STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968140	R **02/28/2017**
NAME OF PROVIDER OR SUPPLIER **NEW HORIZON HEALTHCARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3114 PHILIPS HWY** **JACKSONVILLE, FL 32207**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

The deficiency was corrected at the time of the follow-up visit.