

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/03/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 2940 NE 207 STREET AVENTURA, FL 33180		
(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 Complaint investigations (Complaints #2022013978, #2022014228, #2022018178, and #2022018517) were conducted at Plaza at ParkSquare from 01/10/2023 to 02/03/2023. Deficiencies were identified at the time of the survey and were cited under event IDs: 5VNJ12 and JQGS14.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE