

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>AL11966933</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/27/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORAL WAY SENIOR CARE, INC</b> |                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2451 SW 143 COURT</b><br><b>MIAMI, FL 33175</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>A revisit to a standard biennial survey was<br>conducted at Coral Way Senior Care, Inc on<br>10/27/2022. Deficiencies were found to be<br>corrected at the time of the visit. | {A 000}                                                                                     |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE