

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968790	(X3) DATE SURVEY COMPLETED 05/11/2016
NAME OF PROVIDER OR SUPPLIER ANGELS WINGS SYNERGY RETREAT, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1920 N 44TH ST FORT PIERCE, FL 34947	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR#2016001695, was conducted on 05/11/2016 at Angels Wings Synergy Retreat. The facility had no deficiencies at the time of the investigation.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 20, 2016

Administrator
Angels Wings Synergy Retreat, LLC
1920 N 44th St
Fort Pierce, FL 34947

RE: CCR #2016001695

Dear Administrator:

This letter reports the findings of a complaint survey completed on May 11, 2016 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547

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