| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965449** | R<br>**05/11/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**QUALITY CARE OF FLORIDA, INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1261 TUMBLEWEED DRIVE**<br>**ORANGE PARK, FL 32065** | |

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.