

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969931	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/13/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEYS RESIDENTIAL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6205 VELDA DAIRY RD TALLAHASSEE, FL 32309		
(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 biennial survey, including a generator assessment, was conducted in conjunction with a complaint investigation for complaint #2025014258 at New Journeys Residential Care Home in Tallahassee, FL, on November 13, 2025. At the time of the survey, the facility was in compliance with the requirements for Assisted Living Facilities.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE