

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPANO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An unannounced Relicensure, Initial Extended Congregate Care (ECC), Complaint (#2025010294) and Generator Monitoring survey was conducted on _____ at Angel Care ALF Inc. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000			
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of	A 026			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAHO BEACH, FL 33062			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 026	Continued From page 1 scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that, the facility failed to provide an ongoing activities program for at least of 12 hours per week and failed to post the schedule in areas where residents normally congregate. The findings included: During a tour of the facility conducted on _____ between 8:00 AM and 8:30 AM, this surveyor observed that a monthly activities calendar was not posted. Additionally, from 8:30 AM to 3:00 PM, no activities were observed conducted by staff. The Administrator was requested to provide the current activity schedule. During an interview conducted on _____ at 1: 45 PM, the Administrator stated that she was unaware that the facility was required to post a monthly activities and to provide residents with an ongoing activities program. The Administrator acknowledged the findings; however, no additional documents were provided. Class	A 026			
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND (). A staff member who	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAHO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 083	Continued From page 2 has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure that direct care staff maintained current and valid First Aid training cards for 2 of 2 sampled staff (Staff B and Staff C). The findings included: Review of personnel files conducted on revealed that Staff B (Caregiver), hired on and she is scheduled to work 7:00 AM - 7:00 PM Monday to Friday (Live -in) did not have a current valid First Aid training cards in her personnel file. Staff C (Caregiver), hired on , and she is scheduled to work Friday 7:00 PM to Monday 7:00 AM (Live in) did not have a current valid First Aid training cards in her	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPANO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 083	Continued From page 3 personal file. Further review of the staffing schedule revealed each worked alone on the shift and neither had current First Aid credentials on file. An interview conducted on _____ at 1:50 PM with the Administrator, she stated that she is new to her position and was not aware that staff were required to maintain valid First Aid training cards in their personnel files. The Administrator Acknowledged the findings. Class III	A 083			
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a _____ ; and,	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPANO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 160	Continued From page 4 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with _____'s or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAN0 BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 160	Continued From page 5 inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to provide	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAN0 BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 160	Continued From page 6 documentation verifying proof of annual sanitation inspections from the Department of Health (DOH). The findings include: Review of the facility's records conducted on _____ revealed that the facility did not have any evidence of Department of Health inspection report on file. The Administrator was advised to provide documentation of inspections. Review of the facility's staffing schedule revealed the facility has three staff members, including the Administrator and a current census of four (4) residents. During an interview conducted on _____ at 1:30 PM, the Administrator stated that she did not know where the Department of Health inspection reports were located. She further stated that she contacted the owner of the facility regarding the documents. At the time of the survey, no additional documents were provided. The Administrator acknowledged the findings. Class III	A 160			
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. _____, 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number,	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPANO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 7 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAHO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 8 (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for . . . , (. . .), CF-ES 1006, . . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the . . . of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAHO BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 9 (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to have an executed residency agreement signed by the resident and/or their representative completed and on file, upon admission for 4 of 4 residents sampled. (Residents # 1, 2, 3, and 4). The findings included: Record review of the facility's residency agreements on file revealed the following: a) Resident #1 was admitted to the facility on _____, no residency agreement located within the file.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPANO BEACH, FL 33062			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 10 b) Resident #2 was admitted to the facility on _____, no residency agreement located within the file. c) Resident #3 was admitted to the facility on _____, no residency agreement located within the file. d) Resident #4 was admitted to the facility on _____, no residency agreement located within the file. During an interview conducted on _____ at 10:42 AM with the Administrator, she stated that the resident's agreement contracts were not kept at the facility, and she stated that she did not know any of the resident's monthly rate payments. She further stated that she could not provide any additional information or documents at the time of the survey. Class	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL CARE ALF INC

**2821 NE 18 ST
POMPANO BEACH, FL 33062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	ZZ816		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL CARE ALF INC

**2821 NE 18 ST
POMPANO BEACH, FL 33062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if . . . for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, . . . , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . for any	ZZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 NE 18 ST POMPAN0 BEACH, FL 33062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
ZZ816	Continued From page 2 disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the _____ report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure staff completed an Attestation of Compliance form for 1 of 3 sampled staff (Staff A). The findings included: A record review of Staff A's (Administrator)	ZZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL CARE ALF INC

**2821 NE 18 ST
POMPANO BEACH, FL 33062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ816	Continued From page 3 personnel file conducted on _____, revealed that although Staff A was hired on _____, her file did not contain a completed Attestation of Compliance form. During an interview conducted on _____ at 1:00 PM with Staff A (Administrator), she stated that her complete personal file is not physically maintained at the facility. She further stated that she was hired through an agency. No additional information was provided. Staff A (Administrator) acknowledged the findings. Unclassified	ZZ816		