

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966397	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 6/18/2015
Name of Facility COMFORT MANOR INC.		Street Address, City, State, Zip Code 8087 25 AVENUE NORTH SAINT PETERSBURG, FL 33710

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0125 Reg. # 429.27(2) FS: 58A-5.021(3) LSC _____	Correction Completed 06/18/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By	Date: 6/18/15	Signature of Surveyor: _____	Date: _____
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	CMS RO _____			

Followup to Survey Completed on:
5/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 18, 2015

Administrator
Comfort Manor Inc.
8087 25 Avenue North
Saint Petersburg, FL 33710

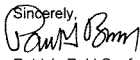
Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on June 18, 2015 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the desk review. **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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,
for 
Patricia Reid Cauffman
Field Office Manager

PRC/cit
Enclosure: State Form (5000-3547)

