

Agency for Health Care Administration

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|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969631</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/11/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MIA CASA AT NORTH MIAMI LLC</b> |                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1221 WEST DIXIE HWY</b><br><b>NORTH MIAMI, FL 33161</b>                      |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 000}                                                                | Initial Comments<br><br>An announced initial licensure revisit was conducted at Mia Casa At North Miami on 03/11/2020. Deficiencies were found to be corrected at the time of the inspection. The facility is recommended for licensure of 118 beds. | {A 000}                                                                        |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE