

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 01/16/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967694	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER Sharing Facility	STREET ADDRESS, CITY, STATE, ZIP CODE 2897 Harson Wy Fort Pierce, FL 34946	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility relicensure survey was conducted on 01/09/2014 at Sharing Facility. The facility had no licensure deficiencies identified at the time of the survey.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 17, 2014

Administrator
Sharing Facility
2897 Harson Wy
Fort Pierce, FL 34946

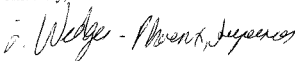
Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on January 9, 2014 by a representative from this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


for Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547

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