STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943082	08/31/2016
NAME OF PROVIDER OR SUPPLIER **COMFORT RESIDENCE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **935 SW 9 STREET** **MIAMI, FL 33130**	

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

0000 Initial Comments

A Change of Ownership (CHOW) Survey was conducted on / . Comfort Residence, Inc with a Limited Mental Health license # 8369 had the following deficiency found at the time of the survey:

0079 Staffing Standards - Levels

Based on observation, record review, and interview the assisted living facility failed to maintain a written work schedule which reflects its correct staffing pattern for a given time period.

Findings Included:

On / at 8:15 AM, observed staff B and C working in the facility.

Record review showed that Staff B and C were schedule to work from 7:00 AM to 7:00 PM and Staff D was not on the schedule.

A review of the Background Screening Clearinghouse database showed that staff D was hired on .

On / at 11:21 AM, the Administrator stated that he just forgot to put Staff D on the schedule because she comes to cover when other caregivers do not come to work.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Comfort Residence, Inc
935 Sw 9 Street
Miami, FL 33130

Dear Administrator:

This letter reports the findings of a state licensure Change of Ownership survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite 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,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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