

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>AL11911412</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/17/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COURTYARD PLAZA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15520 NW 2 AVENUE</b><br><b>NORTH MIAMI BEACH, FL 33160</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 biennial relicensure survey was conducted at Courtyard Plaza on . A deficiencies was identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {A 000}                                                                                                 |                                                                                                                          |  |                                                                    |
| {A 182}<br>SS=D                                            | 59A-36.019(3) FAC Emergency Mgmt - Plan Implementation<br><br>(3) PLAN IMPLEMENTATION.<br>(a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment.<br>(b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all staff were sufficiently trained to implement the emergency management plan.<br><br>Findings Included:<br><br>A review of the facility records showed an emergency management training (evacuation and fire extinguisher) with staff was completed on .<br><br>Interviewed on at 9:54 am Staff I (Home Health Aide) hired date . was asked if the residents can't re-enter the building where would the residents go Staff I stated, "to the activity room."<br><br>Interviewed on at 9:58 am Staff J | {A 182}                                                                                                 |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COURTYARD PLAZA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15520 NW 2 AVENUE</b><br><b>NORTH MIAMI BEACH, FL 33160</b> |                                                                                                                          |  |                                                                    |
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| {A 182}                                                    | <p>Continued From page 1</p> <p>(Housekeeper) hired date _____ was asked what she would do in case of an emergency and the residents needed to evacuate she stated she'd take the residents to the dining room. Further asked Staff J If the dining room was damaged where else would you take the residents she stated, "no, only to the dining room."</p> <p>In an interview on _____ at 10:01 am Staff K (Maintenance) hired date _____ stated that he would open all the doors and take the residents to the parking lot area or to the activities area. Also, Staff K stated that maybe he would contact 911 because he didn't know where else to take the residents.</p> <p>Class III</p> | {A 182}                                                                                                 |                                                                                                                          |  |                                                                    |