

Agency for Health Care Administration

|                                                             |                                                                                                                                                                     |                                                                                            |                                                                                                                          |                          |                                                        |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911036</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/28/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHARITY CARE INC</b> |                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>461 EAST 31ST STREET<br/>HIALEAH, FL 33013</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 generator monitoring was conducted at Charity<br>Care Inc on May 28, 2025. The provider had no<br>deficiencies at the time of the survey. | A 000                                                                                      |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE