Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D0979133	01/05/2018
Name of Provider or Supplier	**Street Address, City, State**	
Florida Healthcare Associates Pl	11195 Jog Rd Ste 3, Boynton Beach, FL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies
No Tags	No deficiency details available.