

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                               |                                                                                          |                                                                                                                          |  |                                                        |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11912046</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORAL PLAZA ALF</b> |                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5850 MARGATE BLVD.<br/>MARGATE, FL 33063</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 unannounced Licensure Complaint survey,<br>complaint #2025002594, was conducted on<br>03/05/2025 at Coral Plaza ALF. The facility had<br>no deficiencies at the time of the visit. | A 000                                                                                    |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE