

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/13/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968901	(X3) DATE SURVEY COMPLETED R 04/12/2018
NAME OF PROVIDER OR SUPPLIER BARAK HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1473 W 14TH ST JACKSONVILLE, FL 32209	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments All of the deficiencies were found corrected at the time of the desk review.		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/22/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968901	(X3) DATE SURVEY COMPLETED R 04/12/2018
NAME OF PROVIDER OR SUPPLIER BARAK HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1473 W 14TH ST JACKSONVILLE, FL 32209	

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

0000 - Initial Comments

All of the deficiencies were found corrected at the time of the desk review.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968901	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/12/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BARAK HOUSE

**1473 W 14TH ST
JACKSONVILLE, FL 32209**

(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 All of the deficiencies were found corrected at the time of the desk review.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE