a copy of the menu approved by the dietician for . On at approximately 1:30 PM the Chef stated he was not able to locate the approved menu for . An interview was conducted with the Administrator on at approximately 3:21 PM. The Administrator was not able to produce the approved menu for .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Residences Of Panama City Beach
95 Grand Heron Dr
Panama City, FL 32407

RE: CCR #2015006834

Dear Administrator:

This letter reports the findings of a state licensure complaint survey and an Extended Congregate Care monitoring survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call me at (850) 412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

Tallahassee Field Office
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Tallahassee, FL 32308
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