

Agency for Health Care Administration

|                                                            |                                                                                                                                                            |                                                                                         |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969161</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LLINA'S ALF LLC</b> |                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>28122 SW 160 CT<br/>HOMESTEAD, FL 33033</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 re-licensure survey was conducted at Lina's ALF LLC on 07/18/2023. The provider did not have deficiencies at the time of survey. | A 000                                                                                   |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE