



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 16, 2012

Administrator
Country Comfort Care, Inc
15340 Mallory Lane
Clermont, FL 34715

Dear Administrator:

This letter reports the findings of an initial Licensure survey conducted on November 7, 2012 by representative(s) of this office. Enclosed is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey. **You will not receive a copy of this report in the mail, you will only receive this faxed report.**

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 surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure

MP96



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2012
NAME OF PROVIDER OR SUPPLIER COUNTRY COMFORT CARE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 15340 MALLORY LN, CLERMONT, FL 34715		
(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 Initial Survey was conducted on 10/07/2012. No deficiencies found at the time of the visit.		A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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If continuation sheet 1 of 1