STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968808	**10/20/2016**
NAME OF PROVIDER OR SUPPLIER **HARMONY CARE HOME II**	STREET ADDRESS, CITY, STATE, ZIP CODE **372 SW TODD AVENUE** **PORT SAINT LUCIE, FL 34983**	

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

0000 Initial Comments

A licensure complaint survey, CCR 2016009013 and 2016009755, was conducted on 10/20/2016 at Harmony Care Home II (license number 12687). The facility had no deficiencies identified at the time of the survey.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 7, 2016

Administrator
Harmony Care Home II
372 SW Todd Avenue
Port Saint Lucie, FL 34983

RE: CCR #2016009013 & 2016009755

Dear Administrator:

This letter reports the findings of a complaint survey completed on October 20, 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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