

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 05/03/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942921	(X3) DATE SURVEY COMPLETED R 04/25/2016
NAME OF PROVIDER OR SUPPLIER COMPANION HOME CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 1997 SW 17 COURT MIAMI, FL 33145	

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

0000 Initial Comments

A Complaint Investigation Survey (CCR#2016000871) Revisit was conducted on April 26, 2016. Companion Home Corp. with Limited Mental Health and Extended Congregate Care had no deficiencies identified at the time of the survey.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 3, 2016

Administrator
Companion Home Corp
1997 Sw 17 Court
Miami, FL 33145

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on April 25, 2016 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 revisit.

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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Arlene Mayo-Davis".

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

DT9D

