

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2025
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NAME OF PROVIDER OR SUPPLIER COMFORT HOMES ASSISTED LIVING FACILITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2150 SW IMPERIAL ST PORT SAINT LUCIE, FL 34987
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An announced Initial Licensure survey for an Assisted Living Facility (for capacity of 5 residents) and a Generator Monitoring survey was conducted on 04/07/2025 at Comfort Homes Assisted Living Facility. The facility had no deficiencies identified at the time of the survey.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE