

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>AL11966548</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/14/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HEAVENLY HOME CARE OF FLORIDA, INC</b> |                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17321 SW 109 AVENUE<br/>MIAMI, FL 33157</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 complaint investigation (#2025005412) was<br>conducted at Heavenly Home Care of Florida on<br>05/14/2025. No deficiencies were identified at<br>the time of the investigation. Uncorrected related<br>deficiencies were cited under Aspen ID 9BA912 | A 000                                                                                   |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE