| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11910300** | **05/21/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**ARLINGTON ADULT RESIDENTIAL FACILITY INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**6300 ARLINGTON EXPY.**<br>**JACKSONVILLE, FL 32211** | |

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

**0000 - Initial Comments**

A biennial re-licensure survey was conducted at Arlington Adult Residential Facility, Inc. on March 21, 2019. The provider had no deficiencies at the time of the visit.