

Agency for Health Care Administration

|                                                                   |                                                                                                                                                                            |                                                                                     |                                                                                                                          |  |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11943082</b>      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMFORT RESIDENCE, INC</b> |                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>935 SW 9 STREET<br/>MIAMI, FL 33130</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                               | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                             | Initial Comments<br><br>A re-licensure survey was conducted at Comfort<br>Residence, Inc. on July 17, 2024. The provider<br>had no deficiencies at the time of the survey. | A 000                                                                               |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE