

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/26/2020
NAME OF PROVIDER OR SUPPLIER CAPE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 4616-4614 SW 7 PL CAPE CORAL, FL 33914		
(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)	
A 000	Initial Comments An unannounced capacity increase and focused control survey was conducted on at Cape West, an assisted living facility in Cape Coral, Florida. The following is description of the deficiency.	A 000		
A 151	59A-36.014(2) FAC Physical Plant - Existing Facilities (2) EXISTING FACILITIES. (a) An assisted living facility must comply with the rule or building code in effect at the time of initial licensure, as well as the rule or building code in effect at the time of any additions, modifications, alterations, refurbishment, renovations or reconstruction. Determination of the installation of a fire sprinkler system in an existing facility must comply with the requirements described in section 429.41, F.S. (b) A facility undergoing change of ownership is considered an existing facility for purposes of this rule. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with the building code in effect at the time of request for a capacity increase for 2 (# and #) of 2 rooms observed for capacity increase. The findings included: Review of the building code section 434.2 revealed specification: "Resident bedrooms designated for multiple occupancy shall provide a minimum inside measurement of 60 square (6 m2) of usable floor space per room occupant."	A 151		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/26/2020
NAME OF PROVIDER OR SUPPLIER CAPE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 4616-4614 SW 7 PL CAPE CORAL, FL 33914			
(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 151	Continued From page 1 On at 3:00 p.m., ... # ... # each measured 120.15 square . Each room had a built in closet (non usable floor space) measuring 10.8 square leaving a total of 109.35 square ... of usable floor space. The measurements were obtained with the facility's house manager. She stated "I didn't think the rooms were big enough." Class III	A 151			