Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969128	A. BUILDING: _____ B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELCARE WITH A VISION LLC	108 WAGNER ROAD BONIFAY, FL 32425

(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
{ZZ000}	Initial Comments An unannounced second revisit to the biennial survey, originally conducted on 10/8/2024, was conducted on 3/3/2025 - 3/4/2025 at Angelcare With A Vision, LLC, an assisted living facility in Bonifay, FL. A revisit to a separate complaint survey was conducted concurrent to this survey. At the time of survey, all areas of concerns for the biennial revisit was found to be corrected.	{ZZ000}		
{A 000}	Initial Comments	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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